Social, Economic, and Political Dynamics Shaping Health, Health Services and their Access: A Case Study of Malabar Region

Thesis submitted to Jawaharlal Nehru University for award of the degree of

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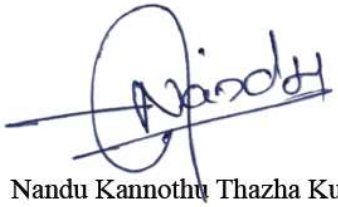
Declaration

The thesis entitled "**Social, Economic, and Political Dynamics Shaping Health, Health Services and their Access: A Case Study of Malabar Region**" is submitted for the award of the Degree of Doctor of Philosophy of Jawaharlal Nehru University. This thesis has not been submitted previously for the award of any other degree of this or any other University and is my original work.



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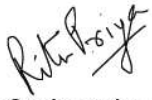

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Dedicated to my parents

Narayani Thaniyulla Parambath

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CONTENTS

ABBREVIATIONS

AGMS	Adivasi Gothra Maha Sabha
APL	Above Poverty Line
ARI	Acute Respiratory Infection.
ASHA	Accredited Social Health Activist
AVS	Atma Vidya Sangam
AYUSH	Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy
BJP	Bharthiya Janatha Party
BPL	Below Poverty Line
C&AG	Controller & Auditor General
CHC	Community Health Centre
CMC	Calicut Medical College
CPI(M)	Communist Party of India (Marxist)
CRS	Civil Registration System
DHS	Directorate of Health Services
DLHS	District Level Household and Facility Survey
ESZ	Ecologically Sensitive Zones
GSDP	Gross State Domestic Product
HDI	Human Development Index
ICDS	Integrated Child Development Scheme
ICU	Intensive Care Unit
IERB	Institutional Ethics Review Board
IMR	Infant Mortality Rate
INC	Indian National Congress
IUML	Indian Union of Muslim League
KSCSTE	Kerala State Council for Science, Technology and Environment
KSPB	Kerala State Planning Board
KSSP	Kerala Sasthra Sahithya Parishad

LDF	Left Democratic Front
LIFE	Livelihood Inclusion and Financial Empowerment
LKG	Lower Kindergarten
LPG	Liquid Petroleum Gas
MES	Muslim Education Society
MMR	Maternal Mortality Rate
MNREGA	Mahatma Gandhi National Rural Employment Guarantee Act
MPCE	Monthly Per-capita Consumer Expenditure
MSME	Micro, Small and Medium Enterprises
NCD	Non Communicable Disease
NDA	National Democratic Alliance
NDP	National Democratic Party
NFHS	National Family Health Survey
NSS	Nair Service Society
NSSO	National Sample Survey Office
OBC	Other Backward Caste
OOP	Out-Of-Pocket
OPD	Out Patient Department
PCI	Per capita Income
PDS	Public Distribution System
PHC	Primary Health Centre
SC	Scheduled Caste
SECC	Socio Economic and Caste Census
SHG	Self Help Groups
SNDPY	Sree Narayana Dharma Paripalana Yogam
SRS	Sample Registration System
ST	Scheduled Tribe
TV	Television

UDF	United Democratic Front
UHC	Universal Health Coverage
UNDP	United Nations Development Programme
UNESCO	United Nations Educational, Scientific and Cultural Organization.
WGEEP	Western Ghats Ecology Expert Panel
WHO	World Health Organization

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Introduction

On the eve of a day in 2016, a meeting of some villagers had started in the verandah of a house in a rural village of Kozhikode to discuss the crisis emerged out of a health emergency in the family of a daily wage labour. The meeting was attended by 28 men from different social groups of the neighboring houses and formed a 'treatment relief committee'. A retired schoolteacher among them addressed the group first by explaining the patient's current health situation, Mr.Sajeevan, who was admitted into the ICU of a private hospital in the Kozhikode city, 55 km away from the village. The group consisting of one Gulf returnee, a businessman, some local construction contractors and remaining daily wage labourers, all contributed to the discussion about the family's poor financial condition and collecting financial assistance from the villagers to help the patient. Accordingly, they were divided into three groups for the next seven days and collected financial assistance from the villagers.

The financial contribution collected by the treatment relief committee ensured quality care for the patient at one of the well-known private hospital in the district. However, Mr. Sajeevan does not completely recovered, after three months of treatment; he has been bedridden at his house. His elderly mother,wife, and children of eight and ten years old lived with him in his partially constructed house. By understanding the loss of income from the sole breadwinner of the family, the treatment relief committee extended support to complete the construction of his house. The committee deposited the left-out amount collected from villagers into a newly opened bank account of the children to use in future. The committee also took the initiative to get a job for his wife as sweeper in an allopathic clinic in the nearby village.

His story is not unique; it reflects the social resources available to some of the labouring poor in dealing with the obstacles which confront while seeking health care in catastrophe. But such social networks and resources are not available to all; a large section of marginalized communities in the state does not enjoy such safeguards. What does the marginalized do then and who are the others enjoying the benefits of various resources which necessitate the protection of health, are all important to be explored to understand the inequity in health and health care utilization. Besides health care utilization, such social networks and resources also influence in shaping the health of people. Social variables have a much more direct and

fundamental influence in inducing adversity or enrichment in health outcomes (Cockerham 2008). In the above narrative, Mr. Sajeesh is a daily wage labour belonging to Thiyya community from one of the rural villages of the Malabar region of Kerala. All daily wage labours from the region do not enjoy such supports; what helps him in getting support is the socioeconomic background of his family, the wider social structure and social dynamics in the village he lives. Among the major social groups in the Malabar region, the marginalized Dalits and Adivasis are least equipped to get any such support compared to upper caste Hindus, Muslims, Thiyyas, and Christians. To understand these differences in health resources among various social groups, the present study looks into the socioeconomic characteristics of various social groups in the backdrop of their diverse social histories and their health and health care outcomes.

The social context of an individual shapes the risk of exposure, susceptibility of the host, and disease's course and outcome, even if the disease is infectious, genetic, malignant, or degenerative (Conley et al. 2003). To understand the social context of people from Malabar under which their health has been shaped, the analysis needs to be undertaken at various levels, at the family level in the backdrop of the household resources available, at the village level in the background of the diverse social histories of various social groups, and at the district and regional level to understand the social process of development as it happened in the state. The developmental process that happened in the state leads to relative gains of some social groups and sub-regions and the relative lack of some other social groups and sub-regions. In fact, there is an intersection of the least developed sub-regions and social groups, leading to further deprivation of human development and health status in certain sub-regions of the state. Studies from the region found that caste and ethnicity interact with socioeconomic variables on health by magnifying or buffering the effect among different social groups (Mohindra et al. 2006).

As elsewhere in the country, marginalized communities face exclusion and discrimination in various spheres of public life in the state too. However, in Kerala they enjoy a comparative advantage in terms of health as compared to other parts of the country (Bhat and Rajan 1980; UNDP 2006). Even after the comparative advantage over their counterparts from the rest of the country, within the state, marginalized communities face a large disparity in quality of life compared to other social groups. The Adivasi, followed by the Dalit community, have the lowest

level of socioeconomic resources available at the household level compared to other social groups in the state. For example, the district-wise deprivation index calculated on the basis of the quality of housing, availability of drinking water, sanitation and electricity for 2001 shows the highest deprivation index for Adivasis and Dalits in all districts of Kerala (UNDP 2013). Further poverty is recorded highest among them, their health status remains the lowest, their representation in government employment, in the leadership of social and political organizations, and in higher education is lower. In fact, during 2001, Kerala has the highest gap between the tribal and no-tribal populations in various socio-economic development indicators compared to the rest of the country (Chandran 2012). Marginalized communities, especially Dalits and Adivasis from the region and from all over the state face higher levels of morbidity and necessitous access to healthcare (C&AG 2014; Haddad et al. 2012; Kannan et al. 1991; Navaneethan and Kabir 2009). Further, on general population health indicators, including the rate of infant mortality, maternal mortality and under-five mortality, the marginalized communities lag behind others (Ministry of Tribal Affairs 2013).

On the other hand, communities, like, Thiyyas and Muslims from the state were able to succeed in many aspects of social life. They become politically strongholds in the state through the establishment of political parties and socio-religious organizations and through the benefits of reform movements happened among them. The earlier untouchable caste Thiyyas were able to articulate a higher social status comparable with the *Nayars* (Panikkar 1983). They did not face discrimination on caste lines as much as that of other lower castes like Dalits in the state. Thiyyas emerged as a powerful social group in the Malabar and all over the state, and there existed an atmosphere in which the claims of a backward Thiyya group could be articulated and substantiated (Mundon 2003). The Muslim community, as a result of the affluence of emigration and the reform movements, widely embraced the modern values of health and education (Osella & Osella 2009). Muslims as a community developed status to influence the socioeconomic and political development of the Malabar region. A large section of Muslims from the region were not only able to avail care from private health care institutions, but also able to study in such institutions, as a result of the affluence of remittance from the Gulf and the emergence of many minority medical educational institutions (Nafeesathul 2014, Nazeer 2011). The improved socioeconomic status of Muslims bears a direct positive impact on their health, especially the health of their children (Banerjee et al. 2002).

The upper caste Hindu Nayars were formerly the ‘dominant caste’ of Kerala in economic, social and political power (Jeffrey 1994). From a very early time itself, the upper castes' share of enrollment in educational institutions was higher than their share in the total population (Aiyar 1918). The case of upper castes in representation of government employment is also not different (KSSP 2006). Their employment situation is in complete contrast to that of the lower castes and their participation in manual labour is almost nil (Scaria 2014). Previously medical profession was generally opened to the affluent communities like upper caste Nayars and Christians only until the other communities attained middle-class status (Wilson 2010). As a result, the upper caste Nayar community was always able to take advantage of development that happened in socioeconomic and health sectors of the Malabar region.

The most common strategy followed by caste groups for acquiring a presence in the development of Kerala during the early twentieth century was to build modern community organizations that would then negotiate with the state for resources. All caste groups followed this strategy, but when lack of economic resources was a major hurdle in the path of the lower-caste groups, higher castes were easily succeeded in modern community formation (Zacharias and Devika 2006). Social groups like Muslim, Christian, Nayar, and Thiyya communities were able to succeed in such ways. Even though there were attempts and limited success in Adivasis and Dalits' political organization, they lacked resources to support their movements. While the reform movements and developmental process uplifted the Malabar region from its historical backwardness, the benefits of this development varied from one sub-region to another and the marginalized communities like Adivasis, Dalits, agricultural workers, women, and fishing community were left out to a large extent (Kurien 1995; Mencher 1980; Omvedt 2006; Tharamangalam 2006).

The development of various social groups in the Malabar region happened in the background of differential socioeconomic development happened among three regions in the state. Before the formation of the state of Kerala in 1956, the area consists of three erstwhile administrative units – the princely state of Travancore, Cochin, and the Malabar district of the Madras presidency. In the differential socioeconomic development of these three regions, the Malabar lags behind the other two regions. Additionally, within the Malabar region, there existed immense variation in the development of various sub-regions. This variation has impacted the development of health

resources among various social groups and health infrastructure among the sub-regions, and also in the health outcomes of the people living in the different sub-regions.

The differences in processes and outcomes of development in the three erstwhile regions are the historical background of regional disparities in Kerala's development experience (CDS-UN 1975; Kabir and Krishnan 1992; Tharakan 1996; Ramachandran 1997; Jeffrey 2016). There were widespread differences in development among the three regions until the state formation. Travancore in the south had maintained significant progress in its population's educational and health status compared to Malabar in the north. Kochi in the middle of the state, achived development experience par with Travancore. During the last several decades, the Malabar region has made remarkable achievements in expanding public facilities and developmental outcomes, bridging the gap with other parts of the state (Kabir and Krishnan 1992). However, the region still lags in developmental indicators due to disparities among social groups and sub-region within Malabar. When the inequalities in socio-economic development between the southern (Travancore and Cochin) and northern (Malabar) part of the state are equated with health-related differences, the southern part that performed better in socio-economic development reported better health status and health resources.

Both the regions' political arena was too different that until independence, the southern part was ruled by progressive kings who gave importance to social development (Desai 2005; Kabir and Krishnan 1992; Tharakan 1984; Panikar 1975). On the other hand, right up to independence, the Malabar region was under the direct control of the colonial government, which gave the least importance to people's socioeconomic betterment. Besides, Malabar's political arena was unrest for an extended period due to frequent mutinies and invasion by rulers of Mysore from 1766 to 1792. Such differences can also be observed in the experience of social, cultural and reform movements among these regions. The reform movements of lower caste that happened in the southern part of the state improved the social status of many Dalits and other marginalized (Bose 2006; Oommen 2004). In the Malabar, even though the lower caste Thiyya and poor Muslims were able to build up their social and cultural capital, such major movements did not bring substantial improvements in the social status of scheduled tribes (ST) and Dalits (Steur 2011). The presence of Christian missionaries in the Travancore played a significant role in the progress of many poor (Cleetus 2007; Desai 2005; Tharakan 1984), which has not happened in a similar

manner at Malabar. The differences in developmental experiences of the regions in itself is not the problem, the problem is that these differences have proved immune to a plethora of development policies pursued over several decades from the state formation. This necessitates looking into the issue in greater detail in the context of the intersection of area level inequality with social group wise inequality in the state.

The concern over health and ill-health most probably suggest remedies through hospitals, doctors, nurses and drugs in the mind of most. A much broader range of factors like food, housing, income and employment generally not conjure up. In the case of the agricultural labour in the above narrative, beyond ensuring quality health care, the food requirement, education of children, housing requirement, and livelihood of the family are all protected to ensure a speedy recovery of the diseased and better health of other family members. However, such benefits are not available to all, in fact, the social, economic, and political processes responsible for the variegated development across different social groups and sub-regions resulted in a situation where some were not able to achieve minimum attainable health and effective use of existing health care facilities. Nevertheless, within the marginalized communities, Thiyyas and Muslims were able to catch-up with the dominant communities in terms of socioeconomic and political status, and also improvement in their health and access to health care resources. From a health system perspective, the present study, looks into these issues of health inequality under the socioeconomic and political conditions in which certain social groups and sub-regions are unable to make a significant change in their health status. For an in-depth analysis the five major social groups from one of the sub-region of Malabar are examined through their social and health histories in the backdrop of the overall development experience of the region.

The organization of chapters

Guided by an understanding of basic issues in public health and social development, the first chapter presents the key discussions in literature informing the arguments presented in this thesis. In the first part, the review draws on recent debates in the social process of development and its relationship with health outcomes. Further, it discusses the politics of social determinants in health through the concepts of Equity / Inequity and Equality / Inequality in health and the issues concerning its measurement. The second part examines the health status and development experience of the state by discussing the regions of Kerala and their development experiences,

the health status of regions and social groups, and the development of health services. The third part examines the development experience of the Malabar and its sub-regions. It thus explores the experience of socioeconomic development among various social groups and sub-regions of Malabar along with the development of health and health services.

Chapter two outlines the methods used to understand the process through which uneven developmental trajectories resulted in health status disparities within and across different social groups and sub-regions in Malabar. Chapter three explores the developmental experiences of the village, panchayat and the district where an in-depth study has been done by presenting historical development, present overall situation and differences across various social groups. Chapter four explores the diverse social histories of all major social groups in the study village in the backdrop of the wider social structure and nature of Kerala society. Chapter five explores the health seeking behaviour of all five social groups selected in the context of the development of health care resources among them. The final chapter brings all ideas together to illustrate the shaping of health perception and health care utilization by weaving in all the various dimensions examined in the thesis. It first discusses the shaping of health perception among various social groups and then the characteristics of health care utilization among social groups in the context of their diverse health and social histories. In the last section, the bases which ultimately shape health perception and health care utilization among different social groups are discussed.

Chapter I

Development as a Social Process with Health Outcomes: A Review of Literature

Guided by an understanding of basic issues in public health and social development, this chapter presents the key discussions in literature informing the arguments presented in this thesis. Through which the chapter first contextualize the significance of the research problem and then sets out the background for research questions to be answered. In the first part, the review draws on recent debates in the social process of development and its relationship with health outcomes. Further, it discusses the politics of social determinants in health through the concepts of Equity / Inequity and Equality / Inequality in health and the issues concerning its measurement. The second part talks about the health status and development experience of the state by discussing the regions of Kerala and their development experiences, the health status of regions and social groups, and the development of health services. The third part discusses the development experience of the Malabar and its sub-regions. It thus explores the experience of socioeconomic development among various social groups and sub-regions along with the development of health services.

Part A: Development as a social process with health outcomes

Twentieth century has witnessed a growing concern towards unequal regional growth; and the need for a wider explanation to it which is beyond the economic development measured through per capita income growth. In line with this, it is estimated that all over the world and particularly in India, even the basic opportunity for life is inequitably distributed (World Bank 2005). Inequality of opportunities nurtures extreme deprivation and often weakens prospects for overall prosperity and economic growth among nations and regions within them. As a result, the development never shapes uniform either for various population subgroups or regions. The differences in development can be observed internationally – between the developed, developing, and the least developed countries; for example, the difference in life expectancy at birth between low and very high human development countries is still 19 years (UNDP 2019). The differences

can also be observed nationally – between different regions of the country, for example, between the Empowered Action Group States and the Southern states in India (Bose 2007; Yadav 2017). Lastly, there can be differential development inside a region and even within a village; for example, even after a total decline in rural poverty in India, evidence shows that the progress has been slow and irregular and that inequalities within villages have been persisted. (Lanjouw and Jayaraman 1999; Rawal and Swaminathan 2011).

The most affected groups by such inequitable development are the marginalized sections that being deprived of all possible opportunities. For example, mutually reinforcing factors shape socially excluded also economically marginalized, and economically marginalized remain socially excluded (Kurian 2007).Across the world, inequality tracks differences of social identity such as gender, race, ethnicity, religion, caste, class, and sexual orientation. This arbitrarily marks some social groups as superior to others in the opportunities they enjoy, the powers they command, and the respect others owe them (UNDP 2019). Thus, in addition to area-level inequality, another aspect of understanding disparity in development is the inter-group inequalities in distributing a society's burden and benefits. For example, the Human Development Index (HDI) of Scheduled Caste (SC) and ST estimated in India for the year 2000 was as low as 0.303 and 0.270 respectively compared to 0.393 for all other social groups together.

Further, even the state of Kerala that recorded the highest HDI among Indian states shows a similar trend of lower HDI for SC (0.661) and ST (0.613) compared to other social groups (0.755) (Thorat 2007). In fact, in the Indian context, there is a need to look inward, within the country to identify groups that fare poorly in human development as against spatially. Deprivation in India has an apparent face of exclusion, the schedule castes due to social exclusion, and the schedule tribes due to geographical and cultural exclusion (Madhya Pradesh State Development Report 2002).

On the other hand, increasing equality reduces poverty, favors sustainable overall development, and delivers an increased opportunity to the poor (Bourguignon and Morrisson 2002). As a result, in order to obtain equality, balanced development and convergence across regions become the main criteria for action by the governments (Thorat 2007). Developing countries are

increasingly engaged in extending all kinds of services to rural areas that were formerly neglected. This includes activities like building roads, building canals for irrigation, introducing better seed and fertilizers, opening schools and higher educational institutions, and establishing rural health institutions. At various levels, the governments have started adopting group focus approaches on the development policy like recognition of group-specific problems, provision of legal safeguards, reservation, and various other affirmative action policies (Thorat 2007). However, nothing more than equalizing outcomes becomes the goal, without much intervention to look who owns the productive resources and uses them for what purpose. Showing that the tide of development has not yet reached everywhere, and the followed conceptualization of development does not touch some of the important aspects of human life. What kind of a rising tide lifts all the boats together? and why does a particular nature of development lift only a few boats? are all important. This shows equalization of outcomes is not enough and structural changes are needed, which in turn opens ways towards a discussion on the nature of development followed.

The development has been traditionally associated with economic growth. The definition of development- resulting from macro and micro inequalities increasingly promoted during the 1970s and 1980s stressed the importance of combating poverty rather than promoting industrialization and modernization. Even though it was strongly welfare-oriented, it did not challenge existing political structures (Mosley 1987). Since the early 1990s, there has been another noticeable shift in the focus of development thinking from mere economic growth to enhancing human wellbeing (Dasgupta 2007; Sen 1985, 1999). By understanding the development needs of the society, the concept of development has been defined and redefined over and again and, accordingly, evolved the terms like sustainable development, participatory development, and human development. A recent measure of economic and social deprivation that received much international attention is the Human Development Index offered by the United Nations Development Programme in 1990. This is a composite index; it seeks to combine data on three essential features of the quality of life- adequate level of income, good health, and education into a single index.

The recent advancements in the thought of development resulted in the focus on the person as the unit of analysis instead of the economy, and the space in which progress is assessed is made of

capabilities and freedoms instead of income (Conconi and Viollaz 2017). Here Amartya Sen's (Sen 1999) approach is important, that goes beyond the total average wellbeing in society and more precisely looks at the opportunities available to each person. Such a change of paradigm also brought several practical concerns in understanding and measuring development. The focus on persons instead of society reflects moving from the concept of development to that of human development. Further, multiple dimensions of human development are flexible, meaning that different cultural and national contexts may have a distinct set of dimensions (Sen 2004). Development is viewed as a more diverged concept denoting improvement in the quality life of people extending much beyond direct gain from increased production of commodities and services. "It is not only people having more but being more; more just, more concerned, more cooperative, more sharing and more human. Development is people involving in transforming themselves and in transforming the structure that dehumanizes and oppresses them so that they can have and be more. It is in other words, people regaining control over lives and destiny" (Joseph and Desrochers 1985). Thus, development is not limited to having growth in various aspects of human life and society, but also being able to alleviate inequality and marginalization in society. Thus, it involves the reorientation and reorganization of the entire economic and social system. It involves radical changes in the institutional, social, and administrative structure as well as in popular attitudes and in many cases customs and beliefs structure (Singh 2009).

Development involves having and being able to have material and non-material resources for all sections of the population. This can be obtained only by addressing inequality, which is people having differential abilities based on the resources available to them; and addressing marginalization, which is the deprivation of resources among certain population subgroups. The concept of inequality has been traditionally focused on measuring the spread of the distribution of outcome variables, such as level of income, educational achievement, or health status (Conconi and Viollaz 2017). However, among populations, the way outcomes are converted into well-being depends on many factors, including demographic characteristics, and other household level and societal level socio-economic, and political factors. Thus, understanding the marginalization process in society is vital while comparing outcome variables. For example, the way education, health, and wealth affect the wellbeing of marginalized communities is not the same way as it happens among the fortunate who do not face any difficulties of marginalization. Here, along with equalizing resource availability, the opportunities people have to practice their

freedoms are important. Because inequalities of opportunities like constraints to people's choices and freedoms negatively impact human development and wellbeing (UNDP 2005).

The development experience of Kerala state has been presented by studies, especially for its considerable progress in various aspects of social development(CDS-UN 1975; Drèze and Sen 2005; Franke and Chasin 1992). The state has been able to provide for the basic needs of most of its citizens by prioritizing health and various social determinants of health. For example, the decline in Kerala's mortality rate during the early decades of the twentieth century can partly be traced to the decline in mortality due to infectious disease. Further, such a large decline in mortality due to infectious diseases was mainly attained through public measures in various aspects of social development with a focus on health. This includes public works in sanitation, drainage, protected water supply, public health education, and schemes to promote personal and environmental hygiene (Panikar 1975). Thus, evidence from the state itself and rest of the world has already shown that a comprehensive social process of development that goes beyond mere economic growth, and values various socio-political and cultural aspects of human life will render better health outcomes (Panikar 1975; Bourguignon et al. 2008). Thus, it is vital that governments of various levels ensure that health and determinants of health are prioritized within overall development policies. Nevertheless, there are still some groups and sub-regions who have not been able to derive benefits from development of basic services as others (Deshpande 2000; Scaria 2014; Jacob 2014; Nandu 2015; Thresia 2018; Edison and Devi 2019; Haddad et al. 2012; George et al. 2020). The state human development report 2005 reported significant variation in the level of human development across districts and social groups in Kerala. In case of HDI, the district of Ernakulam is in the topmost position, followed by Thrissur and Kottayam in 2001. At the same time, the district Wayanad occupied the bottom position followed by Idukki and Palakkad.

Similarly, there is significant variation in the level of human development across various social groups in the state. The marginalized communities ST and SC in the state lag behind other social groups in human development. In fact, the data shows that it is these regions and social groups that lag in human development that has the worst health outcomes in the state (Haddad et al. 2012; Nayar 2007, also see table 1.1). The developmental process that happened in the state leads to relative gains of some social groups and sub-regions and the relative lack of some other

social groups and sub-regions. In fact, there is an intersection of least developed sub-regions and least developed social groups, leading to further deprivation of human development and health status in certain sub-regions in the state, especially in Malabar.

Social epidemiology of development

As discussed in the previous section, health and health outcomes among the people are interminably linked to the overall development paradigm. When the inequalities in socio-economic development between southern and northern part of the state are equated with health-related differences, the southern part that performed better in socioeconomic development reported better health status and health resources. Similarly, throughout the state and especially in Malabar, marginalized communities lag in socio-economic development and health status (Deshpande 2000; Nayar 2007). When we look into the reason for developmental inequality among different regions and social groups in Kerala, we can see the crucial role of various social, economic, political, and cultural factors. Both the regions' political arena was too different that until independence, the southern part was ruled by progressive kings who give importance to social development (Desai 2005; Kabir and Krishnan 1992; Tharakan 1984; Panikar 1975). On the other hand, right up to independence, the Malabar region was under the direct control of the colonial government, which gave least importance to people's socio-economic betterment. Besides, Malabar's political arena was unrest for an extended period due to frequent mutinies and invasion by rulers of Mysore from 1766 to 1792. Such differences can also be observed in the experience of social, cultural and reform movements among these regions. The presence of Christian missionaries in the Travancore played a significant role in the progress of many poor (Cleetus 2007; Desai 2005; Tharakan 1984), which has not happened in a similar manner at Malabar. The reform movements of lower caste that happened in the southern part of the state improved the social status of many Dalits and other marginalized (Bose 2006; Oommen 2004). In the Malabar, even though the lower caste Thiyya and poor Muslims were able to build up their social and cultural capital, such major movements did not bring substantial improvements in the social status of scheduled tribes and Dalits (Steur 2011).

When we recognize people’s health status as part of the larger work of human development, we recognize the fact that people do not get sick randomly, but concerning their living, working,

environmental, social, and political contexts, as well as about biological and environmental factors that are unevenly distributed in the population. In the case of socioeconomic and health status, Malabar and marginalized communities turn out to be outliers in Kerala's overall development history. It shows disparities in development among different regions and social groups in the state, resulting in avoidable mortality, morbidity, poorer quality of life, and setback in other aspects of wellbeing. Further, when we point out that to mitigate health inequity a proposal of redistribution of social determinants of health and health services is needed, we must show that the current distribution has aspects of discrimination that are avoidable in several senses, including technically, financially, and morally (PAHO WHO 1999). The way we identify avoidable health differences could vary from region to region and time to time, but explorable by comparing with what is happening in the rest of the society. In other words, to understand certain situations as inequitable, the cause must be studied and judged to be unfair in the backdrop of what is going on in the rest of the society (Whitehead 1992). In a widely cited paper, Whitehead defined health inequities as differences in health that are unnecessary, avoidable, unfair, and unjust(Whitehead 1992). This means that not all health disparities are unfair or avoidable. For example, as Braveman and Gruskin (2003) pointed out, generally people expect young adults to be healthier than the elderly population. Men have prostate complications, while women do not. It would be difficult, however, to argue that any of such health inequalities are unfair. However, differences in nutritional status between girls and boys, or religious or ethnic differences in the likelihood of receiving appropriate care for any disease, would be causes for grave concern from an equity perspective.

What is important here is the difference between inequity/equity and inequality/equality. The concept of health equity focuses attention on the distribution of resources and other processes that drive a particular kind of health inequality—that is, a systematic inequality in health (or in its social determinants) between more and less advantaged social groups, in other words, a health inequality that is unjust or unfair (Braveman and Gruskin 2003). The concept of equity is inherently normative - that is, value-based (Whitehead 1992); while equality is not necessarily so (Chang 2002). In line with this Kawachi et al. (2002) defines these terms. They define health inequality as the general term used to describe variations and disparities in the health achievements and risk factors of individuals and population sub-groups that need not imply

moral judgement. Further, defined health inequity as those inequalities in health that are deemed to be unfair or stemming from some form of injustice. They further express that, on one account, most of the health inequalities across social groups are unjust because they reflect an unfair distribution of the underlying social determinants of health. The condition that needs to be met for regarding health inequalities as fair is, in fact, extremely stringent. Thus, many genetic differences, exposure to different childhood conditions, differences in most health behaviors, as well as most environmental exposure are unfair (Kawachi et al. 2002).

To the understanding of equity and equality, the critical question to be answered is "equality of what?", arguing that this question provides the necessary discipline to allow for a proper consideration of inequality in a given field (Sen 1995). For Sen (1995), understanding inequality in human societies begin with an appreciation of humankind's inherent heterogeneity, that all individuals are not created equal as they are genetically and socially different. Therefore, any notion of equality must somehow accommodate these personal and circumstantial variations and it is vital to understand inequalities within the complexity of the social world (Forbes and Wainwright 2001). Thus, any definition of health disparities simply reflects differences in health outcomes, like defining inequality as unequal in a purely mathematical sense is not enough. The heterogeneous population with different ethical, philosophical, legal, cultural, and technical perspectives may generate different definitions of health disparities or inequalities.

Health disparities more adversely affect groups who are already disadvantaged socially, putting them at a further disadvantage to health brings more difficult to overcome social disadvantage (Sen 1999). This reinforcement of social disadvantage is what makes health disparities relevant to social justice and human rights. Further, health differences adversely affecting socially disadvantaged groups are particularly unacceptable because ill health can be an obstacle to individual rights to overcome social disadvantages. Briefly, the concepts of health equity are rooted in internationally recognized ethical and human rights principles. Thus, health is seen as a fundamental right and something which should be enjoyed by all without any discrimination. As outlined in the WHO Constitution (WHO 1946), the right to health is the right to "the highest attainable standard of health." However, this notion of ‘highest attainable standard’ has been criticized for being difficult to operationalize. Nevertheless, the health levels of the most privileged groups in a society at least reflect minimum standards of what should be possible for

everyone in that society within the foreseeable future (Braveman and Gruskin 2003). Here identifying the privileged and underprivileged or pointing out the inequity in a society is more open to interpretations. Moreover, at a societal level, it is generally those who are in positions of power are likely to be determining what is equitable and what is not, regarding the allocation of resources necessary for health (Braveman and Gruskin 2003). Instead of the power hold by some, any attempts to interpret equity need to be justified by the human rights concept of non-discrimination and public responsibility to eliminate adverse discrimination.

Any health disparity between more and less advantaged social groups constitutes an inequity not merely because we are knowledgeable about the proximate causes of that disparity and judge them to be unjust. Instead, for the reason that the disparity is strongly associated with unjust social structures (Braveman and Gruskin 2003). Those unjust structures are the ones that systematically put disadvantaged social groups at increased risk of ill health and compound the social and economic consequences of ill health. Therefore, what is important in assessing equity is comparing how better-off and worse-off social groups are faring in relation to each other. Any measure of health disparities without respect to how the disparities are distributed socially cannot be treated as a measure of equity and such measures do not reflect fairness or justice with respect to health (Alleyne, Casas, and Castillo-Salgado 2000; Anand 2002; Braveman, Krieger, and Lynch 2000). Further, when a particular health disparity in society is systematically seen across income groups, the underlying causal differences could be in factors associated with income rather than income itself; thus, it would be a mistake to assume that efforts focused only on equalizing income would necessarily be effective in reducing that inequity. Equity in health thus implies that resources are distributed, and processes are designed in ways most likely to move toward equalizing the health outcomes of disadvantaged social groups with the outcomes of their more advantaged counterparts. (Braveman and Gruskin 2003).

Issues in measuring health inequality

Along with increasing inequality studies in health, concerns over measuring disparities in health are on the rise. To find a suitable measurement strategy, understanding how health is distributed among people in a region and exploring the mechanisms which lead to health disparity is important. Asada (2005) point out, this is done mainly in two ways, one by examining the

uneven distribution of health between regions without reference to population subgroups within the regions and the other by examining differences in health status across population subgroups categorized based on age, sex, ethnicity, religion, and social class. In such studies, measuring differences in health by group, for example, income, education, or ethnicity, has become the standard method for health inequality analysis (Asada 2005). However, this has been criticized by the World Health Organization (WHO) by proposing individuals, instead of groups, as the unit of analysis (Murray, Gakidou, and Frenk 1999). This has stimulated discussion on why and how we measure health disparity. The choice of unit of observation and socio-economic variables depends on the objectives to be addressed. Evaluation of interventions aimed at individuals requires individual-level observations, whereas intervention focusing on whole areas requires group observations or individual observations with the group variables (Regidor 2004).

Authors have cautioned that conclusions derived about the trend in health inequity might vary depending on the type of measurement (Almeida et al. 2001, Murray et al. 1999). To overcome this Asada (2005) proposes three essential steps in measuring health inequity. Beginning with defining the unequal health distribution, then determining the measurement strategy appropriate to operationalize the concept of equity, and finally quantifying health inequity information. Defining strict equality in health distribution is not well-accepted, on the one hand, it neglects personal choices and on the other hand, it subdued that some of the determinants of health are beyond human control. Thus, it demands to relax the strictness in defining health equity in one way or another (Asada 2005). One of the ways to drop the strict equality in health is by focusing on various determinants of health. In other words, health inequities are the product of inequality between different determinants of health. The WHO bulletin (Murray et al. 1999) proposes considering health inequalities caused by factors amenable to human intervention as inequitable (Asada and Hedemann 2002). Thus, as Braveman & Gruskin (2003) point out a fair operational definition for measuring health equity could be the absence of disparities in health (and in its key determinants) that are systematically associated with social advantage/disadvantage.

Evidence has already been built up from different parts of the world to prove that socioeconomic factors like income, wealth, and education are essential factors that affect health outcomes (Braveman and Gottlieb 2014). Concerns with poverty and socio-economic aspects of health started being widely emphasized since the WHO initiative at Alma Ata in 1978. The Black report

of the United Kingdom in 1980, the Jakarta Conference on health promotion in 1997, and the report of the WHO Commission on Social Determinants of Health in 2008 are some of the prominent documents that have attested to the role of poverty and other socio-economic determinants on health. Most countries have adopted the legal commitments to achieve universal health coverage with an emphasis on social determinants; however, translation of legal commitment to a comprehensive public health care system is found lacking in political will in several developing countries (Stuckler et al. 2010). Further, what is observed is a move towards focus only on the health service system, and further promoting selective primary health care focusing on selected health problems only (Banerji 2004). Such acts are against the idea of equity that is based in ethical principles and closely related to human rights principles. Hence, it is vital to consider the aspects of justice, particularly when dealing with the health of marginalized or other socially disadvantaged groups who experience social inequality embedded with injustice.

Part B: Health status and development experience of Kerala

In its present form, the state of Kerala was founded in 1956 by merging three erstwhile administrative units – the princely state of Travancore, Cochin, and the Malabar district of the Madras presidency. The differences in processes and outcomes of development in these three erstwhile regions are well documented while studying the historical background of Kerala's development experience (CDS-UN 1975; Kabir and Krishnan 1992; Tharakan 1996; Ramachandran 1997; Jeffrey 2016). The Human Development Report published in 2006, gives a brief picture of disparities in development among regions in the state for the period before state formation. The report suggests widespread differences in development among three regions as one of the state's major developmental challenges during its formation. During the time, Travancore in the south had maintained significant progress in its population's educational and health status compared to Malabar in the north. Kochi in the middle of the state fell in between. During the last several decades, the Malabar region has made remarkable achievements in expanding public facilities and developmental outcomes, bridging the gap with other parts of the state (Kabir and Krishnan 1992). However, the region still lags in developmental indicators due to disparities among social groups and sub-region within Malabar.

Travancore and Cochin were princely states under their local rulers until the independence of India. Even at the time of the colonial period both the regions were ruled by local kings by having treaties with the British (Sugeetha 1997). On the other hand, in Malabar, even before the conquer of Britishers the region met with invasion from Mysore rulers from 1766 to 1792. Through Tipu Sultan's defeat in 1792, the region comes under direct British rule for around one and half-century. Such vast differences in regions' political scenarios had far-reaching impacts on various sectors of development like agriculture, education, and health. For example, the agrarian structure in the three regions was explicitly different and it had far-reaching effects on the economies of each region. In Travancore, a substantial proportion of the land was brought under state control and was cultivated by numerous tenants, who have subsequently conferred ownership rights through a Royal Proclamation in 1865. Nearly half a century later in Cochin, a similar proclamation of conferring land ownership rights to state's tenants was promulgated in 1909. On the other hand, in Malabar, no serious legislative measures for tenancy reforms were taken up until the second decade of the 20th century. In fact, the agrarian history of Malabar throughout the colonial period was one of rack-renting and impoverishment of the peasantry (Radhakrishnan 1989). Over the period, the comparative advantage of the two southern regions in land ownership and agriculture led to shaping their economic environment much more supportive of improving people's wellbeing compared to Malabar (UNDP 2006).

The advantage created by the commercialization of agriculture and the modernization programmes initiated during the 19th century in Travancore led the progress in education and health (Tharakan 1984). The increase in the revenue of the Travancore government through expansion in trade and agriculture facilitated the government to increasingly spend on social services, especially in education and health care. Even though not up to the extent of Travancore, Cochin also had made remarkable progress in education and health care by the turn of the 20th century. In Malabar, instead of focusing on the socioeconomic betterment of the public, the colonial government's attention was on accumulating their revenue (Radhakrishnan 1989). Even though the colonial government made attempts to extend education and health care facilities since the 1860s, the burden of opening schools and medical institutions was left almost entirely to local initiatives. With limited resources, the progress that the local bodies could make in education and health care was too limited.

Again, unlike in Travancore, where commercialization of agriculture had raised incomes of different sections of the community, in Malabar, benefits of the limited progress of commercialization were restricted to the landlords and the rich upper-class tenants, as also to large traders in the urban centres (Radhakrishnan 1989). The initial momentum in social development that Travancore had generated during the second half of the 19th century became stronger during the first half of the 20th century. This was because of proactive state response to caste or religion-based social reform movements. The reform movements raised the question of access to health care and education of the socially excluded as a matter of right and placed it before the State (Tharakan 1996). Again, Malabar lagged with little progress in education or in other areas.

The role of socio-religious reform movements among the lower and outcastes during the 19th and early 20th centuries to ensure some of the essential civic rights have been documented (Tharakan 1996). Some low castes, especially the Thiyyas (Ezhava's), seized the opportunities offered by the economic changes from the latter half of the 19th century to improve their economic position. The Sree Narayana Dharma Paripalana (SNDP) Yogam, established in 1903 to propagate Sri Narayana Guru's teachings were the torchbearer of the emerging consciousness among Thiyyas. Parallelly, Ayyankali, the leader of the Pulayas (Dalits) made momentum in their fight for the cause of the depressed castes. Another noticeable progress through the socio-religious reform movement was among Muslims and Christians (Houtart and Lemercinier 1978). Initially, each organization raised its demands independently without forging alliances, and gradually, the caste-based movements gave way to organized political movements (UNDP 2006). By the end of the second decade of the 20th century, Christians, Muslims and Ezhavas came together to form the Civil Rights League and later the Joint Political Congress.

The wave of social change that Travancore witnessed had its reverberations in Cochin and to a small extent in Malabar. For example, the social reform movements among the dominant communities in Malabar, Muslims and the earlier untouchable Thiyyas, helped these two communities to build upon both traditional and modern lines (Houtart and Lemercinier 1978; Kannan 2012; Khadeeja 1995). They have been able to assert themselves in religious, economic, and political aspects more than any other marginalized group. Over the period, the progress in Malabar picked up in response to movements with economic and political overtones merged with

the rising of socialist, communist and nationalist movements and movements of peasants (Tharakan 1996). In sum, the socioeconomic and political history of the regions in Kerala is too different to make substantial differences in the lives of people from each region. In brief, the earlier political and social history of Malabar was one of dominance by the business interest of colonial government and conqueror rulers that had led to lag in socioeconomic development. On the other hand, the political and social history of the southern part of the state is one of political dominance by progressive rulers of princely states.

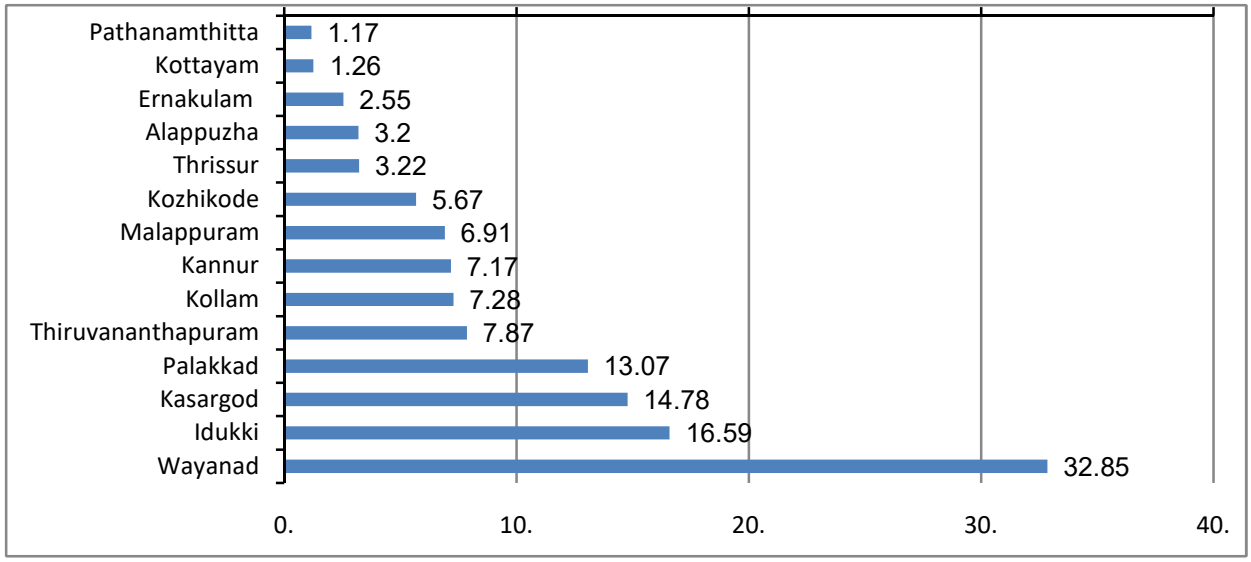
The regions of Kerala and its developmental experience

Even though there are no such administrative units like Travancore, Cochin, and Malabar in present-day Kerala, are well-known names and heritage. At present, these three regions are divided into fourteen districts. Even though being the districts of a single native Malayalam-speaking region, there is a wider disparity in the socioeconomic development achieved by fourteen districts. The historical differences in the politics and governance among these regions not only left disparities between regions but large disparities even within sub-regions. An analysis of poverty in the state reveals that poverty in Kerala is not randomly distributed, but it shows stratification across districts. While ten of the fourteen districts show a poverty rate of less than ten percent, district Wayanad records the highest poverty rate, more than thirty percent (see Figure 1.1). Idukki, Kasargod, and Palakkad are the other three districts that have a poverty rate of more than ten percent. Incidentally, the four districts with the highest poverty rate are the district with the highest percent of Adivasis and Dalits in the state. Further, among the four districts, three are from Malabar; and Idukki is the only district from the southern part.

Socio-Economic and Caste Census (SECC), 2011, was the latest major step taken by the government of India to count its poor households. The SECC ranks the rural households based on socioeconomic status and estimates a deprivation index to overcome the issues in the current definition of poverty. To attain a broader definition of poverty, deprivation is estimated along seven chosen criteria. The criteria are size and condition of the house, households with adult members aged 15-59, female-headed households, those with no able-bodied members, SC/ST households, those with no literate members, and landless households of casual labours. The deprivation index shows a wider disparity between districts in the state. The highest deprivation

is recorded in Palakkad district (42.33 percent), followed by Thiruvananthapuram (38.36 percent) and Wayanad (36.33 percent).

Figure 1.1 District wise poverty rate in Kerala during 2011-12



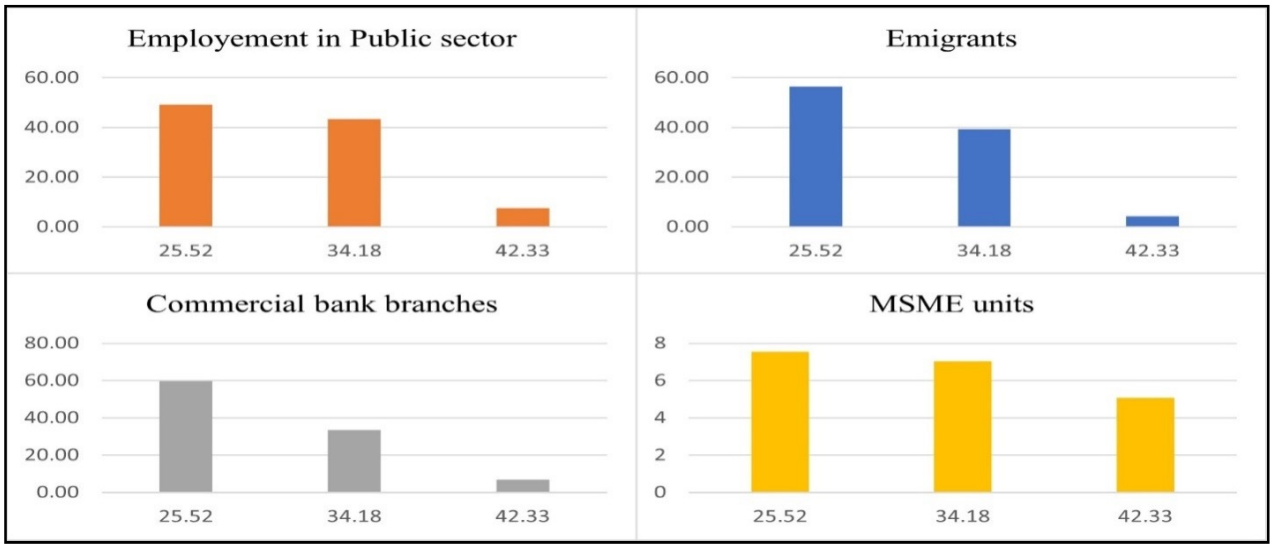
Source: Indicus analysis based on Tendulkar poverty definition for 2011-12

On the other hand, the lowest deprivation is recorded in Ernakulam district (20.30 percent), followed by Kottayam (23.02 percent) and Kannur (24.25 percent). This shows that the highest deprived districts recorded more than double deprivation recorded in the lowest deprived district. Further, the deprivation index not only shows that the highest deprivation is in Malabar, but it also shows the highest inequality in Malabar between districts in terms of deprivation. For example, the highest deprivation of 42.33 percent and the lowest deprivation of 24.25 percent are recorded between Palakkad and Kannur districts of the Malabar region.

Spatial poverty in the state shows that areas with a lower rate of poverty are better equipped with public institutions and facilities. In fact, parts of the state that have fewer public facilities of schools, hospitals, and commercial banks have a greater share of the poor. Figure 1.2 shows area-level inequality in economic opportunities and business opportunities available in the state. It shows that in those areas where higher poverty and deprivation, the share of employees in the public sector and the number of emigrants also recorded the lowest. On the other hand, in the areas where an average deprivation is only 25.52, the share of employees in the public sector and the share of emigrants is highest. Similarly, in those areas where deprivation is lowest, the share of Micro, Small, and Medium Enterprises (MSME) and commercial bank branches are highest.

This hints that the areas with the lowest deprivation index are the areas where individuals have better employment and income, better facilities like banking services, and an overall better environment for MSME's to develop.

Figure 1.2 Percent share of employment in the public sector, emigrants, commercial bank branches, and MSME units among areas with different deprivation indexes.



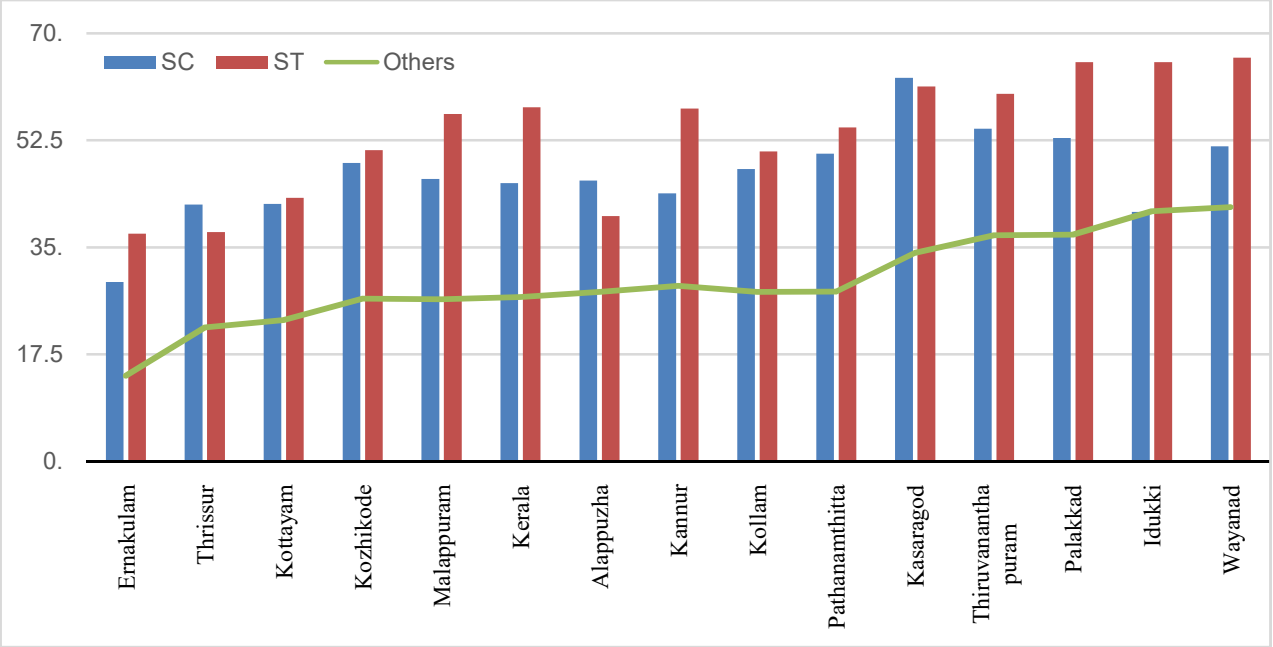
X-axis: deprivation index among districts for 2011; Source: deprivation index: Percentage of deprived rural households against their total number of rural household from Socio Economic and Caste Census (2011), GoI cited in Economic Review 2019 (KSPB 2019); District wise Employment in the public sector in Kerala by branches (2018-19); Emigrants: District-Wise proportion of Emigrants in Kerala; Commercial bank branches: Reserve Bank of India -Quarterly Statistics on Deposits and Credit of Scheduled Commercial Banks, March 2019; MSME units: Directorate of Industries & Commerce

Even though Kerala is appreciated for being the state with the lowest poverty and highest human development, the distribution of poverty and deprivation among various districts show that there is a concentration of poverty in certain pockets. In addition, the concentration of deprivation is highest among the marginalized communities, SECC of 2011 shows that around 57 percent of SC households and around 61 percent of ST households are deprived.

The deprivation of SC and ST households is not a new phenomenon, and no substantial improvements have occurred in their status during the last several years. The district-wise deprivation index calculated based on another set of indicators for the year 2001 also shows poor social status of both the communities. The deprivation index estimated based on the quality of housing, availability of drinking water, sanitation, and electricity is shown in figure 1.3. It shows the highest deprivation index for Adivasis and Dalits in all districts of Kerala. Further, even in

the districts Wayanad, Idukki, and Palakkad, where Adivasis and Dalits have a good share of their population, deprivation among both these communities are high. It is interesting to note that the communities other than SC and ST also recorded the highest deprivation in Wayanad, Idukki, and Palakkad district. In fact, the deprivation of others in these districts is recorded even more than that of the deprivation recorded among Adivasis and Dalits in the better-developed district Ernakulam.

Figure 1.3 District-wise Index of Deprivation (non-income terms) by Social Groups, 2001

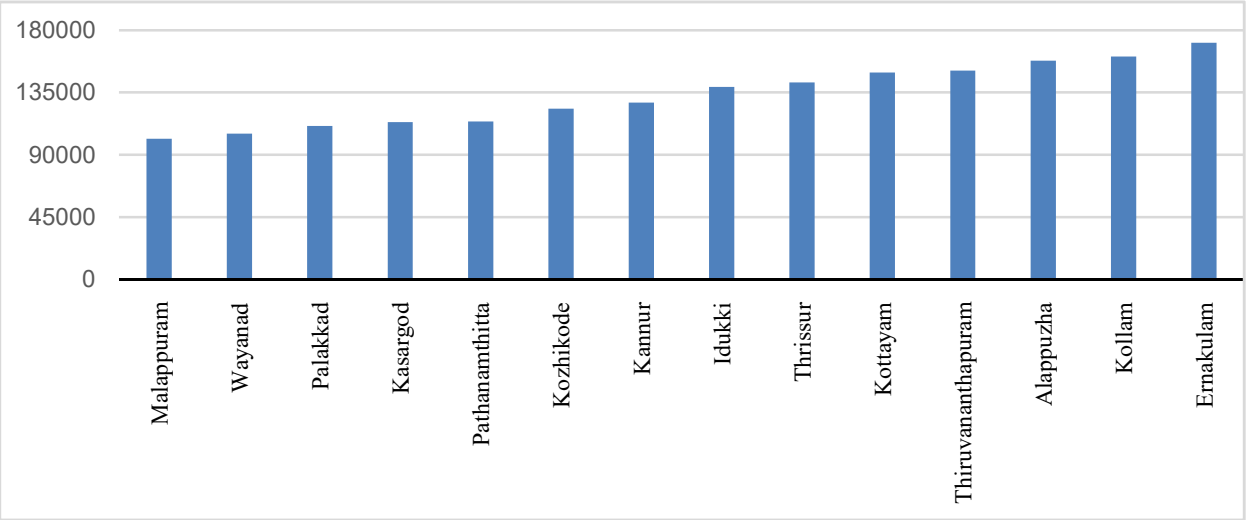


Source: Human development report Kerala, 2005, page no. 62

Ernakulam is the better-developed district in the state in terms of district per capita income. As shown in figure 1.4, Kollam, Alappuzha, and Thiruvananthapuram from the southern part of the state are the other districts that better perform in terms of per capita income. On the other hand, districts from Malabar, Malappuram, Wayanad, Palakkad, and Kasargod recorded the lowest per capita income. It is interesting to note that the districts with the highest and lowest population, Malappuram and Wayanad respectively, are the two districts that recorded the lowest per capita income. However, when Malappuram records a growth rate of 2.4 percent in PCI, Wayanad lags well behind and records a growth rate of 0.5 percent during 2019-20 (KSPB 2021). Data from the economic review of 2020 shows that it is the better performance of the secondary and tertiary sector in Malappuram compared to Wayanad, which helps it record a high growth rate. As the

trend in district per capita income, households' annual income also shows a trend of greater advantages to some districts. District-wise distribution of households by monthly income and households with salaried employment also shows that the better-developed districts have households with a greater share of salaried employees and employees with higher monthly income (see figure 1.2 and 1.13).

Figure 1.4 District wise Per Capita Income (₹) at Basic Prices for the year 2017-18



Source: Department of Economics and Statistics, Kerala.

In sum, irrespective of the method of poverty estimation through consumer expenditure or with broader socioeconomic indicators, poverty in the state shows a trend among the districts. Where some performed better, and some others lagged well behind. In fact, better-developed districts are better developed in health status indicators and health infrastructure indicators. Further, it is in the better-developed districts from different regions, which shows high growth in private health infrastructure and health care professionals. Table 1.1 shows the district-wise socioeconomic and health indicators for the period 2008 to 2014-15. It shows that six districts from the state, two each from regions, have an urban population of more than fifty percent. Further, these six districts recorded a high per capita income, low deprivation, and high literacy rate, showing comparatively better socioeconomic development. Regarding health status and health care facilities too, these districts do not show a different picture.

It is these better-developed districts, Thiruvananthapuram, Ernakulam, Thrissur, Kannur, and Kozhikode recorded the lowest Maternal Mortality Ratio (MMR) and lowest Infant Mortality

Rate (IMR). Further, about health care facilities, it is the better-developed districts that have the lowest bed population ratio, and better health care facilities both in public and private sectors (also see table 1.5 and 1.6).

Table 1.1 District wise socioeconomic and health indicators

	Districts	The proportion of urban population[1] 2011	Per capita Income[2] 2014-15	Percent of deprived HH 2011	Literacy rate[4] 2011	Bed Population Ratio[5] 2008	Maternal Mortality Ratio[6] 2014-15	Infant Mortality Rate[7] 2014-15
Malabar	Kasargod	38.9	67579	32.82	90.09	1211	29	8.9
	Kannur	65	98960	24.25	95.1	883	25	4.6
	Wayanad	3.9	77593	36.33	89.03	936	80	9.2
	Kozhikode	67.2	86919	30.89	95.08	592	30	4.5
	Malappuram	44.2	76467	32.71	93.57	1581	36	6.5
	Palakkad	24.1	84461	42.33	89.31	1091	47	7.6
Cochin	Thrissur	67.2	102552	28.57	95.08	662	27	4.4
	Ernakulam	68.1	161472	20.3	95.89	690	19	3.9
	Kottayam	28.6	107622	23.02	97.21	530	24	5.6
	Idukki	4.7	124298	33.99	91.99	1129	54*	8.6
Travancore	Alappuzha	54	111674	27..78	95.72	497	41	8
	Pathanamthitta	11	87111	26.61	96.55	922	26	5.7
	Kollam	45	121251	28.11	94.09	1112	55	7.8
	Thiruvananthapuram	53.7	122030	38.36	93.02	463	22	5.3
	Kerala	47.7	104198	30.33	94	-	32	6

Source: 1 and 4: Census Population 2011, GOI; 2. Economic review 2015, Economic and statistics department; 3. Human Development Report 2005, Kerala, page no.62; 5,6 and 7: Directorate of health services Government of Kerala cited in Gender Statistics 2014-15, (Ecostat GoK 2016) page no.66 and 67. * data for the year 2012-13

The socioeconomic inequality among districts in the state presented through poverty rate, deprivation index, and other indicators show a clear trend of advantages and disadvantages to certain districts. On the other hand, health status indicators, and availability of health care facilities among district also shows a trend of greater advantage to some districts, that better benefited from socioeconomic development. Both these trends are not happened by chance but shaped in connection with each other in the context of the socioeconomic development that happened in the state. The direct relation between income inequality and inequality in access to health care has already been established by studies done in the state (Aravindan 2006; Gangadharan 2003; Subramanian 2004). The role of basic amenities like; quality of housing, availability of drinking water, sanitation, and electricity in maintaining the quality of life and

good health is a generally accepted fact. Authors like Kurien (1995) pointed out this in their study on socially disadvantaged groups in the state. In this context, the district-level data on socioeconomic development and health status points to the trend of better socioeconomic development coupled with better health status and health care facilities among certain districts in the state.

Health status of regions and social groups in Kerala

Even though Kerala performs better than most other Indian states in terms of average poverty estimates and human development, there are still several pockets of deprivation in the State (KSPB 2021; UNDP 2006). Poverty in the state is mainly concentrated in some social groups such as Dalits, Adivasis, fisher folk, and artisans; and sub-regions in districts such as Wayanad, Palakkad, and Idukki (KSPB 2019). The differences in the socioeconomic and political development among different parts of the state and social groups within them have led to a differential shaping of health status among regions and social groups in the state. The disadvantaged groups, especially Dalits and Adivasis did not have general health indicators anywhere near the state average. Evidences suggests less reason to believe that difference between the social groups is narrower in the state of Kerala especially in terms of health status (Zachariah and Patel 1983; Rajan 2000; Navaneethan and Kabir 2009; Haddad et al. 2012; George et al. 2020). A comparison of important general health indicators among the regions and social groups given below clearly depicts the disadvantages in health status faced by certain social groups and sub-regions.

District wise Infant Mortality Rate for selected years from 1972 to 2016-17 given in table 1.2 shows a clear trend of disadvantage for certain districts. During 1972, except for the district Idukki in the Cochin region, all other districts of Cochin and Travancore has a comparatively lower IMR than that of districts in Malabar. During the year, the highest IMR is recorded in Palakkad district and the lowest is recorded in Thrissur district. Over the years, Wayanad, Kasargod, Idukki and Palakkad are districts that show a persisting high IMR in the state. Even though some other districts show a high rate of infant mortality at some years, after 2000 they show a study decline. For example, Kozhikode and Kottayam show high IMR up to 2000 and a study decline after that. Further, data from both Civil Registration System (CRS) and Directorate of Health Services (DHS) shows that throughout the period IMR for Wayanad, Palakkad, Idukki

and Kasargod remain high compared to other districts (DHS 2018; Ecostat GoK n.d.).

Table 1.2 District wise health status indicators for three regions of Kerala

Districts		Infant Mortality Rate							Maternal Mortality Ratio			Life expectancy at birth
		1972	**1980**	**1990**	**2000**	**2013-14**	**2015-16**	**2016-17**	**2009-10[3]**	**2013-14[3]**	**2015-16**	**2000**
Malabar	Wayanad	-	-	9.5	8	11	10	8	46	58	28	73.5
	Palakkad	25.7	20	12.2	6.5	7.5	7	6	43	36	48	76.1
	Malappuram	21.4	11.5	7.5	3.6	7.5	6	6	38	34	42	75.6
	Kasargod	-	-	9.4	2.6	8.2	8	10	34	66	58	75.7
	Kannur	19.4	14.9	6.7	5.5	5	4	4	27	35	14	75.6
	Kozhikode	24.0	19.2	18.6	14.2	6.4	5	4	8	23	26	75.4
Cochin	Thrissur	12.9	10.6	11.9	9.8	4.6	5	5	38	35	32	76.4
	Ernakulam	15.9	16.4	13.5	6.6	3.9	3	3	52	42	17	75.9
	Idukki	34.7	21	10.6	9.2	5.5	9	8	49	54	51	72.4
	Kottayam	18.3	17.1	14.2	13.1	6.6	4	5	47	23	37	75.6
Travancore	Thiruvananthapuram	17.3	19.9	14.7	5.7	6.4	5	6	33	32	30	75.2
	Kollam	12.7	12.5	9.3	5.1	8	7	6	47	47	38	77.1
	Alappuzha	15.5	9.6	11.1	3.5	8.9	7	7	33	45	49	77.1
	Pathanamthitta	-	-	7.1	4.6	6.4	5	3	32	39	14	76.7

Department of Economics and Statistics Govt of Kerala n.d., table no.21, IMR for 2013-14 and 2016-17 and MMR for the year 2015-16 obtained from DHS data cited in Health at a glance for the years 2014 and 2018, (DHS 2018); Life expectancy at birth obtained from State Human Development Report, Kerala 2005 in page no. 168; Maternal Mortality Ratio is the number of Deaths due to puerperal causes / Number of Live Births x 100000 (WHO Metadata Registry List n.d.)

One thing important to note here is the source of data. Data for IMR up to 2000 is obtained from Civil Registration System, and IMR for the remaining years are obtained from the Directorate of Health Services data[1]. The registration of births and deaths under Civil Registration faced huge bottlenecks during the yesteryears and it did not happen in a similar way among all districts (EcostatGoK 2007). The districts with better facilities tend to ensure better registration under CRS, thus the high IMR shown by districts like Kozhikode and Kottayam could be because of the high registration in those districts.

[1] The figures are different from the figures given in the bulletin of Sample Registration System (SRS)– 2013 published by the Registrar General of India. The SRS data recorded an IMR of 12 and MMR of 66 in the state, which is higher than the DHS data. District-wise figures are not available in the SRS bulletin, thus latest figures from DHS is taken.

Further, table 1.2 shows the maternal mortality ratio for the years 2009-10, 2013-14, and 2015-16. It shows highest IMR in Ernakulam and Idukki during 2009-10, but after that a decline in Ernakulam and an increase in Idukki. During the same period, Kasargod, Wayanad, and Palakkad from the Malabar region also recorded a high maternal mortality ratio. At the same time, Kozhikode, Kannur, Thiruvananthapuram, Pathanamthitta and Thrissur district records a comparatively low maternal mortality ratio in the state. Life expectancy at birth, another important indicator ranges from the highest of 77.1 in Kollam district of the Travancore region to the lowest of 73.5 in Wayanad district. This shows a 3.6-year difference between the lowest and highest-ranking districts in the state and a difference of 2.6 years among districts in Malabar. Thus, as shown in the table IMR, MMR, and life expectancy at birth among districts in the state are distributed with greater disadvantages to certain districts and advantageous to some other districts.

Table 1.3 District wise health status indicators for three regions of Kerala 2

	Districts	% Children under 5 years who are underweight (weight-for-age)		% of children with Low Birth weight		Stillbirth rate		
		2019-20	2015-16	1998-99	2012-13	1982	2007-08	2011
Malabar	Wayanad	22.5	27.2	30	5.2	11.5	1.0	5.41
	Palakkad	27.7	19.1	16	-	7.7	1.6	2.69
	Malappuram	21.4	17.3	17	10.6	6.6	0.7	2.99
	Kasargod	21.4	13.9	15	8.6	10.3[#]	1.3	4.86
	Kannur	17.9	10.5	15	5.1	8.3	0.0	5.17
	Kozhikode	18.9	18.5	17	10.3	13.1	0.3	8.75
Cochin	Thrissur	17.3	14	13	5.8	8.9	0.0	4.33
	Ernakulam	19.4	12	18	9.8	10.7	0.0	4.77
	Idukki	23.6	14.8	15	-	7.8	0.0	2.17
	Kottayam	17.3	11.3	18	7.2	7.8	0.5	7.53
Travancore	Thiruvananthapuram	15.2	21.6	11.4	8.7	7.8	1.6	8.24
	Kollam	17	14.2	12	7.6	9.5	0.9	2.06
	Alappuzha	20	17.2	12	13.3	3.5	0.5	5.01
	Pathanamthitta	11.2	11.4	18	-	4.5[#]	0.7	2.42

data for the year 1985; Stillbirth rate is the number of fetal deaths (stillbirths) per 1,000 live births plus fetal deaths (stillbirths); % of Children under 5 years who are underweight (weight-for-age), Below -2 standard deviations, based on the WHO standard, NFHS-5; % of children with Low Birth weight: for 1998-99 from State Human Development Report, Kerala 2005 in page no. 29; for 2012-13 from DLHS 4 data cited in Directorate of Health Service, Government of Kerala, Health at a glance 2014, Page no 28-52; Still birth: for 1982- Government of Kerala,

Department of Economics and Statistics, Vital Statistics A trend Analysis, table no.21; for 2007-08- DLHS-3, Kerala State Report page no. 56; for 2011-12 from CRS data cited in Annual vital statistics report – 2011, Kerala

Coming to another set of health status indicators, table 1.3 shows data on child health and stillbirth rate among districts in the state. A child can be underweighted for his age because of stunting (height-for-age) or wasting (weight-for-height) or due to both. Weight-for-age is a composite index of weight-for-height and height-for-age. Children who are more than two standard deviations below the median (-2SD) of the WHO reference population in terms of weight-for-age is considered as underweight (WHO 2010). As shown in Table 1.3, among the districts of Travancore underweight in children ranges from 11.2 to 20 percent during 2019-20. Among the districts of Cochin, it recorded little higher and ranges from 17.3 to 23.6 percent. However, the districts of Malabar recorded the highest, it ranges from 17.9 in Kannur to 27.7 in Palakkad. The districts Palakkad, Wayanad, Kasargod, Malappuram, and Idukki record the highest percent of underweight children in the state. Data for the year 2015-16 also shows a similar trend of greater disadvantage for certain districts from Malabar region.

The case of percent of children with low birth weight during 1998-99 and 2012-13 does not show a different picture. The percent of children with low-birth-weight ranges from the lowest of 11.4 percent to the highest 18 percent among the districts of Cochin and Travancore. In Malabar, it ranges from the lowest 15 to the highest of 30. When Wayanad district, which lags in socioeconomic development records the highest percentage of low birth weight, Thiruvananthapuram district that better performs in socioeconomic development recorded the lowest. In fact, it is already found that low maternal socioeconomic status is an important determinant of low birth weight in the state (Radhakrishnan et al. 2000). The other important indicator, stillbirth rate, is a pregnancy outcome that is not a live birth but has occurred after 28 weeks of gestation. Data for stillbirth rate for 2007-08 is taken from District Level Household and Facility Survey -3 (DLHS-3), which shows a comparatively lower rate for all districts compared to CRS data for the years 1982 and 2011. However, the SRS estimate of stillbirth in the state shows a further higher rate of 8 percent during 2009 and 5 percent during 20118. Data from both CRS and Sample Registration System (SRS) shows differences in stillbirth rates among districts in the state. CRS data shows a high rate in districts of Kozhikode, Kottayam, and Thiruvananthapuram, which are better developed and have well-established facilities to ensure better registration under civil registration. On the other hand, DLHS data shows a higher rate

among comparatively lesser developed districts Wayanad, Palakkad, and Kasargod along with Thiruvananthapuram.

As seen above, health status indicators not only show a difference between districts in the state but also differences within each sub-region. Data on health status indicators below district is not available to make any comparison, however, the district wise comparison along with social groups wise comparison will help to get some idea in this regard. While advancements in socioeconomic development have progressed in the state during the last several decades, leading to significantly improving prevention and treatment of diseases, such benefits have not been shared equally. Even after a better health sector achievement in the state, studies and reports highlights greater disadvantage for marginalized communities in terms of morbidity and mortality (C&AG 2014; Haddad et al. 2012; Kannan et al. 1991; Navaneethan and Kabir 2009). In fact, on the general health indicators in which Kerala state have recorded highest achievements, including IMR and MMR marginalized communities in the state lag others (Ministry of Tribal Affairs 2013).

Over the last several decades infant and child mortality rates in Kerala have fallen in all sections of society (Zachariah and Patel 1983). However still large inequalities exist among various social groups. Table 1.4 shows more than a threefold higher IMR for Dalits and more than fivefold higher IMR for Adivasis compared to that of the total population in the state. Social category-wise disaggregated data at the district level on infant and maternal mortality are not provided by any regular national or state-level estimates. However, a survey among children in the age group of zero to 72 months in the Wayanad district during 2012-13 by the district administration shows a high infant mortality rate among the marginalized communities. The survey-based on 1855 births from four Grama panchayats reported the highest infant mortality rate of 41.47 among Adivasis (C&AG 2014). Such a difference in health status among social groups can also be found in the case of maternal mortality. The maternal mortality ratio in the state during 2007-08 is recorded lowest in the country, but when it was recorded 66 for all social groups together, for Adivasis highest MMR of 81 is reported. Even though district-level maternal mortality data is not available for various social groups, it is shown that lower caste status can trap women into poor health status (Mohindra, Haddad, and Narayana 2006). It is pointed out that being from an

upper caste can buffer women from the poor health effects related to low socioeconomic status, whereas being from a lower caste can magnify these effects.

With regard to under-five mortality, Table 1.4 shows that Dalits have around fourfold and Adivasis have around fivefold higher mortality compared to that of all social groups together. During 2001 under-five mortality were 83 and 54 for Adivasis and Dalits respectively, but for the same period, it was only 14.1 for all social groups together in the state. In the case of percent of stillbirth, when the state has recorded an average of 0.6 percent, Adivasis and Dalit community recorded more than twofold higher stillbirth during 207-08. The backwardness of marginalized communities in health is not limited to the high mortality among them but it also reflected in the high morbidity among them. During 2007-08, children who had suffered from diarrhea and ARI shows a high prevalence of both among children from Adivasi and Dalit communities compared to that of children from OBC and all social groups together.

Table 1.4 Social category wise health status indicators

Social Category	IMR 2001	MMR 2007-09	Under-five mortality 2001*	% of Stillbirth 2007-08	% of children suffered from diarrhea 2007-08	% of children suffered from ARI 2007-08	Morbidity rate per l000 population 2004	Annual Hospitalization Rate 2004
SC	42	-	54	1.4	6.6	15.1	268	9
ST	60	81	83	1.4	8.4	15.5	238	8.6
OBC	-	-	-	0.6	6.3	11.3	242	9.8
Others	12.1[#]	66	14.1[#]	0.6	3.9	10.2	261	9.8

IMR and under-five mortality for all social groups together; Source: IMR SC and ST: District Level Estimates of Child Mortality in India, Census of India, 2001 cited in (Ministry of Tribal Affairs 2013); MMR for ST: Special Bulletin on MMR, June 2011- Registrar General of India cited in (Ministry of Tribal Affairs 2013), MMR for others SRS Bulletin, Vol. 49. No. 1; % of Stillbirth, % of children suffered from diarrhea and ARI are taken from District Level Household and Facility Survey 2007-08 Kerala, (DLHS 2010); Morbidity rate per l000 population 2004 is the number per 1000 of persons reporting ailment during 15 days prior to the survey. NSSO 60th round, report no. 507, page no. A-133 to A-150; Annual Hospitalization Rate 2004 computed from NSSO unit level data of NSSO 60nd round cited in (Simon 2007)

The other category that faces health backwardness is the 'Other Backward Class,' which records slightly better health indicators than Adivasis and Dalits but not as better as the forward castes (category 'others'). The self-reported morbidity rate during 2004 given in table 1.4 shows the highest morbidity rate for Dalits, but the morbidity rate is a little lower among Adivasis and other backward class compared to the forward caste groups. However, while understanding this, the limitation of taking self-reported morbidity should be bear in mind that perception of illness

and reporting may vary depending on the position of the individual in terms of factors like education and income (Sen 2002). In support of this, a study conducted among three districts of Kerala found that morbidity is negatively associated with socioeconomic characteristics in Thiruvananthapuram and Kannur district (Navaneethan & Kabir 2009). The same study reported the highest rate of morbidity for Adivasis in comparatively better-off district Kannur and lowest for comparatively backward district Malappuram.

Disaggregated data for each social group are not available to compare the health status of socials groups in each district. The above comparisons show that it is those districts that lag in socioeconomic development and have a larger share of marginalized communities, which shows the disadvantage in health status indicators. Further, data also shows that marginalized communities in the state lag well behind other social groups in terms of health status. Thus, it is reasonable to conclude that the IMR, under-five mortality, stillbirth, the prevalence of ARI & diarrhea among children, and morbidity rate among sub-regions in Malabar lags and the Dalits and Adivasi is the one who faces a greater disadvantage.

Health service development in the state and its regions

Kerala's achievement in health care is well appreciated and famous for its tradition of indigenous medical care even before the arrival of colonial rulers. However, the colonial intervention and coming of western medical practice radically altered the status enjoyed by Ayurveda and other indigenous medical practices (Cleetus 2007). In the earlier period of colonization, Ayurvedic physicians were respected to an extent. This can be understood from the writings of colonial administrators. Somervell, a colonial administrator who served in southern Kerala writes.

> *Ayurvedic men do with skill and patience, and in which they very often cause marked improvement to their cases, is the side of physical medicine-massage, manipulations etc. l am often quite content to let my patients, if they are suitable cases, take the treatment of Ayurveda in these respects, although its foundation and premises are entirely unscientific, in practice it works out all right'. (Somerwell, 1955 cited in Nayar 2009).*

Along with the importance of Ayurvedic physicians and their acceptance, such writings also show that thousands of native physicians were freely practiced in the villages. However, an

analysis done based on the colonial writings by Sunitha Nayar (2009) points out the colonial administrators assumed indigenous healing practices of pre-colonial and colonial period as irrational, unscientific, and barbaric in comparison with western medical practice. On the other hand, the princely state of Travancore was supportive of the indigenous system as its government even extended grant-in-aid to qualified Ayurveda practitioners. Though the colonial government of Madras gave recognition to Ayurveda in 1923-24, the policy continued to be 'lukewarm and halfhearted.' With respect to indigenous medicine, the policy of antipathy followed by the colonial government in India from 1835 stood in sharp contrast with the supportive policies of the princely state Travancore (UNDP 2006).

Available literature shows that the Dutch were the first European power who tried to strategically introduce the western medical practice in Kerala. Dutch had run a Leprosy Asylum in Malabar and later that went to the British. There were references to the presence of surgeons in the British factories in Malabar in the second half of the 17th century. Initially, the British set up institutions only to cater to the British and their employees but by realizing the periodic epidemics in the region facilities were also made available to native people. CA. Innes (1908) writes that it was in 1845 the first public hospital opened at Calicut, followed by one in Palakkad and Cochin. In the 1860s, the hospitals at Calicut, Thalasheri, Palakkad, and Cochin were handed over to the respective municipalities. The local boards, which began to function about the same time also opened hospitals or dispensaries gradually at all taluk centres and at important villages like Chowghat and Angadippuram (Innes 1908). However, the repeated struggle and resistance against colonial rule in the region, and the constant uprisings against the British by the local Mappila population (1836-1921) lead the British to spend only on administrative matters. The lack of resources for native initiatives and setback in the British support led to the stagnation of health facilities in Malabar region (Kabir and Krishnan 1992).

On the other hand, in Travancore, the princely rulers were keen on institutionalizing Western medical practice and established departments and appointed officials. The favorable attitudes of the Maharaja led the development of western medicine in Travancore from 1811 onwards (Kabir and Krishnan 1992). Under the supervision of British, the first hospital opened in the region in 1817. Within a decade, 27 hospitals, 30 dispensaries and 12 grant-in-aid institutions were established, and in 1928 the government took advice from the Rockefeller Foundation to

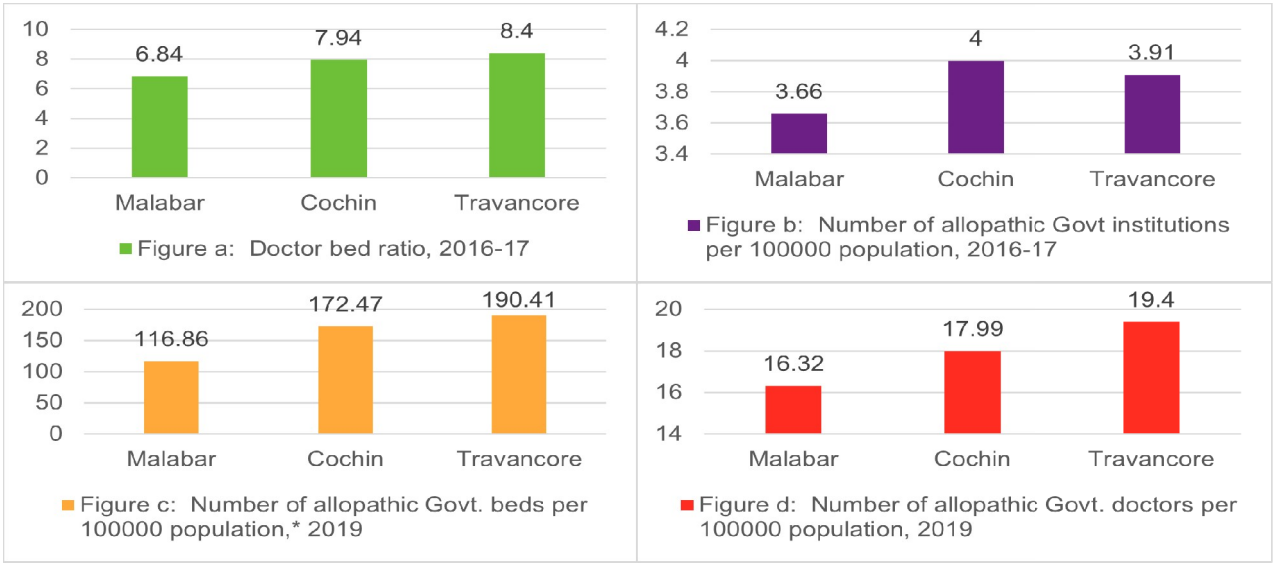
organize a public health department along the modern line (Kabir 2003). In Travancore State, there was a proclamation in the year 1880, through which vaccination was made compulsory for all government servants, students in schools, persons seeking medical help from hospitals, inmates of jails, and persons depending on charities. Later, it was made compulsory throughout the rural areas (Panikar and Soman 1984). Different from Malabar, very early itself native people from different social classes in Travancore received training in medicine. In the beginning, the Maharajas sent Brahmins to train in medicine at Madras Medical College, then forward caste Syrian Christians and Nayars supported to study in European medicine (Kabir and Krishnan 1992). By 1925-26, there were 13 qualified women doctors, two of whom held European degrees. Women from the Nayar, Muslim, and Brahmin communities were trained as vaccinators. As female education extended, women were also integrated into health services provision.

A significant change in the expansion of health care facilities in Kerala happened after the state formation. Raman Kutty (2000) observes, after the state formation its investment in the health sector is mainly directed by three policy coordinates: first is ensuring a public allopathic medical institution in every panchayat, secondly to provide medical education by the government to ensure an adequate supply of professionals and finally to support traditional medical system. As a result, along with the expansion in allopathic institutions, Ayurveda and Homeopathy record an important share of medical institutions in the state. Raman Kutty describes the development of allopathic health care facilities in the state after its formation up to 1990 into three major periods, the first period from 1965 to 1975 characterized by a rapid increase in the number of institutions to reach one institution for every 25000 populations by 1975. The period also witnessed a large-scale reduction in the regional variation in health care facilities to remove the existing north-south divide among the districts. The second period was marked from 1975 to 1985 with further expansion and equalization of facilities across the state. Lastly, the period beyond 1985 witnessed the large-scale expansion of facilities to reach a position where one institution is available to 20,000 populations in all districts by 1990. As a result, by 1995, beds per one lakh population from all systems together in Kerala became 143; by 2006-07 it becomes 159 in the government sector (NCAER 2014).

Even though infrastructure development in government sector reduced the variations in health care facilities across regions in Kerala, it has not been completely removed. Further, the

expansion of health facilities within Malabar was not similar in all districts, but it maintains disparities between districts. A look into the recent data on general service availability indicators across Kerala's sub-regions will help us understand this. Availability of government institutions and doctors under allopathic system and beds under all systems together, across different regions and districts are presented in figure 1.5.The number of health facilities, number of doctors, and number of beds available under the government sector is the lowest in Malabar compared to other parts of the state. When only around 91 hospital beds are available for one lakh population in Malabar, it is around 136 in Travancore and around 126 in Cochin region. The trend is similar in the case of the number of healthcare institutions per one lakh population and the number of doctors per one lakh population, by marking the lowest share in Malabar compared to the other two regions. However, in case of doctor-bed ratio, that is the number of beds available relative to one doctor, Malabar seems to have favorable figures. But it must be noted that the lesser doctor bed ratio in Malabar is not because of the larger availability of doctors but because of the non-availability of beds similar to other parts of the state (see figure 15.c).

Figure 1.5 Indicators of general health service availability in various regions of Kerala



Source: Calculated from DHS data cited in Health at a glance 2019, Government of Kerala; number of beds under allopathic system in DHS and DME.

The comparative disadvantage of the Malabar region in case of beds available per one lakh population shows a historical trajectory, as it was much higher during 1995 (see table 1.5). Earlier this disparity was even wider; during 1901 there were 35 hospital beds for one lakh

population in Travancore compared to only 15 in Malabar (UNDP 2006). Such a historical path of disadvantage in Malabar can also be found in the availability of health care institutions. The number of institutions available in 1960 and 2019 among various regions in Kerala is presented in table 1.5, which shows the comparative disadvantage of Malabar with the greater disparity in the past. Table 1.5 further shows the availability of infrastructure and resources within each region in the state. Data on the availability of infrastructure and medical professionals for administrative regions below the district is not available. District wise comparison shows that Palakkad, Malappuram, and Kasaragod districts lag other districts in terms of availability of beds per one lakh population in 1995 and in 2019. In the case of government allopathic institutions per one lakh population, the two most populous districts in the region, Malappuram and Kozhikode fall behind in 2019. Further, in the case of doctors per one lakh population, the three districts Malappuram, Kozhikode, and Palakkad lag other districts in Malabar and recorded an estimation below the state average.

Table 1.5: Availability of health care facilities under government sector in Kerala

	Districts	Medical institutions (Allopathic)		Hospital beds (Allopathic)		Institution per one lakh population (Allopathic)	Bed per one lakh population (All system) ***		Doctor per one lakh population (Allopathic)+
		1960	2019	1960	2019	2019	1995	2019	2019
Malabar	Wayanad	11	45	90	1367	5.51	139	191.08	28.01
	Palakkad	30	114	605	2769	4.06	94	105.83	15.55
	Malappuram	19	125	245	3129	3.04	77	83.85	13.46
	Kasargod	7	57	98	1087	4.36	79	98.05	19.88
	Kannur	20	111	749	2966	4.40	104	136.22	19.73
	Kozhikode	14	93	1215	5811	3.01	177	201.08	13.44
Cochin	Thrissur	38	118	1947	5201	3.78	159	178.74	15.28
	Ernakulam	42	115	1633	5025	3.50	150	180.02	16.78
	Idukki	14	63	71	1288	5.68	93	136.88	23.80
	Kottayam	27	84	775	4849	4.25	202	265.57	21.01
Travancore	Thiruvananthapuram	53	118	3131	8577	3.57	250	295.41	19.05
	Kollam	35	88	810	2610	3.34	97	109.09	14.76
	Alappuzha	38	89	1607	4489	4.18	208	224.36	20.72
	Pathanamthitta	-	66	-	1960	5.51	96	178.3	28.22
	Kerala	348	1286	12976	51128	3.85	143	169.72	17.65

Source: data for 1960 and 1995 from Kerala Development Report, planning commission 2008, Page Number 304,305,309; data for 2019 from Directorate of Health Services, Government of Kerala, Economic Review 2019;

*** Number of beds from all system of medicine under the directorate of Health Services and Directorate of medical education; + Include all government medical officers and dentist under the allopathic system

Development of private health care institutions in the state

Along with the public sector, the private sector played an important role in the delivery of health care services in the state. However, while acknowledging the vital role of the private sector in the service delivery, there are questions about its capacity to serve the poorer sections and under-developed regions in the state (Levesque et al. 2006, 2007). Such concerns are serious becausethe private health care sector has grown on its own and is already the major provider in the state where there is historical regional variation in the availability of facilities under public sector. It has been already observed that there has been an unexplained growth of private health care institutions in certain districts (Dilip 2008). Incidentally, these are the districts of Malabar that faced impediment in the development of public health care facilities; and that largely benefitted from the Gulf remittance (Zachariah and Rajan 2007). Duringthe 1930s, there were onlya few private practitioners in the area and most of them were migrated from the southern parts attracted by the opportunities in the area (Osella and Osella 2000). One of the major factor which helped the rapid development of private health care institutions in Malabar is the affluence of remittance through migration to the Gulf countries (Dilip 2008). Reports on the private medical institutions in Kerala published by state government show this trend of rapid growth in private medical facilities, especially after the 1980s. The reports show that out of the total private institutions in the state, 15.54 are established before 1990, another 15.47 during 1990 to 2000 and 22.39 percent during 2000 to 2010. The recent among the reports estimated a rapid growth after 2010, out of the total private medical institutions in the state 46.6 percent established during this period (DES Kerala 2020).

The growth of the private sector in the state happened parallel to the public sector and later surpassed the public sector in infrastructure development. As a result of government intervention, by 1995 bed per one lakh population from all systems together became 143 in the public sector in the state; by 2006-07 it becomes 159 and by 2019 it becomes 169.72 per one lakh population. Parallel to this, the private sector also established its space in the state, by 2006-07 bed per one lakh population become 17 in the co-operative sector, and 221 in the private sector (NCAER 2014). By 2018 bed per one lakh population become 315.43 in the private sector. A study by Sankar (2001) shows that, during 1970, the government sector employed only

less than two-fifth of the total allopathic medical practitioners in the state, and thereafter the rate shows a steady decline. In the case of AYUSH services, the performance of the public sector in employing medical and paramedical staff was further poor. Among the registered practitioners in Ayurveda and Homeopathy, the proportion of physicians employed in the government sector remain around five to seven percent from 1975 to 1990 (Sankar 2001). Overall, such a trend of dominance by the private sector continued in the 1980s, for the year 1987, KSSP study (Kannan et al.1991) found 78 percent of the medical institutions, 64 percent of the hospital beds, 66 percent of the doctors, 67 percent of the nurses, and more than 80 percent of the paramedical staff was employed in the private sector. By 2017-18, the number of institutions under the allopathic system in the private sector become more than fivefold of that in the public sector. In other words when the allopathic institution per one lakh population is 3.85 in the public sector; in private sector it is 20.71 in the state (see table 1.5 and 1.6). In the case of medical education institutions also such dominance of private sector can be seen, during 2017, out of the 29 allopathic medical colleges 19 are in the private sector and one is a government-sponsored self-financing college. Out of 17 Ayurveda medical colleges 12, out of five Homoeopathic Medical Colleges one, and the only one Siddha and one Unani medical college in the state are under the private sector (Commissioner of entrance examination Kerala 2017).

As already mentioned, the growth of the private sector was strongly influenced by the positive impact on the state's economy like the inflow of remittance from Gulf countries. On the other hand, the development in the public sector met with the bottleneck of the state government's financial crisis. Until the 1970s the share of health expenditure to Kerala state's total budget was higher than that in the rest of India. The yearly average health expenditure accounted for 10.45 percent of total revenue in Kerala and only 8.3 percent in all India during 1960-65. The latter years show a reverse trend, during 1985-90 it becomes 9.07 percent in Kerala and 9.54 percent in all India (Sadanandan 1993 cited in Nabae 2003). Kutty (2000) points out, as a continuum to this, after 1985 capital spending for infrastructure facilities tended to stagnate and only health expenditure on salaries to health professionals and consumables shows an increase. He also notes that this decreasing capital spending in the health sector started to reflect on primary and secondary level healthcare provisioning, as essential requirements and facilities remained unavailable to Primary Health Centres (PHC) and Taluk hospitals.

As similar to the public sector, the private sector also has more institutions under the allopathic

system of medicines. As given in table 1.6, number of private allopathic institutions in the state is more than the institutions under all AYUSH systems together. However, the difference is narrow in the private sector compared to public sector. Further, the estimate done by Sankar (2001) based on 1996 data shows that 96 percent of Ayurveda medical institutions and 98 percent of Homeopathic medical institutions are working with less than five staff including the physician, and only less than 40 percent of allopathic institutions work with less than five staff. Most of the medical institutions with large staffing are functioning in the allopathic system.

Table 1.6 Availability of health care facilities under private sector in Kerala 2017-18

	Districts	Medical institutions (Allopathic)	Medical institutions AYUSH	Institution per one lakh population			Bed per one lakh population (All systems)
				Allopathic	AYUSH	Total	
Malabar	Wayanad	149	174	18.23	21.29	39.51	279.42
	Palakkad	404	267	14.38	9.50	23.88	233.49
	Malappuram	780	651	18.96	15.83	34.79	213.16
	Kasargod	275	229	21.03	17.52	38.55	138.14
	Kannur	519	482	20.57	19.10	39.67	284.74
	Kozhikode	687	584	22.26	18.92	41.18	283.97
	Total			19.20	16.29	35.48	241.29
Cochin	Thrissur	569	455	18.23	14.58	32.81	360.98
	Ernakulam	991	895	30.19	27.27	57.46	542.47
	Idukki	278	225	25.07	20.29	45.36	449.42
	Kottayam	464	559	23.50	28.31	51.81	386.01
	Total			24.26	22.49	46.76	439.32
Travancore	Thiruvananthapuram	628	436	19.02	13.21	32.23	313.44
	Kollam	519	393	19.69	14.91	34.61	303.37
	Alappuzha	400	517	18.80	24.30	43.10	193.25
	Pathanamthitta	257	221	21.46	18.46	39.92	490.47
	Total			19.48	16.92	36.40	305.85
	Kerala	6920	6088	20.71	18.22	38.94	315.43

Source: Report on private medical institutions in Kerala 2017-18, Department of Economics & Statistics, Kerala 2020

Among the institutions with more than 50 staff, more than 90 percent are allopathic institutions. Among the paramedical staff working in the private sector, around 90 percent of them are working under the allopathic system. Such a large-scale institutionalized provision of allopathic services compared to indigenous medical services created the impression that allopathy is the dominant system in Kerala's health sector (Sankar 2001). However, data in the utilization of

services under the public sector itself shows AYUSH systems with limited institutional resources are serving a large share of patients. During 2003 in the public sector, about half of the outpatient services are rendered by Ayurveda and Homeopathic systems of medicines (see table 1.10). Even though there is a reduction in it by 2018-19, about 23 percent of outpatient care in the public sector in the state is provided by Ayurveda and Homeopathic system through its limited infrastructure facilities (KSPB 2019).

The comparative disadvantage of Malabar and regions within it, in general service availability indicators remain reflected in the private sector too. As shown in table 1.6 in the case of institutions per one lakh population in 2017-18, Kochin region remains the first position with 46.76 institutions, followed by Travancore with 36.4 institutions. Malabar region maintains the third position with 35.48 institutions per one lakh population. Such a trend found remains similar while calculating institutions under the allopathic system alone and institutions under AYUSH systems. In the case of bed per one lakh population also Malabar lagged with other regions with larger disparity. When Kochin and Travancore recorded 439.32 and 305.82 beds respectively, Malabar reported only 241.29 beds per one lakh population. Further, if we look within Malabar, the districts Palakkad and Malappuram recorded the lowest in institutions per one lakh population. In the case of beds per one lakh population, Kasaragod, Malappuram, and Palakkad recorded the lowest number of beds. If we look into Wayanad, it is the only district in Malabar with more institutions under AYUSH systems than the Allopathic system.

The development of such an environment for the dominance of the private sector in the state's health sector has to be understood in the context of the academic and political discourses that happened. In a study, Sabitha Nayar (2009) points out that in line with the Alma Ata declaration, academic discourse of the 1980s in the state advocate for intersectoral integration. She points out in Kerala, the academic talk of the period began to advocate for health reform integrating community participation in the making of health projects and sharing its cost, which was a step towards decentralization. With regards to decentralization, she argues that, rather than the health and wellbeing of the people, rather the growth and development of the health service system was the main concern for the scholars. Thus, the study found it as just another developmental strategy prescribed by external funding agencies in the context of a fiscal crisis in the State. It suggests mobilizing funds from the local people and asks them to plan and implement their requirements.

The academic discourses on decentralization and health further advocated for co-operative and private investments in health service institutions. Those who support this argument legitimized this attempt as such move will reduce state burden and reduce the unequal distribution of institutions (Nayar 2009). However, evidence shows that co-operative sector fails while competing with private health care institutions (Nayar and Razum 2003). The focus of established cooperatives in the state was limited to medical care; issues related to equitable access to medical care were not addressed. Overall, the changes that took place in the state created an atmosphere for decentralization, cooperative health care provisioning, public-private partnership, and development of private health care facilities.

As an initial step of creating a health care system by incorporating private sector, meetings on public-private partnerships were started in the state by 2003 (Nabae 2003). The Kerala Perspective Plan 2030 published in 2014 by the state planning board explains its policy framework and action plans to be implemented in the coming years. To strengthen and ensure quality health care service the report proposes programmes directly involving private partnerships. This includes distribution of medicines to the poor in partnership with private and civil society partners, franchising health care services in public health facilities to private players, the involvement of health experts from the private sector in primary health care facilities to strengthen local capacities and performance-based compensation to health workers in specific government-run programmes. The report says the health sector is the backbone of economic and social prosperity, but the policies it proposes to attain the same reflects that the state itself sees health provision as a profit-making business. To attain economic prosperity through health, the document proposes building medical cities of excellence with world-class facilities in education, training, health care services, support infrastructure, and encouraging trade in services. When the document says it proposes to increase the health expenditure to Gross State Domestic Product (GSDP) ratio from 0.6 percent in 2012 to 4 to 5 percent by 2027−31, many of its suggestions show states gradual withdrawal from public health care provisioning.

In sum, the private health care institutions and its resources become a major part of the health service system in the state. During the period of state formation, private health care services in the state were largely run by charity institutions like mission hospitals (Nabae 2003), but presently private sector in the state is dominated by for-profit enterprises. The private hospitals

vary from single-doctor hospitals to multi-specialist hospitals providing a range of services. As secondary care in the government sector is restricted to Community Health Centre (CHC) and above, the private sector is the major provider of services in some remote areas of the state (HFWD 2013).The private sector in the state is heterogeneous mainly in terms of institutions' size, the system of medicine, and ownership. As there are socioeconomic differences in the development experience of various districts in the state, we can see such a difference in the development of private health care institutions among the districts. Dilip (2008), in his analysis based on the survey of private health care institutions for 1986, 1995 and 2004 states that Malappuram, Palakkad, Alappuzha, and Kollam have a large number of small and medium scale hospitals in the state. He also pointed out the consolidation of large private hospitals in the districts Kannur, Kasargod, Thiruvananthapuram, and Pathanamthitta during the period. In such large hospital's specialist clinics were widely established and modern technologies were largely utilized for diagnosis. Further, such hospitals started to compete to get patients by increasing the latest technologies and facilities on offer. The major users of private institutions are the members of middle-class and rich families than very poor, for whom utilization of a private provider was less likely. As the majority of Kerala's families are in the middle-income group, with fewer families among the extremely poor as compared to other states. The middle class emerged as major stakeholders of private health care institutions by contributing to health care professionals and by utilizing private health care. However, the widespread establishment of private facilities and the inability of the public sector to serve everyone created a situation where dependence on private health care institutions by people from all socioeconomic groups being inevitable.

Part C: Development experience of Malabar and its sub-regions

The poor socioeconomic status and disparities in health status typical of yesteryears in Malabar region of Kerala are not visible today. During the last century, the region has made remarkable achievements in health status, bridging the gap with other parts of the state (see table 1.1, 1.2, & 1.3). However, even now disparities among social groups and sub-region in health status persist within the region (see table.1.2, 1.3 & 1.4). Further expansion of health care facilities throughout the region is the government's current strategy to overcome the lingering disparities in health indicators. This strategy is based on the assumption that the expansion of allopathic health care facilities and overall socioeconomic development will help to triumph over the existing

disparities in health. However, the available literature on the region proves that, even before developing these modern health care facilities, the health status of the region had been improving (Mencher 1980). Further, despite the present development strategy, there remain wide disparities in health status, social and economic development between different sub-regions and socioeconomic categories in Malabar, which brings into question the advisability of the development strategy being pursued.

What gets little attention while dealing with health disparities in the Malabar region is the variations between sub-regions and social groups within Malabar in terms of health status, despite the attempts to a fair distribution of health care facilities throughout the region. The case of Attapadi, a sub-region in Malabar is a good example of lower health status despite expansion of health care facilities and financial protection (George et al. 2020). It shows the mere expansion of health care facilities and financial protection are not enough, but there are more troubling social factors to get addressed. The socio-economically lesser developed taluks and villages in the districts of the Malabar region constitute the sub-regions, which continue to lag better-developed villages. It is not just the area level differences that shape the sub-regions in Malabar, instead, it is also because of the larger social group-wise inequalities in such areas. The intra-regional variations coupled with inter-community variations show that the marginalized social groups like Adivasis, Dalits, agricultural workers, women, and the fishing community of the region have not benefited as much as others from the development experienced by the region as a whole.

Among the districts in Malabar, it is the better performing districts in socioeconomic indicators that better performed in health status and health infrastructure indicator. Table 1.7 shows the districts Kannur and Kozhikode have the highest share of the urban population, high per capita income, lowest deprivation index, and high literacy rate compared to the other four districts in the region. These two districts recorded the lowest Maternal Mortality Ratio, Infant Mortality Rate, and bed-population ratio compared to other districts during 2014-15. The other districts, especially Wayanad, Palakkad and Kasargod show the least development in indicators of socioeconomic and health development. A taluk wise analysis in the next sections shows that it is the taluks in these three districts that record a greater disadvantage due to the intersection of area-level inequalities with social group inequalities.

Table 1.7 District wise socio-economic and health indicators in Malabar

Districts	Proportion of urban population[1] 2011	Per capita Income[2] 2014-15	Deprivation Index[3] 2001	Literacy rate[4] 2011	Bed Population Ratio[5] 2008	Maternal Mortality Ratio[6] 2014-15	Infant Mortality Rate[7] 2014-15
Kasargod	38.9	67579	37.6	90.09	1211	29	8.9
Kannur	65	98960	29.7	95.1	883	25	4.6
Wayanad	3.9	77593	46.3	89.03	936	80	9.2
Kozhikode	67.2	86919	28.3	95.08	592	30	4.5
Malappuram	44.2	76467	28.6	93.57	1581	36	6.5
Palakkad	24.1	84461	40.4	89.31	1091	47	7.6
Kerala	47.7	104198	29.5	94	-	32	6

Source: Same as table no 1.1

Though the socioeconomic condition of the marginalized communities in other regions of the state is not much different, there remains one important difference that marginalized communities' i.e., the Adivasis, the Dalits, and the Muslims are much more concentrated in the Malabar region. The region constitutes 43.8 percent of the state's total population from all groups. According to the 2011 census, 67.82 percent of Adivasis, 35.54 percent of Dalits and 71.8 percent of Muslims who constitute 1.45 percent,9. 09 percent and 43.5 percent respectively in the state's population reside in the six districts of the Malabar region (Compiled from Censuses 2011). Even though Adivasis and Dalits have their significant share of the population in the state is living in Malabar, they are not the numerically dominating groups in the region. The region's population composition includes 2.24 percent of ST, 7.7 percent of SC, 43.5 percent of Muslims, 5.81 percent of Christians and 40.8 percent of other backward caste and forward caste Hindus (Census of India 2011). Intuitively speaking, a larger share of the population should enable a community to assert its rights. The case of Muslims in the region is an example of this; they are numerically dominant in Malabar, especially in Malappuram district, with strong political identity and relative economic stability and prosperity (Kumar 2001; Mathew and Nayar 1978; Menon 1995). However, this is not true for all communities, in the case of forward communities like Nayar and other forward castes in Hindus and Christians, their share in the population of the state is smaller compared to other major social groups, but they are well represented in government employment (Zachariah 2016); among entrepreneurs (Joseph 2003), in the leadership of major political parties and among legislators (Kumar 2009). However, in the case of Dalits and Adivasis they are not well represented in government employment,

higher education, business and in the leadership of major political parties in relation to their share in the population.

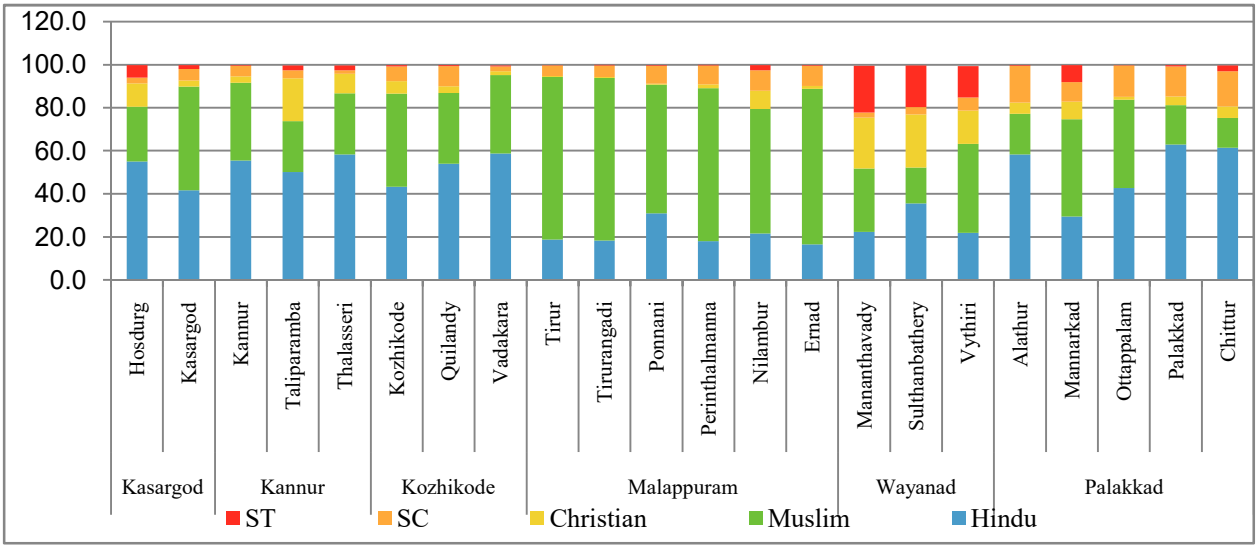
The high social sector achievements experienced by the state get wide attention among scholars and policymakers. Various scholars have attributed these achievements to democratic policies of successive governments (Franke and Chasin 1994; Rammohan 2000); and to the role of progressive Maharajas, church, social reform movements (Bose 2006; Cleetus 2007; Oommen 2004) and public action (Dreze and Sen 1997). In the case of Malabar region, there has been not much role of the princely rulers as the region was under the direct control of the colonial government for an extended period. The idea of public action formulated by Amartya Sen and Jean Dreze appears more suitable to the region. The region witnessed public action in the form of movements backed by a different class, caste, and religious organizations along with the nationalists and socialist movements in the colonial period and state intervention backed by political parties in the post-independence period (George 1986; Gopalankutty 1978). However, neither the movements led by different caste, class, religious and political groups nor the post-independence state governments effectively addressed the issues of marginalized communities or sub-regions (Sreekumar and Parayil 2006). Even though there have been labour movements and movements of the Adivasis and lower castes in the region, such movements were absorbed by the nationalist and communist movements and other political parties at different times (Steur 2011). Further, such movements were mainly took place in the urban areas of the districts (Radhakrishnan 1989). The result of this process was the marginalization of lower castes, lower classes and backward sub-regions, and their demands in the larger movements.

Development experience of sub-regions in Malabar

The Malabar region has 22 Taluks in six districts. Each taluk consists of around 21 villages with an average population of 6,97,949. In Malabar, except the taluks of Wayanad district, all other Taluks have more than four lakh populations ranging up to sixteen lakhs. Palakkad is the only district where all Taluks have more than nine percent of the SC population, with the lowest percent in Mannarkkad and highest in Alathur taluk. In the proportion of Adivasis, Wayanad is the only district with more than 14 percent of ST population in all taluks, with the highest of 21.6 percent in Mananthavady. The taluks with a good share of Dalits and Adivasis are Mannarkkad and Vythiri with more than six percent of both communities, followed by Chittur, Nilambur,

Mananthavady, Sulthan Bathery, Taliparamba, and Hosdurg with more than two percent of both communities. However, while considering the comparative representation of all religious groups in a taluk, including Dalits and Adivasis; Alathur, Chittur, Eranad, and Vythiri are identified with the lowest gap in population distribution from various social groups. Among the four, Vythiri constitutes more than 40 percent of the Muslim population, more than 20 percent of the Hindu population, more than 15 percent of the Christian population, more than 14 percent of the Adivasi population, and more than 6 percent of the Dalit population (see figure 1.6).

Figure 1.6 Distribution of Taluks based on SC, ST, and religious wise population.

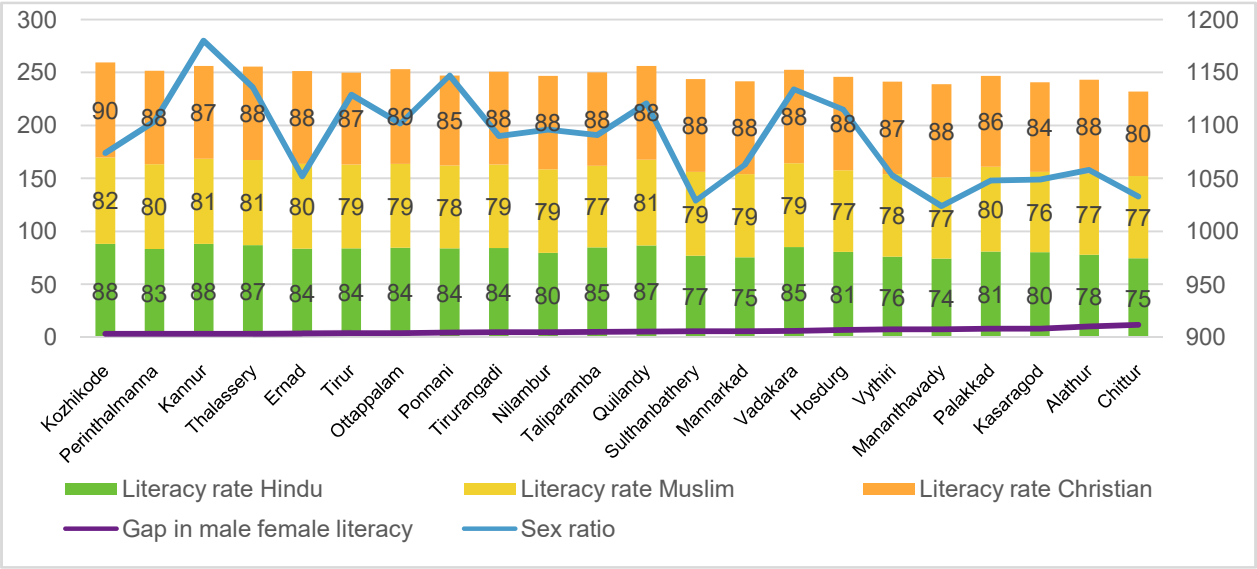


Source: Census of India, 2011

The census data shows that during 2011 all taluks in the Malabar region have a sex ratio of more than 1024, with a maximum of 1180 in Kannur taluk. It is interesting to note that in those taluks where the sex ratio is high, the total literacy rate is recorded as high and the gap in male-female literacy is recorded as low. In other words, taluks with a low sex ratio like Mananthavady, Chittur, and Vythiri are lagging in literacy rate and report a high gap in male-female literacy favoring males. In terms of literacy rate among different social groups, it is highest among Christians in all the taluks except in one. The religious group which ranks second in literacy rate is Hindus but only in 17 taluks. In the remaining five taluks, Muslims rank second even though they rank lowest in all other taluks (see figure 1.7). The five taluks where the literacy rate is

lowest for Hindus[2] are in Wayanad and Palakkad district, where Adivasis and Dalits have a significant population.

Figure 1.7 Distribution of taluks by religious wise literacy rate during 2011

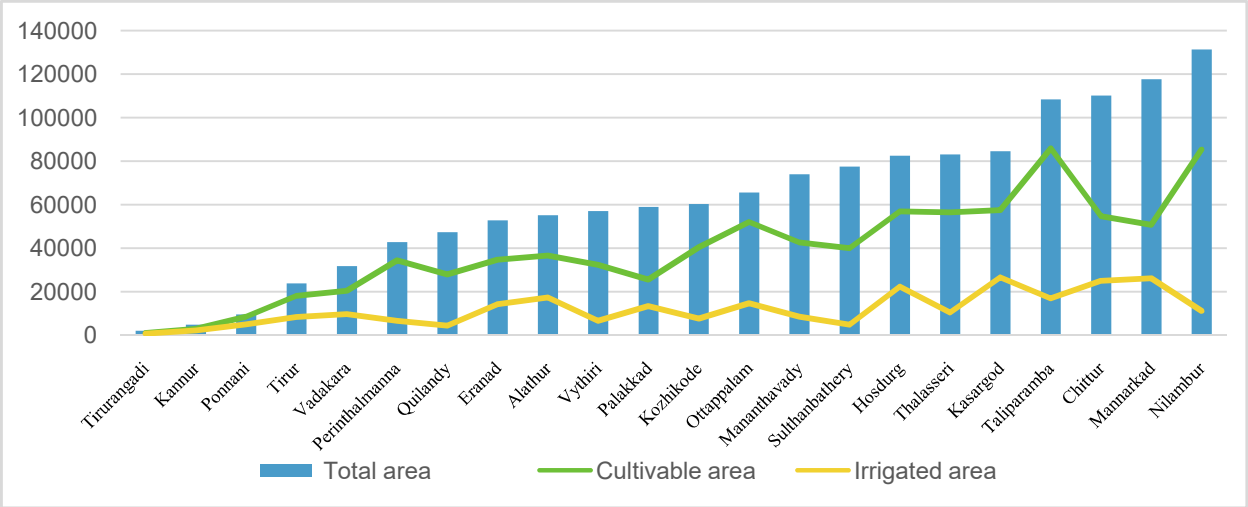


Source: Census of India, 2011

Regarding the area of land, Tirurangadi, Kannur, and Ponnani constituted the smallest taluks, with less than ten thousand hectares of land. On the other hand, Chittur, Mannarkkad, Taliparamba, and Nilambur constituted the biggest taluks with more than one lakh hectares of land. Except for Chittur, Mannarkkad, and Palakkad, more than half of the lands are cultivable in all other taluks. However, only five taluks from the region have more than fifty percent of its cultivable lands been irrigated. These five taluks are in Malappuram, Kannur, and Palakkad districts. Regarding work participation rate, among the top ten taluks with the highest work participation rate, except taluks Chittur, Palakkad, and Mannarkkad, all others have cultivable land more than half of its total land area. However, among them, only two have more than half of its cultivable land been irrigated during 2011 (see figure 1.8).

[2] In the Census of 2011, taluk wise literacy rate given for Hindus includes the literacy of Dalits and Adivasis too.

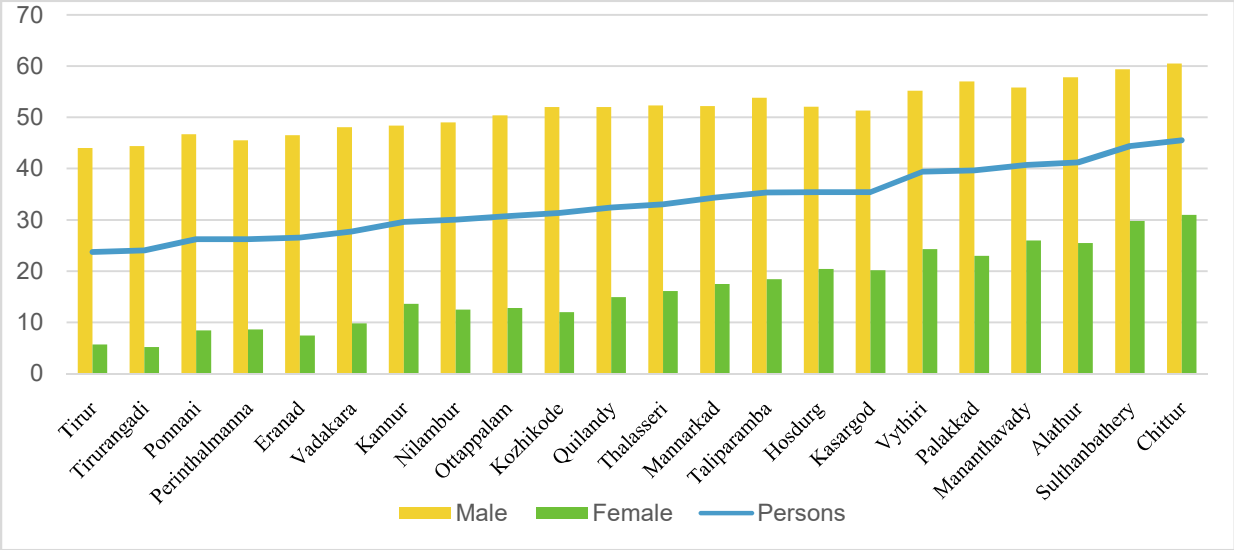
Figure 1.8 Distribution of Taluks based on the total area occupied and land use, 2011.



Source: Census of India 2011

As shown in figure 1.9 the work participation rate is lowest in the taluks of Malappuram district and highest in the districts of Wayanad and Palakkad. The affluence of remittance through Gulf emigration in many households in Malappuram, and the concentration of Adivasis in Wayanad, and the concentration of Dalits in Palakkad will pertinently explain this trend in the work participation rate. Dalits and Adivasis constitute a large number of agricultural workers from the region. On the other hand, the taluks with the largest number of emigrants and households with an emigrant are high in Malappuram. Hence, the affluence from remittance withdraws many workers from these regions leading to a low work participation rate. In the case of female work participation, studies pointed out increase school enrolment as a reason for decreasing female work participation (Kannan & Reveendran 2012; Thomas 2012). However, in the state, especially in areas where Gulf emigrants are concentrated, the affluence of remittance is a reason for low work participation among females. The taluks having the highest migration rate recorded a low female work participation rate and a low emigration rate among women. On the other hand, the Wayanad district, which has a low emigration rate recorded high female work participation. Thus, financial support from emigrants has led to a tendency among women to remain unemployed, and lack of such support leads them to take up some employment (Mazumdar & Guruswamy 2006).

Figure 1.9 Taluk wise work participation rate during 2011



Source: Census of India 2011

In the region, the percent of non-workers[3] is more than 70 percent in eight taluks. Among the workers, main workers[4] are the highest and marginal workers[4] are only less than ten percent in every taluk. As expected, main workers are highest in taluks with high work participation rates, and it is in these taluks where the share of agricultural labourers and cultivators are also high. For example, Chittur, Sulthan Bathery, Mananthavady, and Vythiri are the taluks with the highest number of agricultural labourers along with the highest rank in the work participation rate. Among the different worker categories, household industry workers constitute the lowest among all taluks. Except for Sulthan Bathery and Mananthavady, in all other taluks more than half of the workers are engaged in works other than agricultural labouring, household industry works, and cultivation.

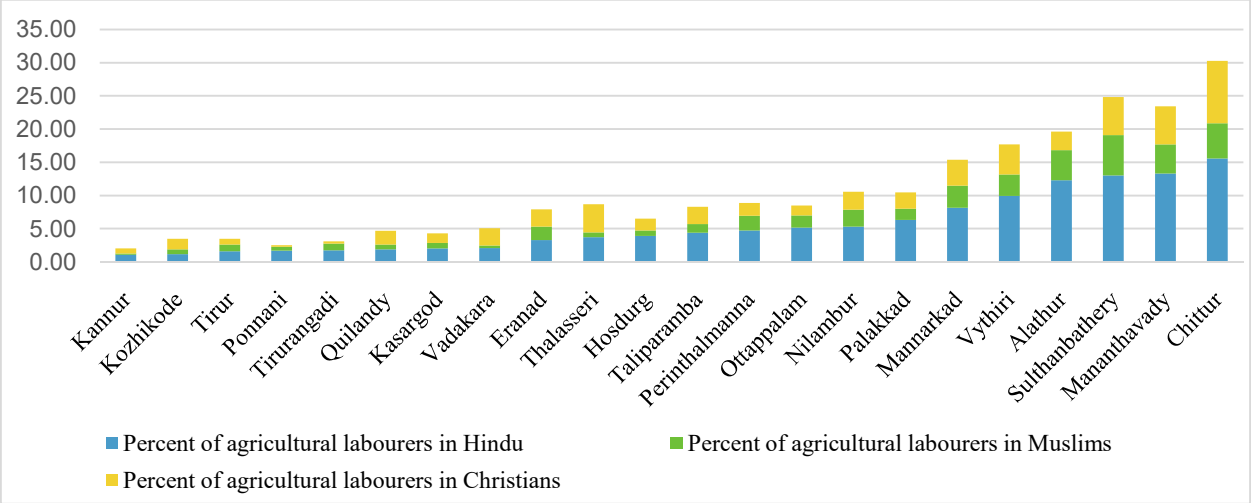
Further, the proportion of agricultural labourers is highest among Hindus in 18 out of 22 taluks. In the remaining four taluks proportion of agricultural labours are highest among Christians (see

[3] According to census of India non workers are, persons having unidentified source of income and with unspecified sources of subsistence and not engaged in any economically productive work during the reference period.

[4] The Census of India classified workers in to two main categories, main and marginal workers according to the number of days they have worked during the reference period. The workers who had worked six month or more (major part of the reference period) is called the main workers and those worked less than six months of the reference period are called as marginal workers.

figure 1.10). The proportion of agricultural labours is lowest among Muslims. In fact, it is lowest among Muslims in the taluks of Malappuram, where they are predominant in population. One of the reasons for the high ratio of agricultural labourers among Hindus is the inclusion of SC and ST populations under the 'Hindu' category by the census data. A comparison of 2001 census data with 2011 shows a decline in agricultural labours in all taluks except taluks in Wayanad and Kasargod district. Besides, these are the only districts that showed an increase in cultivators during the period.

Figure 1.10 Religion wise distributions of agricultural labourers in taluks



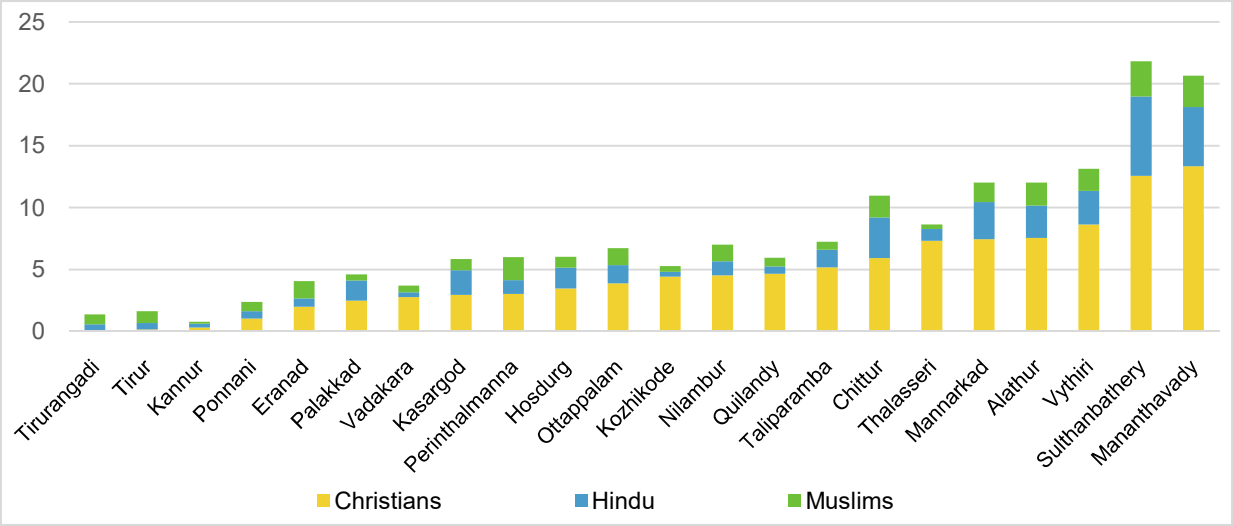
Source: Census of India, 2011

Regarding cultivators, the highest share of cultivators is in the six taluks of Wayanad and Palakkad districts. Further,the proportion of cultivators is highest among Christians in all taluks except three (see figure 1.11). Followed by Christians, Hindus have the highest proportion of cultivators in the largest number of taluks. It is interesting to note that, in the two taluks of Malappuram, the proportion of cultivators is highest among Muslims. Among the household industry workers, Hindus have the highest proportion of workers in all taluks, followed by Christians in more than half of the taluks. Similar to the case of agricultural labourers and cultivators, Muslims account for the lowest ratio of household industry workers among more than half of the taluks.

As we see, the highest proportion of cultivators is in Christians, and the taluks with the highest share of cultivators are the taluks of Wayanad and Kasargod from the region. One of the reasons

for this is the migration of small-scale farmers (settlers) from the southern part of the state to Malabar during the 1940s migration wave (Menon 1995). Menon (1995) notes that these settlers were mainly Christians and largely organized under the political party 'Kerala Congress'; under their pressurization state governments compelled to give title deeds to the settlers. The new cultivators become prominent groups in the region and largely employed native agricultural labours to expand their cultivation. Even though it gave employment to the poor from the region, no substantial improvements happened in the lives of the agricultural labours. Instead, it altered the earlier landlord's exploitation to new forms of exploitation by the settlers (Steur 2011). The native Adivasis and Dalits now become mere agricultural labours under other dominant social groups who come to the region at different times.

Figure 1.11 Religion wise distributions of cultivators in taluks during 2011



Source: Census of India, 2011

Gulf migration is the other major source of employment for many poor from the region. The increased employment opportunities in Gulf countries after the oil boom became the main source of income for many households in Malabar. In the present-day Malabar and Kerala, no sector has in one way or another got influenced by the remittance from Gulf. However, the trend of emigration and remittance it brought are not similar among all sub-regions and all social groups in the region. As similar to many other aspects, some of the sub-regions and social groups have greatly benefited from it compared to others. When the lowest proportion in agricultural labours, cultivators, and household industry workers is recorded among Muslims from the taluks of Malabar, their proportion in emigrants recorded the highest. A Taluk wise analysis of emigrants

and households of emigrants shows that there are pockets of international migration in Malabar. For example, Tirur taluk of Malappuram district recorded the highest number of emigrants having nearly 70 emigrants for every 100 households during 2003 (Zachariah, Mathew, and Rajan 2003). The trend continued during 2011, by having more than one lakh emigrants in Tirur and Thalasseri taluks. The other districts which recorded a high number of emigrants are Eranad, Kozhikode, and Kannur with more than eighty thousand emigrants. On the other hand, emigrants are lowest in Alathur, Mananthavady, Sulthan Bathery, Chittur, and Vythiri taluks with less than twelve thousand emigrants. In fact, Alathur recorded the lowest with less than five thousand emigrants during 2011.

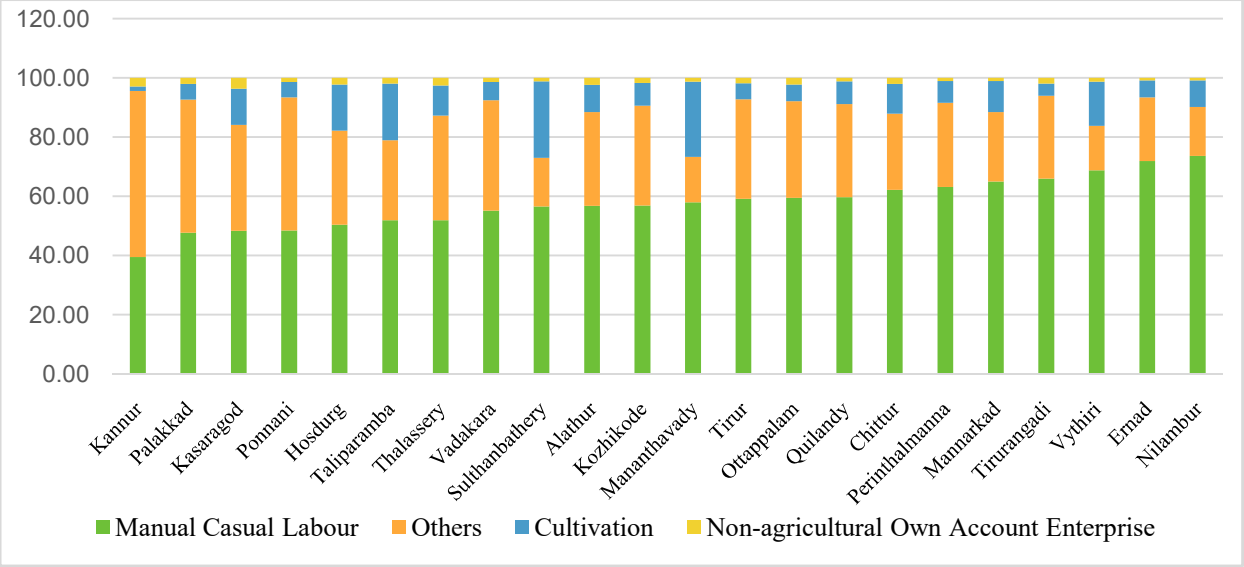
Further, there is a significant difference among the taluks within Malabar in terms of remittance received. When the taluks Tirur, Kozhikode, and Taliparamba earned a remittance of more than two thousand crores, Chittur, Alathur, Mananthavady, Sulthan Bathery, and Vythiri earned less than 250 crores during 2011 (Zachariah and Rajan 2012). Such large differences in the number of emigrants, number of households with emigrants, and the amount of remittance received among various taluks have a differential impact. For example, large-scale emigration of workers from particular localities within the districts or taluk led to the emergence of 'Gulf pockets'. Such Gulf pockets are found largely in taluks with a high number of emigrants, and it is characterized by the presence of a busy local market with Arabian-style restaurants, bakeries, furniture shops and supermarkets. In addition, studies also point out areas in Malabar, where affluence from remittance has led to large investments in business and private institutions, especially in the tertiary sector (Dilip 2008; Harilal and Joseph 2003). In such pockets, after a few decades' continuous exposures to emigration and remittance, the households without any emigrant were also affected by the pattern of use and costs of various basic services including education, health, and child delivery services (Zachariah &Rajan 2008).

The benefit of emigration and remittances it brought has drastically changed the development nature of various sub-regions, even leading to a remittance-based development (Zachariah &Rajan 2009). However, it is found that workers from better-off households are more likely to emigrate and that emigration has contributed to increasing inequality (Zachariah & Rajan 2012). It is evident from the increase in the number of emigrants by 24 percent during 2003 and 2011, without a subsequent increase in the share of households with only one worker emigrated

(Zachariah & Rajan 2012). The APL and BPL categorization of emigrant households based on ration card possessed by the household shows, out of the total cardholders only 22.95 percent of households in Tirur block, which is highly benefited through emigration, fall under the BPL category (Civil Supplies Department Kerala 2014). The proportion of households with a red ration card (indicate that the household is very poor) is 38.2 percent in households without an emigrant, but only 18.4 percent in households with one or more emigrant (Zachariah and Rajan 2012). Such statistics show that in addition to the area level inequalities, emigration has also led to household level inequalities in income.

Now coming to the main source of income for households, except four taluks, more than half of households from all taluks have their main income coming from manual casual labour (see figure 1.12). In the four taluks, Kannur, Palakkad, Kasargod, and Ponnani, majority of households earn their primary income from occupations other than manual casual labour. As similar to the share of cultivators, the households with primary income from cultivation are high in Sulthan Bathery and Mananthavady taluks. The households with the main source of income from non-agricultural own account enterprises are lowest in all taluks. Income from sources other than casual labour, cultivation, and non-agricultural own account enterprises are the second highest for households from most of the taluks.

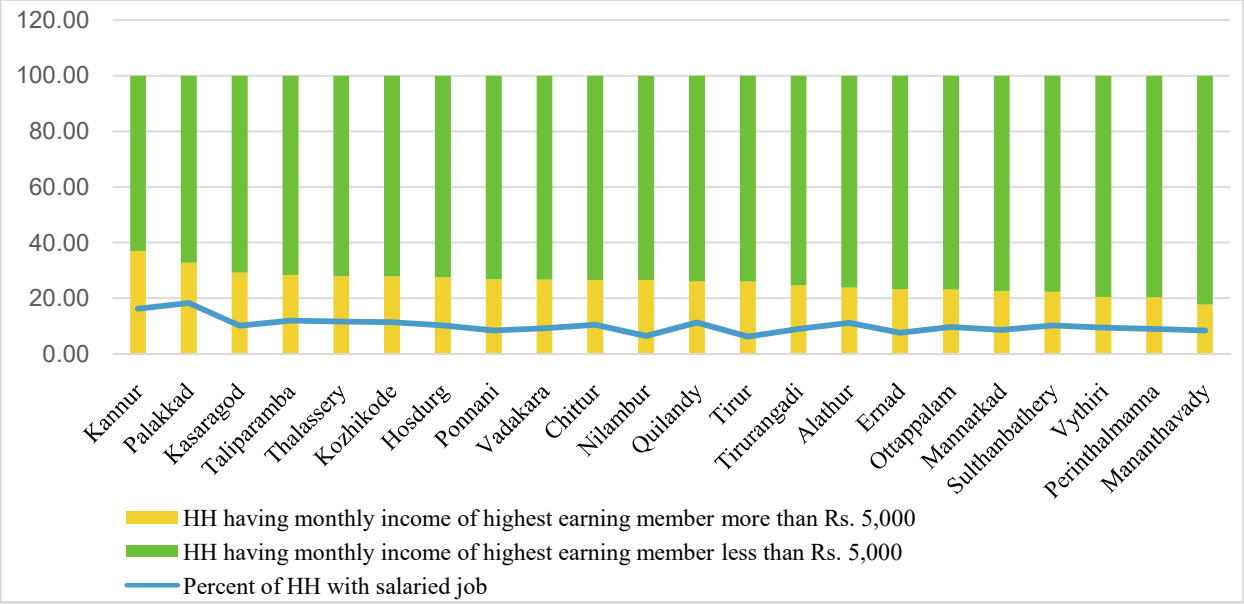
Figure 1.12 Taluk wise percent of households based on the main source of income - 2011.



Source: Census of India, 2011

While coming to monthly income among households, more than three-fifth of households in all taluks have monthly income of highest-earning member is less than Rs.5000. Further, the share of such households with the lowest income is highest in Mananthavady taluk. On the other hand, 13 taluks have more than 25 percent households with a monthly income of highest-earning member more than Rs.5000. The share of such households is highest in Kannur taluk. In line with this trend, the percent of households with salaried employment is high among those taluks which have a better monthly income for most of its households (see figure 1.13). Figure 1.13 also shows that, Vythiri, Perinthalmanna and Manathawady are the taluks with highest share of households having monthly income of highest earning member less than ₹25000 and lowest percent of household with salaried employement.

Figure 1.13 Taluk wise percent of households based on monthly income of highest earning member in Malabar - 2011.



Source: Census of India, 2011

The Sub-regional wise analysis shows a clear stratification of various social groups and concentration of socioeconomic backwardness in certain taluks. Most of the Muslims, Dalits and, Adivasis from the regions were concentrated in certain taluks only. Among them, Dalits and Adivasis were concentrated in those taluks which have the highest work participation rate, the highest percentage of agricultural labourers, the highest percent of cultivators, the highest percent of main workers, the lowest sex ratio, the lowest literacy rate, a high gap in male-female

literacy, low rate of emigration, the lowest share of salaried employees and lowest monthly income. Such characterizations of certain sub-regions are not just happened naturally. As part of the development experience, the socioeconomic and political activities that took place in the region do not reflect equally in all taluks. When some of the sub-regions were able to outperform, some others lag. The wider socio-political and the economic context of the social groups residing in these sub-regions will help us to better understand the shaping of certain sub-regions as least developed.

Marginalized communities of Malabar

As elsewhere in the country, marginalized communities face exclusion and discrimination in various spheres of public life in the region too. However, they enjoy a comparative advantage in terms of health in Kerala compared to other parts of the country (Bhat and Rajan 1980; UNDP 2006). Adivasis, Dalits, fisher community, women, agricultural workers, and other unorganized daily wage laborers constitute the marginalized communities in the region. However, their degree of marginalization varies in various aspects. Even after the comparative advantage over their counterparts from the rest of the country, within the state, marginalized communities face a large disparity in quality of life compared to other social groups in the state. For example, poverty is recorded highest among them, their health status remains the lowest, their representation in government employment, in the leadership of social and political organizations, and in higher education is lower. In fact, during 2001 Kerala has the highest gap between the tribal and no-tribal populations in various socioeconomic development indicators compared to the rest of the country (Chandran 2012). Marginalized communities, especially Dalits and Adivasis from the region and from all over the state face higher levels of morbidity, and poorer access to healthcare (C&AG 2014; Haddad et al. 2012; Kannan et al. 1991; Navaneethan and Kabir 2009). Further, on general population health indicators including the rate of infant mortality, maternal mortality and under five mortality, the marginalized communities lag behind others (Ministry of Tribal Affairs 2013, also see table 1.4).

The Adivasis of Kerala constitutes only a little more than one percent of the total population and thus the major political parties considered them as politically insignificant to influence elections. The membership in political parties and trade unions shows a good share of Adivasis, Dalits, and Muslims are members of political parties (see table 1.8). Nevertheless, when most people from

the Muslim community were organized under a political party that emerged from the community itself, Adivasis and Dalits were part of the already established political parties like communists and congress. Thus, they never represented well in any of the political parties (Steur 2011). One of the studies done in rural village of Malabar shows that even though many of the tribes participate in voting and party meetings, still more than half of the tribal population surveyed did not know the name of the country to which they belong and more than three-quarter of them do not have access to any newspapers (Zacharias 2002). The membership and affiliation with political parties among the majority of Dalits and Adivasis signify nothing more than mere mobilization for party events. Different from other major social groups, the lack of social and political mobilization of the tribal communities leads to a situation where the voice of the tribal was never well represented in the government policies (Aiyappan 1994). The Adivasis continue to face suppression as dominant groups invariably succeed in influencing the government to implement laws and policies in their favor. On the other hand, the growing political mobilization of the tribal communities in Malabar and all over the state had shown a positive impact on the government's initiative towards Adivasis. However, such attempts got strong opposition and there were attempts from major political parties in the state to absorb such efforts of Adivasis (Heller 1999). It is surprising to note that, it was those political parties who were ideologically committed to the cause of Adivasis, including leftist parties who stood against the attempts of Adivasis as a community to organize socially and politically.

Table 1.8 Membership in political parties and trade unions among various social groups in Kerala – 2006

		Political party	Trade Union
Religion	Hindu	25.4	19.6
	Muslim	22.4	9.5
	Christian	18.5	14.2
Caste	Forward caste	20.6	17.2
	Backward caste	25.3	19.9
	Scheduled caste	33.5	20.7
	Scheduled Tribe	42.1	11.7

Source: KSSP 2006

Beginning from the migration of farmers from the southern part of the state to highlands, the number of non-tribal started steadily moving into tribal areas of Malabar (they are called

settlers). These settlers are political heavyweights who have a stronghold in religious and political organizations. Through their arrival, they not only made Adivasis deep into debt, but also made them daily labourers in their own land by taking the land owned by tribal as mortgage (Bijoy 1999; Sreemith and Deepu 2014). The response from both the Left Democratic Front (LDF) and United Democratic Front (UDF) governments who alternatively ruled the state was, instead of passing and implementing pro-Adivasi Act, they try to delay it to protect the interest of settlers. After a long juridico-legal battle when the high-court forced the government to pass and implement the 1975 Kerala Tribal (Restriction on Transfer of Lands and Restoration of Alienated Lands) Act, the government continuously attempted to delay in implementing the same and came up with a pro-settlers amendment to the Act (Sreekumar and Parayil 2006). Thus, instead of ensuring lands to the Adivasis, the unanimous position of continued governments in the state was to protect the non-Adivasi migrant settlers who had grabbed lands of Adivasis (Bijoy 1999).

On the other hands, some other communities were able to become politically strongholds in the state through the establishment of political parties and socio-religious organizations. Social groups like Muslim, Christian, Nayar, and Thiyya communities were able to succeed in such ways. Even though there were attempts and limited success in the political organization of Adivasis and Dalits, they lacked resources to support their movements. On the other hand, for some other communities' availability of such resources made their attempts much easier. For example, the effect of emigration enabled the newly rich from various communities to get into the leadership positions of political parties. Before this, the political leadership in the state came from a small set of communities including some Muslim elites until the 1970s. However, by the end of the 1990s new understanding and assertion of the political process took place in the state because of changes in economic status, education level, and the land relationship among various communities through the affluence of remittance from emigration. The emergence of Muslims as a strong political power in the pockets of Malabar and the state is strongly supported by the affluence of remittance. Altogether a different pattern of emigration from the state influenced the political sociology and sociology of political leaders in the state (Samuel 2011).

When land reform was enacted, tenants in Kerala become owners of the land, but the Adivasis and Dalits remained landless, as they were never tenants although they were the real tillers of the

soil (Mukunthan 2012). The land ownership among different social groups in the state during 2003 shows that the average landholding by households is highest among Christians and upper-caste Hindus with 126 cents and 105 cents, respectively. Further, when households among the Muslim community recorded an average landholding of 77 cents, Dalit households recorded the lowest holding of 27 cents. This shows that even after several decades of well-celebrated land reform, the average land holds by upper-caste Hindu families is around fourfold more than that of a Dalit family (KSSP 2006). In fact, by pointing out the condition of Dalits regarding land holdings, it is argued that the land-caste nexus is far from over in the state. Such an argument is based on the fact that, firstly, historically Dalits were denied land ownership under the caste system. Secondly, the land reform was done by the government, significantly excluded the lower caste, and maintained provisions to hold large tracts of land by upper caste. Lastly, the current trends of land market activities tend to exclude lower castes from land ownership (Yadu and Vijayasuryan 2016).

The creation of 'Harijan colonies' and *'lakshomveedu'* (One Lakh Housing Project) colonies were the post-land reform period programmes for the landless Dalits. However, instead of ensuring social justice, such colonies isolate the poor from the mainstream (Oommen 2006). It led to the ghettoization of Dalits to the caste colonies with a small house in three to four cents of land mostly in the interiors of villages. Such colonies remain indicators for the inferior social status of Dalits, and it distances them from the mainstream of society and helps others to appropriate their labour (Pramod 2020). According to census 2011 data, the percent of houses in fair-good condition among Adivasis and Dalits in the state was only 38 and 45 percent respectively, at the same time the total average among all social groups is 66 percent. Regarding the availability of space among those who have houses, 22 percent Adivasis and 16 percent of Dalits live in single room houses during 2011 compared only 8 percent among all social groups together. In case of the homeless and those lives in houses with poor condition, the state government has come up with a housing scheme called LIFE Mission. However, the new scheme does not learn from the flaws of the earlier housing schemes, and under the new scheme housing complexes with apartments of a small area is what constructing. In fact, land and house are not just an economic asset for Adivasis and Dalits but it is closely linked to their socio-cultural life. Through the earlier housing project, the Dalits were confined into a small house in the tiny piece of land, and under the new scheme, even those pieces of land were not given and confined into

apartments of few square feet. Further, those who receive such apartments can only live in that space as it does not provide any commodity value because the ownership will remain with the government for more than a decade.

The occupational pattern among social groups shows that the informal sector employs the majority of marginalized communities. As the government is the major provider of formal employment in the state, representation of various communities in government employment will give a snapshot of their representation in the formal sector. Table 1.9 shows, Muslims, Adivasis, Dalits, and other backward castes are underrepresented in formal employment. The upper caste Nayar and other forward caste Hindus recorded dominance in government employment more than 40 percent of their representation in the population. The other community which shows a high representation in government employment over their representation in population is Christians. In the case of Muslims, Dalits, Adivasis, and other backward castes, they all recorded a very low representation in government employment in the state during 2006. Even though the Muslim community recorded the lowest representation, they have a greater advantage in other financially beneficial livelihood options like emigration. Thus, the most disadvantaged by lower representation in formal employment under the government sector are the Adivasis, Dalits and other lower caste.

Table 1.9 Representation of social groups in government employments in Kerala- 2006

Category	Percent to the total population	Percent to government employment	Percent increase or decrease
Christian	18.3	20.6	+11
Muslim	26.9	11.4	-136
Nayar	12.5	21	+40.5
Other forward Hindus	1.3	3.1	+56.5
Thiyya / Ezhava	22.2	22.7	0.02
Other backward caste	8.2	5.8	-41
Scheduled Caste	9	7.6	-22.6
Scheduled Tribe	1.2	0.8	-49.5

Source: KSSP 2006

Emigration to Gulf countries is the other major employment opportunity that renders better financial benefit for many skilled and semiskilled employees from the region. The Kerala Migration Survey 2011 point out that emigration to Gulf countries is dominated by Muslims and their share of emigrants from the state (44.3 percent) remains much more than their share of the

total population (26.5 percent). For every 100 households, there are around 59 emigrants among Muslims but only around 18 among Hindus and 29 among Christians. As Muslim households dominate among the emigrants from Malabar and the whole state, they receive nearly 50 percent of the total remittance followed by Thiyya and Syrian Christian households with 13 percent share each. However scheduled castes and scheduled tribes are few among the emigrants and they receive the lowest remittance among the communities. It is estimated that remittance reduced poverty in the state by 3 percent points and the decline was noticed largest among Muslims followed by Thiyya and Latin Christians (Nair 1989, Zachariah, Mathew & Rajan 2000). Further, it is found that the improved socioeconomic background of the emigrants bears a direct impact on the health of their children, through lowering child mortality and malnutrition. Even though, emigration helped to reduce poverty and improve health status among social groups which have a large number of emigrants, to an extent, it led to inequality among emigrant and non-emigrant households among different social groups.

The advantages of certain communities in remittance, trade, and business in Malabar have historical trends. During the mid-nineteenth century, trade of timber, rice, and copra with the Gulf countries were the major economic activities in the region. Koyas,[5] among the Muslims; traders of Gujarati origin, Chetties, Vyavari Nayar, Arabs and few non- Koya Muslims dominated in such trade, which helped the local middle class to accumulate substantial capital after the mid-nineteenth century (Osella and Osella 2007; Nambiar 1963 cited in Subrahmanyam 2002). However, after the decline in Arab trade and the beginning of the Gulf oil boom, remittance from emigrants in Gulf countries became the main source of income for many households in the Malabar region. Osella and Osella (2007) confirm that most of the Koya families in the region have at least one member who migrated to Gulf countries. As Koya's were already wealthy in Kerala, they heavily invested in petty trade in Gulf countries and few also succeeded in setting up transnational or Gulf-based businesses (Osella and Osella 2007). Konya's were outstanding in economic activities compared to other communities in the region through their involvement in money lending, interest in coastal trade, stress upon economic calculations, savings, and thriftiness. The friendship and gatherings among the Koays of same

[5]Koyas are subdivision of Muslims from Malabar who claims their descent from upper class Hindu such as Nayar as well as from the Arabs

Tharavadu[6]or friends were even reproduced in Gulf countries, once they emigrated, in a more organized manner and sometimes led to the beginning of a new business ventures (Osella & Osella 2007). They also realized that Muslims are happy because of Gulf migration and economic opportunities and have gained self-respect, self-reliance, and confidence; for this education is the base and is a must for future betterment. The enthusiasm for reform among Muslims is as high as they have built many educational institutions and modern hospitals all over the state.

The fisher community, agricultural labours, and women are the other groups who failed to catch-up with the development experience of the state. The formerly matrilineal women face far-reaching impacts in the way of curtailing their rights and status through the abolition of the matrilineal system. They were kept away from the political and social leadership in the state, their share in the state legislative assembly was always very low. The high female literacy, good health care available to women, and other benefits like access to a proper public distribution system are termed as benefits earned by Kerala women. However, none of these; education, health care, or access to public distribution system can be taken as an indicator for the freedom, equality, and awareness of women's dignity and individuality in Kerala (Omvedt 2006). There are many examples for this, Omvedt (2006) points out the case of large acceptance for family planning programme among women in Kerala. However, one cannot simply assume that the education they attained led them to receive sufficient knowledge about the method they adopt and aware of their pros and cons. Women in Kerala are not denied access to the public sphere, but the roads to get there are not safe for them. They are nearly invisible in higher levels of cultural, political organizations, and trade unions (Devika and Thampi 2011; Jeffrey 2016). Women from all social and economic group face disadvantages, like when the households of emigrants achieved social and economic mobility, dowry has risen to unimaginable heights among the wealthy (Chacko 2003). When it comes to the lower class and lower caste communities, their lives remain hazardous and insecure. They face multiple disadvantages of being women of a lower class and lower caste community.

[6]Tharavadu is a joint family system practiced by people from Kerala.

Agricultural workers, another numerically dominant group in the region, are the landless agricultural workers[7] employed by farmers on a daily wage. According to Mencher (1980), agricultural workers failed to catch up with the development benefits achieved by the state as a whole. By examining employment, fertility, land reform, nutrition, education, and other public facilities, she argues that the largely attributed socio-demographic achievements of the Kerala model do not really benefit the agricultural workers. Kannan (2002) points out, even though agricultural workers are organized under the welfare fund scheme, they get very low old-age pensions, not receive any gratuity benefits, provident fund, and any other major socioeconomic support. It is also notable that the major shares of these agricultural workers are women (Kannan 2002). The decrease in employment was the other major issue of agricultural labours due to various reasons like an increase in labour force, changes in technology, and a decrease in alternative sources of income for Adivasis due to the nationalization of forestland. However, efforts from the government and trade unions to resolve such issues were minimal. While it is true that the agricultural union was strong in Kerala and it led to a high wage rate compared to other states, but the number of days of employment available for agricultural workers was very low.

Fishing and fisheries have a very significant role in the socio-cultural and economic fabric of Kerala. However, the fisher community was neither benefitted really from its increased value of output nor advantaged at the state's overall improvement in the quality of life (Kurien 1995). Kurien (1995) noted their persistent poverty is largely due to the low quality in the condition of habitat along the narrow strip of coastline land. He finds that the basic amenities like housing, toilet facility, and access to drinking water available to them are of low standard compared to other communities. Panikar and Soman (1984) shows enough examples for the non-existence of Kerala's health paradox, good health development even at economic backwardness, among the fisher community. Their study shows a high prevalence of respiratory and skin infections, diarrheal disorders, and hookworm infection among the fisher community in the state. Kurien (1995) noted that it was only in the early 1980s fishing community began to organize as 'fish workers' as a response to their deteriorating socioeconomic conditions. The pre-independence

[7] Landless agricultural workers are those workers without own agricultural land. Otherwise a good share of agricultural workers in the state has homestead land.

social movements and the post-independence politicization of social causes failed to involve the issues of fisher communities, as the former was restricted to Hindu communities in the agrarian sector and later has seen them only as a vote bank (Kurien 1995).

In brief, not just in health status but in broader determinants of social development marginalized communities lag other social groups in the state. Their progress is not aligned with the overall development of the state. The dearth in their progress can be better understood through their educational attainment especially in higher education. The enrolment of students in higher education among Adivasis and Dalits remains as low as 1.01 percent and 1.02 percent, respectively. Their share in teaching posts also shows a dearth of representation, as the percent of teachers in higher education is only 0.21 among Adivasis and 2.7 among Dalits in the state during 2013[8]. Even considered to be ruled by 'progressive' political forces for several years, the state has not been able to create enough opportunities for Dalits, Adivasis, Muslims, and OBC in various aspects of social development. In the move to attain higher progress in overall social development, the state governments focused little on issues affecting marginalized communities.

Marginalization of communities and development of health care facilities in Malabar

As already discussed, marginalized communities in the state face multiple disadvantages, resulting in the experience of lower quality of life and health than other communities. One of the pathways through which this marginalization in health happens is due to the exclusion of certain communities from the health care system. To understand this marginalization of certain communities from the region's healthcare system, it is important to understand the social process that shaped the region's healthcare system. That will further help to contextualize the responsiveness of the healthcare system towards various social groups.

Kabir & Krishnan (1992) shows evidence for differences in the socialization of Allopathic medicine in Malabar and Travancore as: in Travancore, attempts were made to integrate women in healthcare provisioning, provided access to the disadvantaged castes in public dispensaries, appointed health care providers (vaccinators) from different social groups, made vaccination

[8]Source: All India Survey on Higher Education 2012-13 (Provisional), 2014

compulsory for school children[9]. The member of the Royal family themselves inoculated first to avoid doubts and reservation on the usefulness of vaccination. Instead, in Malabar, the vaccinators were from the lower caste and the upper castes refused to get vaccinated by lower caste vaccinators. Further, the demand to appoint vaccinators from different social groups in Malabar remained unheard by the colonial authorities, unlike what happened in Travancore (Kabir & Krishnan 1992). Further, the princely state of Travancore provided western medical care as a superior form of therapeutic practice by establishing government dispensaries and aiding Christian missionaries for their medical services (Cleetus 2007). On the other hand, Malabar lacks such attempts from colonial government and there were no such substantial attempts on health from Missionaries in Malabar.

Development of modern health care facilities in the state beyond 1965 witnessed a large-scale reduction in the intrastate variation in health care facilities to remove the existing north-south divide among the districts. Kabir and Krishnan (1992) argue that this was mainly achieved through the replication of policies and programmes successfully implemented in the southern regions of the state in Malabar. In other words, the secret of the Kerala model of health care lies in the fact that when the policies and programmes that succeeded in the princely states of Travancore and Cochin were implemented in Malabar, they not only produced similar results but also achieved them within a much shorter period. The underlying philosophy of the policies implemented by Travancore and Cochin was their attempt to social intermediation with a view to make the western health care system acceptable to a large segment of the population (Kabir and Krishnan 1992). As a result, allopathic institutions and its services got well accepted throughout the region. For example, Osella & Osella (2009) observes elites from the Muslim community, because of the affluence of emigration and consequent expansion of private facilities in health and education, widely embraced the modern values of health and education. Hence there was no acknowledgment of the need to integrate traditional beliefs of Adivasis into the health system's practice (George et al. 2020). As a result, activities to address the health care needs of Adivasis got limited success as utilization of health care facilities remains lowest among them. In Attapadi, it is found that even after providing free public facilities along with financial support, the Adivasis showed little interest in utilizing public health care facilities. George et. al. (2000)

[9] Cover file number 201 and 1878 Kerala state Archives cited in Kabir & Krishnan 1992

through their study in the sub-region opined that in order to reach interventions to promote universal health care among marginalized communities the health services must be culturally safe, locally relevant, and planned with the active involvement of the community.

In the case of indigenous systems of medicines, in which some of the social groups in Malabar have the expertise, it also got limited efforts to provide its service throughout Malabar under the public health services. Sujatha (2014) observes, during the initial phase of colonial rule in India, British policies encouraged Indian drugs and remedies. However, when the professionalization of western medicine and surgery in Europe grew, colonial medical policies become unfavorable to Indian systems, instead they promoted western medicine. K N Panikkar (1995) observes, after the Bombay Medical Registration Act of 1912 the practitioners of indigenous medicine were assigned an inferior status. Hence, the act did not suspend the practice of indigenous medicine, but the indigenous practitioners did not receive the state's approval. Records show that the officials of the colonial government have the belief that, the medicines of the indigenous system are poor in quality and its practitioners had no ability to establish the cause of disease. Lord Pentland, the governor of Madras from 1912 to 1919, himself argued that such a system of poor quality and knowledge had no claim on public money (Dhanwantari 1917 cited in Panikkar 1995).

The consciousness from the subjugation of traditional medicine leads to attempts of the revitalization of traditional medicines from a new class of elite practitioners. Cleetus (2007) points out the resolution passed by the 2nd Annual Conference of Travancore Ayurveda Mahamadalam on 21st February 1947 as below:

> *the members argued that since it has become evident that there is no chance of progress for indigenous methods of treatment like Ayurveda, Siddha and Unani, under the Travancore Medical Council wherein Allopathy, has been given the majority, this meeting requests government that indigenous systems of medicine should be brought under a separate council*[10].

[10] Second Annual Conference Travancore Ayurveda Mahamadalam on 21 February, 1947, pp. 1-10, Kerala State Archives, Thiruvananthapuram cited in Cleetus 2007

This shows the struggle faced by the indigenous system of medicines and the lack of government support it receive at the time of independence. However, during 1921-22 data from the urban cities of Madras presidency showed a higher utilization of indigenous system of medicine than western medicine (Panikkar 1995). Cleetus (2007) observes that, in Kerala especially in the princely state of Travancore, the dominant western medicine under the support of government imposed its definition of health and illness on the people and healing practices of indigenous systems of medicines. He further pointed out that the setback was never a complete subjugation of the indigenous system due to the dominance of western medicine; instead, what happened was a reframing of the contemporary healing techniques and practices of indigenous medicines through the overarching ideology of western science and medicine.

The situation of government institutions, bed number, and patients treated under different systems in Kerala during 2003 is given in table. 1.10. Table shows comparatively fewer institutions and bed availability under Ayurveda and Homeopathy in the government sector. In the case of inpatient treated, the difference is high and when 18.12 lakh patients availed treatment under inpatient care in Allopathy, only 0.47 lakh and 0.25 lakh patients availed inpatient care in Ayurveda and Homeopathy, respectively. In the case of outpatient care, patients treated under Homeopathy and Ayurveda are more than 167 lakhs and 187 lakhs, showing a large number of users for indigenous systems of medicine (about 47% i.e., about half the Out Patient Department (OPD) attendance).

Table 1.10 Medical Institutions, Beds, and Patients treated during 2003 under three system of medicine in the Government sector, Kerala

	Number of Institutions		Number of beds*	Patients treated (in lakhs)	
	Public*	Private		IP	OP
Allopathy	1278	4825	43619	18.12	401.21
Ayurveda	857	4332	3920	0.47	187.89
Homeopathy	561	3226	1295	0.25	167.50
Total	2696	15614**	48834	18.84	756.6

*Excluding sub-centres and grand in aid institutions,** Total includes 535 medical institutions working under other system of medicine given in the table; Source: Government of Kerala, Economic review 2004, page 298; Report on Survey of Private Medical Institutions in Kerala 2004

Even after continued subjugation of traditional medical knowledge, and support to the use of the Allopathic system by the colonial government and post-independence governments, almost half of the outpatient treatment during 2003 is served by indigenous systems of medicines. Thus, it deserves more attention and analysis to understand the preference of indigenous medical systems by a large section of the population over the extensive network of allopathic facilities available. This is the data from the government health care institutions only, there is a significant private sector in the state which also provides indigenous medical care. In addition to this, many traditional practitioners and their users are not included in this data. Hence the data shows only the differences in the public provision of health care facilities under each system of medicine.

On the other hand, authors argue that the colonial and post-independence governments' attempt to the expansion of a network of medical institutions with a focus on the allopathic system have influenced the health practice of people from the state (George 2016; Kabir and Krishnan 1992). By the time of independence, western medicine started to develop in its full swing in the Malabar region, the spread of education and modernity in the region further helped this developmental process (Kutty 2000). As the development of public health care institutions in Malabar happened in a short period, the development of private institutions happened much later, in a much shorter period, and even surpassed the growth of the public sector. It was only after the 1970s that the development of private health care facilities took place in Malabar on a wider scale; however, by 1985 the number of private health care facilities in Kerala surpassed the number of health care facilities in the public sector (Palafox 2011).

Presently along with the public health care facilities, several large and small private hospitals are functioning throughout the region. Wilson (2010) observes this as the cities in the region have become a local medical market, where institutions compete to introduce modern technologies and equipments, compete to arrange international facilities, and supreme comfort to attract patients from all over the state and even from foreign countries. On the other hand, the region became a medical marketplace where people developed a high dependency on doctors, hospitals, and technologies; people prioritize spending on health care and shop for treatment in the marketplace; and many looks upon the medical profession as a respectable job to do. The greater dependency on institutional care by people from the state can be understood through the high Out-Of-Pocket (OOP) spending on health care. During 2004 the state possesses the highest

average monthly per capita OOP payments of Rs. 101.8 in rural and Rs. 122.2 in urban areas, compared to 36.3 in rural and 57.4 in urban areas for all India (Joe and Mishra 2009). One of the studies shows that, despite high spending on health in Kerala compared to other states and relatively high health insurance coverage, the state records the highest out-of-pocket health expenditure around 84 percent during 2014 compared to 74.4 for all India (Ravi, Ahluwalia, and Bergkvist 2016). In addition, more than 20 percent of the population reported catastrophic healthcare expenditures above 25 percent of household consumption expenditures in 2014 compared to only 13 percent for the country.

In Malabar, the development of the health service system differently influenced various social groups and sub-regions. Various communities have taken advantage of development in health care facilities mainly in three ways; firstly, the middle class has sought a route or upward social mobility by becoming doctors and nurses; secondly, the rich invested largely in private institutions to gain from the increased spending by the people, and thirdly, through receiving health care by prioritizing spending on health care (Wilson 2010). The major gainers in this development process were the rich and middle class; overall, the marginalized communities were unable to take any advantage. However, among the marginalized, a large number of members from the Muslim community were able to take advantage of this through their emergence as a middle class fueled by the affluence of Gulf remittance (Dilip 2008; Pushpangadan 2003). The sub-regions which considerably benefited from Gulf remittance, Malappuram and Kozhikode, also witnessed an unexplained increase in access to private hospital beds between 1986 and 1996; and a decline in bed-population ratio between 1996 & 2004 (Dilip 2008).

The educational attainment of various communities, especially in medical education also shows a trend of disadvantage to marginalized communities. As in table 1.11, during 1968-69, the educational attainment of Adivasis, Dalits, and Muslims was very low compared to any other community in the state. However, citizens from the Muslim community had a comparatively better educational attainment in Medicine, Ayurveda, and dental surgery. In terms of education attainment, Christians and the category ‘others’ recorded the highest educational attainment in all streams. The category ‘others’ records the highest share of population and comprises the upper caste Hindus and those other backward class which is not included in the category ‘Group 1’. The category ‘Group 1’, the second largest group in the population, mainly comprises the other

backward class, records comparatively good educational attainment in almost all streams.

Table 1.11 Educational attainment of citizens from various communities in Kerala – 1968 - 69

	Percentage of population	Graduate in Arts and Science	Degree in Engineering	Degree in Dental Surgery	Ayurveda	Medicine
SC	7.8	2.6	1.7	0.0	1.9	3.11
ST	1.8	0.2	0.0	0.0	0.0	0
Group 1	22.2	13.3	15.6	0.0	31.7	10.81
Others	33.1	44.1	44.8	66.7	53.9	48.02
Muslims	19.1	6.6	9.3	3.3	5.8	11.46
Christian	16	33.2	28.6	30	6.7	26.60
Total	100	100	100	100	100	100

Source: Nettur Commission Report, 1970. Note: Group1- Billava, Buddhist, Ezhava, Idiya, Illuvan, Ishuwan. Izhawan, Thiyya (comes under the category 'other backward class'.)

During 1968-69, medical education was mainly provided by the government sector, but over the period, this trend changed, and the private sector has become the major provider (see table 1.12). This further reduces the chances of marginalized communities, especially the Adivasis and Dalits, in pursuing medical education. However, a large section of Muslims was able to study in private institutions because of the affluence of remittance from the Gulf and through the emergence of several minority medical educational institutions (Nafeesathul 2014; Nazeer 2011).

Table 1.12 Ownership of medical education institutions in 1991, 2007-08, and 2016,Kerala

	1991		2007-08		2016	
	Total	% of private	Total	% of private	Total	% of private
Medical Colleges*	5	0	13	61.5	33	72.5
Ayurveda colleges	6	16.7	13	61.5	-	-
Dental colleges	2	0	9	66.7	-	-
Homeopathic colleges	5	0	5	0	-	-
Nursing colleges**	3	0	47	89.4	126	94
Pharmacy colleges	1	0	19	89.5	-	-

Source: Economic Review 1991 and 2007, Government of Kerala. * Source of 2016 data: medical council of India, ** Source of 2012 data: Indian Nursing council, this is the total number of B. Sc N colleges in Kerala. – means data not available.

For example, all the private medical colleges in the state are owned by trusts and societies of various religious and social groups. Such trusts and societies are managed by forward caste Hindus, Christians, and Muslims; not a single such trust or society is managed by Dalits and Adivasis (Commissioner of entrance examination Kerala 2017).

To an extent, researchers were able to point out how the rich and middle class from the region has influenced healthcare resources development (Dilip 2008; Osella and Osella 2009). Besides, studies also hinted out how the development of health services of the region have differently influenced the health knowledge and care-seeking behaviour among different social groups and classes within them (Cleetus 2007; Dilip 2008; George et al. 2020; Haddad et al. 2012; Nayar 2009; Wilson 2010). Now in the differential experience of communities and sub-regions regarding the development of health service system in the region, it is important to understand the differences and reason for differences in health care utilization across different sub-regions and social groups of the region.

An illustration for the intersection of area, ethnicity, class, and caste in marginalization and poor health - the shaping of Attapadi as a marginalized sub-region

Development as a social process with health outcomes can be seen as a pertinent conceptualization to describe the case of Attapadi being a marginalized sub-region of Malabar in the state of Kerala. Attapadi is being shaped with high infant mortality and low health status to its people along with socioeconomic underdevelopment when compared with other parts of the state. In addition to the area based sub-regional disparities in socioeconomic development, Attapadi faced the multiple disadvantages of marginalization of Adivasis by other dominant groups. The health indicators of Attapadi, especially of Adivasis remain backward compared to state and national averages. The maternal mortality rate and infant mortality rate are very high among them. Chronic malnutrition and anemia are prevalent among pregnant women and lactating tribal mothers in Attapadi (Eqbal et al. 2013). In 2013, more than 55 infants died in Attapadi, further in 2017 and 2018 the stagnant incidence of deaths proves that the crisis is worsening and is far from over (Nalinam 2019). The governments, from local self-government to Central government intervene and measures were taken to resolve the issue. Expansion of

existing health care facilities and financial protection were the major interventions implemented by governments. However, it was not enough; there were more troubling social factors at play. The issues related to social determinants of health including land, labour, agriculture, and issues related to the recognition of cultural aspects and traditional medical practice of indigenous communities in health care service were least considered in the interventions.

Present Attapadi is a block of Palakkad district consisting of three grama panchayats, namely Agali, Puthur and Sholayur spread over 745 Sq. Km. It has a population of 64,318 (Census of India 2011). Although Attapadi is known to be one of the tribal heartlands, a major portion of the present population includes settlers from other parts of the state and Tamil Nadu. The population of tribal folk has been declining over the years. As a result of the inward migration of settlers, the tribal population of Attapadi had declined from about 90 percent in 1951 to about 40 percent by 2001 (ITDP 2018). However, still, tribes form almost half of the population (27,121) and are represented in three sects called Irula, Muduga and Kurumba. They live in hamlets in and around the hills of Attapadi. There are 188 such tribal hamlets. In the yesteryears, the region experienced the hardship of invasions by rulers of neighboring princely states before it comes under British rule. In 1757 when the Zamorians of Kozhikode invaded the region, the king of Palakkad sought the help of the Mysorian ruler Hyder Ali. However, over the period Hyder Ali subjugated all territories in *Palakkad,* and gradually passed them into the hands of the Mysore rulers. Further, in 1872 all the possessions of Tipu in Malabar, including Palakkad were ceased by the Britisher and brought under colonial rule. However, even after independence the level of development experienced by Malabar or the state as a whole does not reflect in Attapadi. When Malabar as a whole was able to progress through state intervention and various socio-political and religious movements from the hardship it faced in the yesteryears. Attapadi failed to catch up with other parts of the region and lags in socioeconomic development. In fact, Attapadi and its indigenous population continued to face discrimination and marginalization to a greater degree even after independence.

Social determinants of health and development in Attapadi

The changing demography of the area adversely affected the life and sustenance of Adivasis, by the settlers through different ways pushing the indigenous communities out of their land and traditional forms of livelihood (Sreemith and Deepu 2014). During the next years of Indian

independence, more than 90 percent of the Attapadi area constituted deep forests. After that within two decades, the forest cover came down to 82 percent, followed by a steady depletion of forest area, which in 2018 accounts for around 20 percent (Govt of Kerala 2018). In addition to environmental and ecological issues, deforestation widely affected the livelihood of Adivasis. Daily collection of minor forest products become impossible and goat and cattle farming becomes extinct. On the other hand, through the coming of settlers, Adivasis lost their agricultural land and were forced to abandon the cultivation of traditional crops like Ragi, corn, millet, and pulses. Over the period, the tribal has lost over 5000 acres of fertile land to settlers and this land is currently used to cultivate cash crops. However, even today for both the tribes and non-tribe's agriculture is their major means of living. They cultivate a wide variety of crops, from spices to pulses and vegetables. Most settlers are small-scale cultivators and Adivasis are daily wage labourers. The settlers are political heavyweights who have a stronghold in religious and political organizations. Their arrival made Adivasis deep into debt and made them daily labourers in their own land by taking the land owned by tribal as mortgage (Sreemith and Deepu 2014). Even though some of the tribal were manual labourers, they get around ₹300 or more per day for work, but workdays available to them are scarce, usually less than ten days in a month. Though some of the Adivasis have land, the ownership is shared by many family members and the land is often non-cultivable. Those who managed to do some cultivation yearly face an additional set of hardships including flash floods, drought, and wild animals' attacks. Despite several promises by various governments, most of the lands have not been restored to the Adivasis, leading to loss of their livelihood, and depriving them of cultivating their traditional food.

Chronic malnutrition and anemia among pregnant women and lactating mothers are one of the major problems in Attapadi. Iron deficiency is one of the major causes of anemia in pregnant women (Eqbal et al. 2013). Previously, the staple food of these tribes was Ragi, which is a rich source of iron. Additionally, food was also collected from the forest and some were special for pregnant women and lactating mothers. When their traditional way of living was disturbed, and they were now forced to subsist with rice provided through the ration shops. Even though food grains are provided free of cost through the public distribution system, indigenous communities' preferences and cultural practices are not considered, and as like elsewhere in the state food grains are provided. Villagers report that pulses are not provided through the ration shop and

sometimes the less preferred *matta* rice is provided. As *Matta* rice is not generally preferred by the Adivasis in Attapadi they sell this rice to shops and buys white rice, generally get a very less amount of white rice in exchange (Eqbal et al. 2013). Even after it is evident that the dietary change has relation to iron deficiency, even after leading them landless to cultivate their food grains including ragi and maze, what is distributed through Public Distribution System (PDS) is less preferred *matta* rice. Similarly, in anganwadis, instead of ragi-based preparation wheat-based powder is distributing to under-five children. This is provided under a statewide programme without any tailoring made to suit the interest of indigenous communities. One can see such mismatches in understanding the preferences and interests of indigenous communities by the government in various aspects of state intervention. Considering indigenous tribal culture, their traditional medical practice, their beliefs, and rituals as superstition. Lack of recognition of traditional village heads' roles and authority and lack of interest in incorporating their inputs in planning and implementing tribal development projects makes indigenous communities feel these programmes and professionals do not respect their interests (George et al. 2020).

When it comes to the women of marginalized communities, their life remains hazardous and insecure, they face multiple disadvantages of being women of the lower class and lower caste community. The continued sexual exploitation of tribal women by settlers and its consequences to their communities have become issues of wider consideration. In 1997 there were nearly 400 unwed mothers in the two regions of Attapadi and Wayanad. Within four years from 2004, cases were registered by parents of a government tribal schoolgirl’s hostel that 16 minor girls of the hostel had become unwed mothers (Parthasarathy 2015). The increasing atrocities against women, especially against Adivasi women are evidence of their low quality of life. At several points in time, public opinion emerged in the state against the government and oppressors. However, this generally did not last for a long time, and any proper action to seriously address the issues of the marginalized did not happen. The political support and support of thepublic are only available to them for a short period during any adverse incidents of atrocities against women, infant death, maternal death, or starvation death. Unlike the other communities, Adivasis in Attapadi or elsewhere in the state does not develop as a powerful social or political group to influence the governments.

The shaping of health service and its responsiveness in Attapadi

There are three primary health centres, one each in Pudur, Sholayur, and Vattulukki; and one community health centre in Agali. There are 28 sub-centres in this 745-km² block, each caters to 2300 population on average. Besides, there is a 100 bedded tribal specialty hospital in Kottathara set to provide specialist care to tribal people. Around 85 ASHA were appointed to assess the need of the tribal community and help them in their village itself. There are 175 anganwadis in Attapadi to take care of pregnant women and tribal children. There are two Health Mobile Units providing medical help to the tribal hamlets, especially in remote areas. Further, in the private sector, there are two hospitals one each run by religious groups of Hindus and Christians that provide low-cost and sometimes free medical care to tribal. In addition to these facilities inside Attapadi, referrals to tertiary care institutions outside are made free of cost for Adivasis.

Despite these arrangements, specially made after the criticism from different spheres of society, Adivasis continued to experience high infant and maternal death. In addition to the establishment of facilities, the government also introduced financial protection to cover travel cost, cost incurred on food and compensation to loss of daily wage. However, still minimal utilization of services from these institutions by Adivasis questioned the way health care services are established (George et al. 2020). It is found that the folk medical practice of Adivasis did not get any recognition in the establishment of local health services. Besides, such medical practices of indigenous communities are openly rejected by labeling them as superstition. In fact, the local health care providers opposed its practice and encouraged the utilization of formal health care services for all health issues. On the other hand, knowledge and practice of folk medicine are important aspects of tribal life and their conceptualization of health and illness. Attempts to discourage its use rendered them more vulnerable as such it was their immediate response to a lot of minor health issues. However, the health service system that claims to be providing quality care does not recognize the aspects of cultural safety and legitimate expectations of indigenous communities into quality. The lack of integration of local beliefs and exclusion of community voices in the establishment of health services lead to a lack of belongingness among Adivasis towards the health care institutions. Still, to an extent, the community complies with the health service system in the region, but mainly because of the fear of consequences of non-compliance (George et al. 2020).

The Kottathara tribal hospital with specialist care is established to handle the referral cases from the periphery. However, due to a lack of facilities and human resources, the hospital becomes a place where complicated cases are referring to institutions outside Attapadi. Even after continuous maternal and child death, the full-time availability of gynecologists throughout the year is not ensured in the hospital. Even after the appointment of two gynecologists, there were incidents of non-availability of their services in the hospital for several days during 2019 alone. Even though ambulance service is available, the poor condition of roads in the hilly terrain makes the patients' transportation difficult. The cases of CHC and PHCs were also not too different, the lack of facilities and human resources remains an issue for its smooth functioning. In addition, the discrimination towards Adivasis by health care professionals through their attitudes and words makes healthcare facilities less attractive.

Similarly, the mechanism to provide nutritious food to under-five children though Anganvadis is not functioning in a culturally acceptable and respectful manner to the Adivasis. The nutrition services through the Integrated Child Development Scheme (ICDS) and schools are also rendering without addressing the issue of compelling the ideas and values of the dominant culture. As a result, the ICDS programme itself reported severe malnutrition of around seven percent among under-five children during 2013. But a study observed the failure of the ICDS mechanism in capturing all severely malnourished children in the area (Eqbal et al., 2013). The frontline workers, including ICDS workers in Attapadi, are preoccupied with works related to maintaining records and registers, and hence failed to understand the larger picture behind child malnutrition (TISS Kerala Centre 2017).

Conclusion

Even though, Adivasis are the native inhabitants of Attapadi, under the politically and economically powerful settlers, the indigenous communities remain marginalized by experiencing multiple disadvantages. Beginning from a steady decline in population to loss of land and livelihood, depletion in forest and access to forest resources, change in food pattern, and atrocities, especially against women. Further, the subjugation of folk medical practice and domination of a health care system that does not recognize the cultural aspects of indigenous communities. The settlers who were politically and economically established started to control the social life in the region. As a result, Adivasi's way of life-based on indigenous culture and

belief got disturbed and they were forced to accept the dominant culture and its way of life in various aspects. Various governments, over the period, tried to mitigate the poor health outcome of Adivasis in Attapadi through the expansion of health care facilities with little intervention in broader aspects of social development. Studies have already pointed out the disadvantage faced by Adivasis in the state on various aspects including indicators of health and wellbeing (Kannan et al. 1991; Navaneethan and Kabir 2009; Haddad et al. 2012). In the case of Adivasis of Attapadi, they even lag their counterparts in other parts of the state because of the added disadvantage of low socioeconomic development of Attapadi.

The need and motivation of the study

Kerala state witnessed high spending on the social sector by the state government and consequent high social sector development compared to other states in the country until the 1980s. However, it is argued that high spending alone would not guarantee high performance in the social sector (Thomas 2006). For example, the experience of former socialist countries of Europe shows that the high shares of government expenditure will not guarantee high performance every time. The policy environment matters a great deal, and authors argued the policies of democratic government (Franke and Chasin 1992; Rammohan 2000); the role of progressive Maharajas, churches, social reform movements (Bose 2006), and public action (Dreze and Sen 1997) as the major factors in achieving relatively high social sector development in Kerala. However, doubts were slowly raised on whether Kerala's achievements really benefited all sections of people and regions (Kurien 1995; Mencher 1980; Omvedt 2006; Tharamangalam 2006). Kurian (1995) argues that the development experience of Kerala in the literature is largely explained by referring to the 'average situation'. He argues that while concentrating on the central tendency of the development experience, as in the case of all distribution Kerala development experience also has its 'outliers.' He points out the example of the fisher community to show this outlier phenomenon, as this community has been in some respects excluded from the benefits achieved by the state. Similarly, several scholars point out other outlier communities like agricultural workers, Dalits, Adivasis, and Women, as they have been marginalized by the same developmental experience when viewed in terms of criteria other than those commonly celebrated in the literature (Mencher 1980; Deshpande 2000; Omvedt 2006; Steur 2011; Bijoy 1999).

Authors already established the regional backwardness of Malabar, and reasons for the persisting backwardness as the multiple disadvantages faced by the region in social, political, and economic development (Anvar 2003; Kunhaman 1985; UNDP 2006). Showing that, in addition to outlier communities there are outlier sub-regions in the state. On the other hand, there are marginalized social groups like Muslims and Thiyyas in Malabar able to develop substantially in modern and traditional lines. In fact, the socioeconomic and political development that happened among various social groups in the region and all over Kerala are too different to make substantial differences in the lives of people. When the development experience of the state has led to multiple benefits for certain social groups including some of the marginalized, the Adivasis and Dalits faced multiple disadvantages. In sum, as Navarro (2009) point out elsewhere, in the case of sub-regional and social groups wise inequalities, what has been happening in the state is not a reduction of intervention from the state, political parties, and civil societies, but a change in the nature and characteristics of the interventions. Further such changes in the interventions are not happening by chance, rather they are the product of an alliance between dominant groups to maintain the existing religious, caste, class, and power relations.

Whether it is an outlier of the central tendency or a paradox within a paradox or an incomplete agenda, the literature clearly brings out the persisting sign of an unappealing state for marginalized communities and sub-regions in the state of Kerala. What motivates greater interest in the problem is the intersection of an area-level inequality with social group-wise inequality leading to health status disparities. When studies point out the unappealing state of certain groups and regions in the state, what find missing and deserves greater attention is an explanation of inequality in health through the lens of the intersectionality of caste, class, religion, ethnicity, and area. The socioeconomic and health condition of marginalized communities from different regions of the state is not too different. But there is an existing area-level inequality in the state, in which the better-developed regions are capable of having a buffer to the inequalities faced by marginalized communities. On the other hand, the marginalized region Malabar and its sub-regions can magnify the effect of low socioeconomic development among marginalized communities. Thus, it is important to have a study that conceptualizes the intersection of area-level inequality with inequalities of social group-wise characteristics to explore the inequality in health status among social groups in the state.

Chapter II

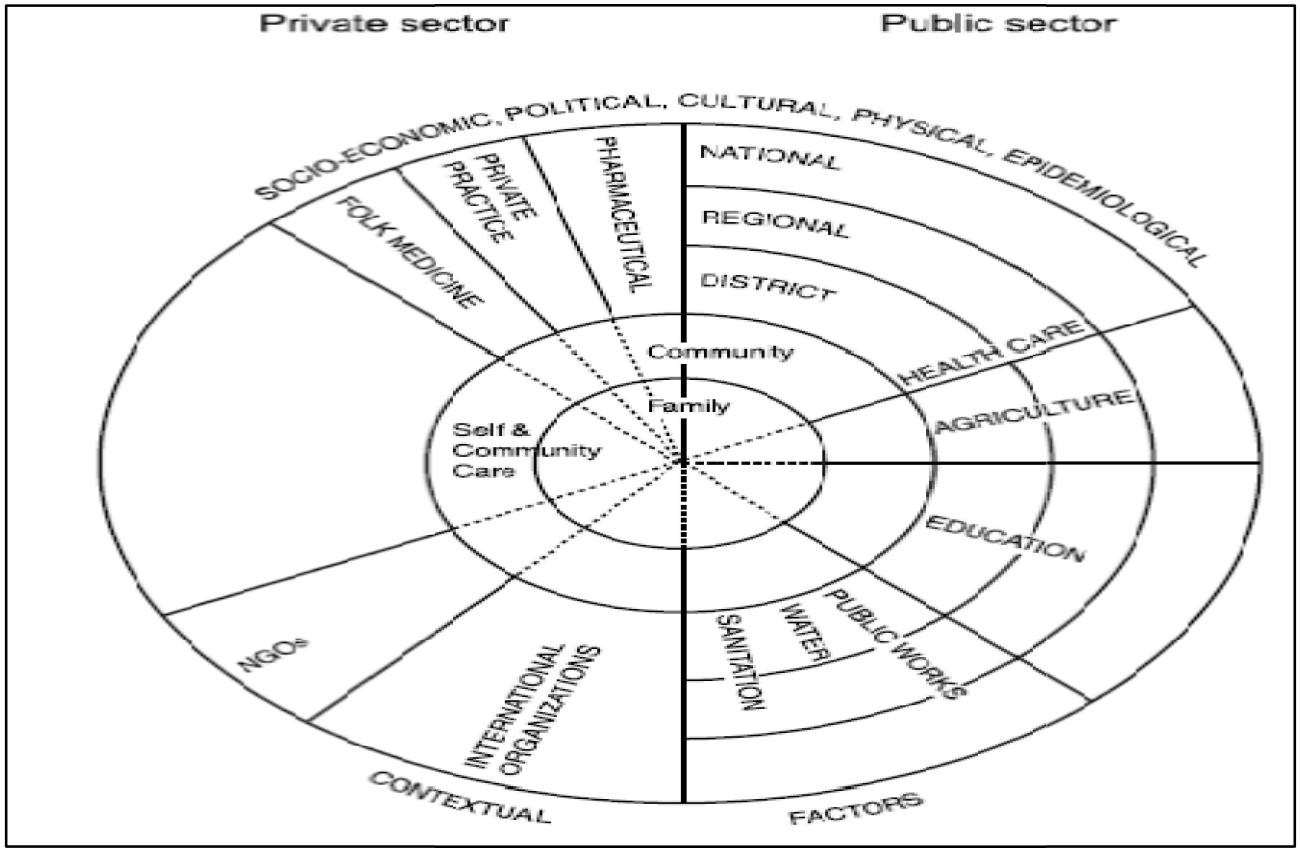
Capturing the Shared and Diverse Social Dynamics across and within Regions: Methodology and Design for the Study

Framework for the study

The development experience of the state of Kerala shown in literature necessitates that inequality in health has to be understood in the context of the inequitable development experience of different regions and social groups in the state. The development experience of Malabar witnessed a setback compared to the better socioeconomic developments that happened among other regions in the state. The shaping of sub-regions characterized by the intersection of area-level inequality with social group-wise inequality is the major factor that dragged Malabar into a comparatively lower socioeconomic development. There is a confluence among reasons for differential levels of development of different sub-regions of the Malabar region of the state and differential development of various socioeconomic and religious communities, since different socioeconomic and religious categories are more or less numerous in different sub-regions of the region. Here, we can see health and health outcomes among the people are interminably linked to the overall development experience they had. Further, the shaping of health care services and its responsiveness towards each social group is also influenced by the nature of socioeconomic development happened. Now, in the underdeveloped sub-regions of the backward Malabar region, all social groups are not enjoying the same level of health status. Rather there is a health disparity between more and less advantaged social groups which is strongly associated with the existing social structure. Further, a close look into such sub-regions will help us to understand the health levels of the most privileged groups and that at least reflect minimum standards of what should have been possible for everyone in that region within the foreseeable future. Health and health care services are part of the social process of development and the development process in itself is shaped by the social determinants of health. Thus, the present study looks into the health of various social groups in a sub-region of Malabar in the context of the socioeconomic development experienced by the region.

Evidence shows that improvement in the health of people is more influenced by the improvement in social and economic conditions than the direct effect of health services (McKeown et al., 1972; Panikar, 1975a). However, the socioeconomic conditions are not the only factor other than health services that determine the ill health of people. The much wider spectrum of the community-level factors also influences the health of a community (Banerji, 1978). By taking such a broad view, the World Health Report (2000) defines health system to include all the activities whose primary purpose is to promote, restore or maintain health. However, beyond the boundaries of this definition, there are factors that influence health, for example, education whose primary purpose is something other than health (WHO, 2010). As in figure 2.1, the complex geographical, socioeconomic, political, cultural, demographic, and epidemiological factors have a greater influence on the health of people.

Figure 2.1 Broadly defined health system



Source: Designing and Conducting Health Systems Research Projects, Volume 1, (Varkevisser et al., 2003)

It is clear from the figure that the factors like health care, folk medicine, pharmaceuticals, and private practices are some of the parts of the system with different levels of functioning, while the health system includes resources from a wider range of other sectors which could support health. For example, the improvement in agriculture helps to improve the nutritional status of the society, education helps to better understand what to do in case of illnesses and improved sanitation provides hygienic living surroundings. Such a broad definition of a health system is used in the present study. However, it is also noted that improvement in agriculture and education will not lead to better nutrition and health care behaviour among all in a mechanical way in the society. Rather, increasing agriculture productivity, first of all, makes agriculture more remunerative. Where a large proportion of the population is dependent on agriculture for living, improved productivity brings improvement in economic wellbeing of the people. It also improves the availability of food, but not necessarily an improvement in nutrition among all. The prevalence of hunger despite the overflowing of granaries is an example of the non-existence of an automatic reduction in hunger or nutrition even after an improvement in agricultural production (Saini & Kozicka, 2014). What matters a lot is the unequal distribution of resources and the failure of policies and implementation to ensure that the basic structure of the society enables an equitable distribution of productive resources.

Moreover, health systems are not just an interconnection of different parts but are also the relationships among the parts, the feedback loops that link them, and the processes of learning and adaptation over time (Smith & Hanson, 2012). Further, as Smith & Hanson (2012) argues, the health system needs to be understood beyond a narrow technical approach and that the health system is explicitly political. This is because all the parts of the health system are subjected to political decision-making. For example, the distribution of power relations and authority within the health system is influenced by political decisions. The distribution of power relation between the health sector and other sectors that influence health like agriculture and education; between patients, health professionals, and their managers decide the importance given to each component of the health system.

The WHO secretariat gives a health system framework consisting of six health system building blocks to help strengthen the health system of nations. The six building blocks comprise service delivery, health workforce, health information system, access to essential medicine, financing,

and leadership/governance (WHO, 2007). Our conceptualization of the health system is broader than the six building blocks suggested by WHO. As the health service system is the complexity of research, education, and delivery system, the framework suggested by WHO is more applicable to the health service system. The health service system is an organized complexity of research, education, and delivery system (Qadeer, 1985) which includes preventive, promotion, and rehabilitative services. Furthermore, the health service system is only one of the many inputs which are required for the improvement of health. Qadeer (1985) observes that different kinds of health services at different levels have been created in various nations based on their objective conditions. She points out the difference in the socioeconomic framework of the health service system in socialist countries as compared to the sophisticated service delivery of developed capitalist countries. Thus, she argues that the health service system is a function of the balance between socioeconomic, political, and technological forces (Qadeer, 1985).

Drawing from our concept of the health system, health resources shall include all household and community level resources that have an impact on a person's health and that facilitates physical and economic access to and utilization of health services. Health resources shall also include but not be limited to economic as well as social resources. These resources may act at the level of individuals or at the level of communities. The unequal distribution of such health resources across geographical and social groups contributes to social inequalities in health via material pathways (Arcaya et al., 2015). Economic resources imply the resources that are directly instrumental in enhancing the purchasing power of the household/individual. These include ownership of productive resources such as land, farm animals, and poultry that are a source of income for the household; sources of employment; any other movable and immovable property such as a house, bank balance, ornaments, etc. On the other hand, social resources include community organizations, other indicators of social capital like resources that people acquire through relationships with other community members; and cultural capital like knowledge, behaviour, and skills which affect health.

The health resources are thus not limited to the advanced medical services, which include a range of social and economic resources like food, housing, clothing, clean drinking water, education, and employment (Qadeer 1985). As already discussed, material pathways create health disparities, which of course are a product of the social, economic, and political paths. The type of

resources that are relevant to health inequalities includes a wide range of resources like food, safe drinking water, good sanitation, and quality education, the chances to choose a healthy lifestyle, adequate housing, employment opportunities, and good health care. Hence, Braveman & Gruskin (2003) argue that resources should be distributed and processes should be designed in a way which will help in equalizing health outcomes between the disadvantaged and advantaged social groups. In other words, focusing on the distribution of such resources thus will help to understand health inequalities via a material pathway across geographies and social groups (Arcaya et al., 2015).

In the context of health and health care the concept of 'marginality' runs concurrently with 'inequality'. Marginalization occurs when some people are systematically excluded from meaningful participation in economic, social, political, cultural, and other forms of human activity. As a result, the marginalized are cut off from the mainstream and do not have access to the benefits of membership of the wider society (Baatjes, 2003). Thus, marginality does not represent just a single aspect of exclusion and discrimination alone; rather it encompasses at least three different types such as cultural marginality, social role, and structural marginality (Billson, 2005). Besides, the definition of what is regarded as marginalized largely depends on the historical, social, and economic context of a society. Cultural differences like race, ethnicity, religion, or any other cultural differences like differences in health culture are the defining variables in cultural marginality, which usually stems from a hierarchical valuation of two cultures in which an individual participates. Social role marginality occurs when an individual cannot fully belong to a positive reference group because of person's or group's role is defined as marginal. For example, women working in traditionally male-dominated professions reflect marginality negatively affecting women (Aisenberg & Harrington, 1988), and the marginalization experienced by indigenous communities and minorities while trying to acquire an education level equal to others also reflects social role marginality. On the other hand, structural marginality refers to the political, social, and economic powerlessness of certain disadvantaged segments within societies. It springs from the location in the socioeconomic structure of society, rather than from cultural or social role dilemmas. In fact, structural marginality is a shift in focus from people and individuals to social structures and institutions. Structures are not neutral and require careful intervention and vigilant monitoring if they are to serve justice and promote inclusion (Powell, 2013). Thus, while studying unequal development

in social groups and areas, the focus is on two important issues: the magnitude of social and special disparities in the level of living, and the root causes of unequal development. To address these issues in an inherently appropriate way, it is important to understand the nature of marginality and the root causes of it.

For the present study, marginalization is conceptualized by covering aspects of cultural, social role, and structural marginality specific to the historical, social, political, and economic context of the study region. Further to account this, the perception of respondents from different social groups related to cultures that are central to the society and which are termed as a marginal culture are analyzed. Similarly, social roles and structural factors like political, social, and economic power which is seen as normal and (which are termed as marginal are differentiated for better exploration of marginalization.

Similar to marginalization, Illsley & Baker (1991) noted that the meaning of inequality in health is contextually determined and that it changes both within and between countries and over time. The views in defining health equality differ in various terms like whether it incorporates the health needs of people or whether it addresses the power relation leading to inequality. For example, Dahl (1994) points out that the use of different indicators of socioeconomic status is rooted in different sociological traditions. He describes that education and income are the indicators often preferred in North America, while European researchers are inclined to use occupational class. Even though the socioeconomic indicators like education, income, and occupation are related to ill health much the same way when studied separately, they do not have the same theoretical meaning. Further Bartley (2003) explains that the major interpretations of inequality in health as material, behavioural, psycho-social, and life-course approaches.

Material interpretation explains health inequalities are a result of the differential accumulation of exposure and experiences that have their sources in the material world. On the other hand, behavioural explanation describes that there is health-damaging and health-promoting behavior, and its differences among social groups influence health inequality. But studies also found such an explanation reveals only a part of the inequality in health. Psycho-social interpretation proposes that psychosocial factors like social support and autonomy at work are important in understanding the effects of inequality in health. The life-course approach reflects that the

pattern of social, psycho-social, and biological disadvantages experienced by individuals over time leads to disadvantages in health. According to this interpretation, factors that are disadvantageous for health tend to accumulate over time and affect the health of individuals. Thus, the complexity of issues in defining and interpreting marginalization and equality in health demands a more comprehensive approach that incorporates different views. By considering the diverging views on marginality and equality, the present study will keep these different views in consideration to reflect upon the data collected for the study.

While studying the health of people in the sub-region of the backward Malabar region by understanding the way the health system of the region is shaped in the overall development process, a broader view on social determinants of health, health services, health care resources, marginalization, and inequality is maintained. As a result, while understanding the health of the more and less advantaged social group, the movement of an earlier backward social group towards better socioeconomic development coupled with better health is noticed. Communities like Namboodiris, Nayars, Upper-class Muslims, Upper caste Hindus, and Gulf emigrants were the multiple gainers of various socio-political and economic developments that happened in the region. The communities in the lower strata were the major losers. Adivasis, Dalits, fisher community, women, and agricultural labourers face multiple disadvantages and are unable to catch-up with other communities. However, the variegated development experience also witnessed the remarkable progress of some earlier untouchable and marginalized communities, especially the Thiyya community and Muslim community (Osella & Osella, 2000a). Both the communities became socially and politically powerful strongholds to influence the developmental policies of the government (Hartmann, 1968; Menon, 1995).

Briefly, from a health system perspective, the present study documents the social, economic, and political processes responsible for the variegated development across different caste and religious communities, both within and across the sub-regions of Malabar. It further explores the health inequality relationship among major social groups under the socioeconomic and political conditions in which certain social groups are unable to make a significant change in their health status, including class variations within the caste and religious communities. As already mentioned, the marginalized communities of the regions have experienced a differential developmental experience. Their experience of health problems differs; the ways they deal with

such health issues also differ. As a community, the factors that influence their strategies differ, and how they negotiate to influence the health care resources also differs. Therefore, further the focus of the study is on the development of various health care resources among Adivasis, Dalits, Muslims, and other backward castes along with forward caste Hindus in the region.

Research Questions

1. What are the differences in the developmental trajectories of different sub-regions, religious, caste, class, and ethnic groups in the Malabar region of Kerala?

2. What are the processes through which uneven developmental trajectories have led to health disparity among different sub-regions and social groups in the region?

3. How has the development of health care facilities in the region benefited the various social groups?

Research Objectives

1. To document differences in the development trajectories of the different sub-regions of Kerala and major caste, adivasi and religious communities of Malabar region.

2. To document the process through which uneven developmental trajectories resulted in health status disparities both within and across different sub-regions, for different caste, ethnic and religious communities of the Malabar region and for classes within them.

3. To study the development of health care resources across different communities and different sub-regions in the context of social, economic, and political processes that happened in the region.

Methodological perspectives for studying marginalization of communities and sub-regions in the health system

Marginalization of communities and regions in health and health care are already studied in the state on various aspects of social life, with major focus on aspects like access (Sankar, 2001; Simon, 2007), health care provisioning (Dilip, 2008; V Raman Kutty, 2000), health discourse

(George, 2016), public policy (S. B. Nayar, 2009), health expenditure (Mukherjee et al., 2011; Caroline Wilson, 2010a) and social hierarchy in health care (Cleetus, 2007; Wilson, 2011). Studies also focused on the traditional system of healing of particular communities, its development and engagement with other systems of medicine to explore the marginalization of communities in health care (Cleetus, 2007). The present attempt to explore marginalization of communities in health service systems uses the development of the health system as a measure of marginalization. For this the health system is taken here as similar to any other social system like the educational system. Like any other social system was expected by its population to meet some common social goal in addition to its core goal, the health system is also expected to deliver some social goals like social and economic mobility of individuals in addition to providing its core goal of good health (Murray & Frenk, 2003).

How does development of the health system act on unequally positioned individuals and communities creating and reinforcing disparities in health status? This is the question to be handled. Braveman & Gruskin (2003) describe health disparities as systematic, plausibly, avoidable differences in health status and its determinants that are associated with discrimination and marginalization. Constructing from Braveman and Gruskin's argument, the systematic, plausibly avoidable differences in health care resources among communities can be found associated with the characteristics of marginalization like ethnicity, religion, geography, gender, age, illness, and political affiliation. The result is the multiple advantages of socially, economically, and politically dominant communities in having access to health care resources, and multiple disadvantages to the marginalized communities.

Studying marginalization requires comparing health care resources between more and less advantaged social groups. Furthermore, to make a reasonable comparison across communities' inequality is usually described quantitatively. Thus, the marginalization of certain communities in the development of the health care system can be studied by taking indicators of material inequality. However, such measures generally fail to capture people's subjective well-being, thus it is essential to go beyond objective circumstances and to find a more comprehensive measure. This is similar to what Sen (1999) proposes, rather than focusing either on resources or outcomes, the focus should be on people's capabilities, which can be understood as freedom. Particular to Kerala, it was capabilities and freedom, which become the underlying theme of the

state's development experience (Oommen, 2010). Sen (1999) describes capabilities as the real ability of a person to achieve those functions considered as important to lead the life that one has reason to cherish and value. Hence, capabilities cannot be measured directly, but Sen noted it can be best measured only through the functioning that people actually alive (Sen, 1999). For example, in health, the functioning of people can be understood from their activities to establish a condition in which they can protect and promote their health. Like, participation in decisions that affect their health and attempts demanding accountability from the people and institutions whose duty is to take the step for the good health of people (UN Millennium Project, 2005). Further, such an approach will help to go beyond health care utilization of a different system of medicine, to people's health knowledge and factors influencing its day-to-day practices. Thus, measuring marginalization should consider the material disparities along with disparity in people's subjective well-being and so the attempt here is to measure disparity through material and subjective aspects.

While understanding the disparities in material and subjective wellbeing of various social groups from the region, one thing noticed important is the possibility of certain social groups being able to negotiate and overcome their structural barriers. The remarkable progress of earlier untouchable caste Thiyya, and the poor Muslims in material and other socio-cultural aspects hinting progress in their health and health outcomes. The health system of the region, developed in a way in which disadvantaged communities cannot gain substantially from the development in education, financial status, employment and leading a lower health status compared to other communities in the region. However, the progress of backward caste Thiyya and minority Muslims, through becoming political and economic stronghold helped them to achieve a better socioeconomic and health status. Both the communities organized socially and politically and began to establish educational institutions, hospitals, etc. to reform and strengthen their communities. When Sree Narayan Darma Paripalana Sangam (SNDP) and major political parties in the state led the reform movements of the Thiyya community; political party like the Indian Union Muslim League (IUML) and organizations like Muslim Education Society (MES) led the efforts to modernize Muslim community (Kumar, 2001). The case of Thiyya is important in understanding the disparity in socioeconomic and health among various social groups. It gives us the proof for the possibility of achieving the highest attainable socioeconomic and health status even for the marginalized. Furthermore, it stands as a scale for contrasting the socioeconomic

and health status among more and less disadvantaged social groups. Thiyya improved their social status by accumulating economic and cultural capital through reform movements, employment, migration, education, politics, and marriage (Kannan, 2012; Osella & Osella, 2000b). In addition to the pan-Kerala reform movements, there existed other reformers and reform movements among Thiyyas in Malabar (Kannan, 2012). On the other hand, the organization of Adivasis and Dalits were not so successful as to build up as a strong sociopolitical force or influence the governance of the state, leading to continued marginalization in socioeconomic and health status.

While studying the marginalization of communities in health care system development in terms of subjective aspects, there are issues related to defining the indicators of the health care system going to be studied. Here, the development of the health care system is examined in three aspects; firstly health care system as a knowledge industry, secondly as an industry in the local economy, and thirdly as a public provisioning. Going by this, the study operationalizes marginalization in three ways- marginalization of knowledge system and of certain perspectives within them, marginalization from participation in the development of health services (as doctors/nurses/other health care providers, as entrepreneurs of health care in the private sector, etc.), and marginalization in access to services by communities. It also considers class variations within the social groups and communities. These are studied as historical, social processes influenced by the social, political, and cultural changes over the past three decades contextualized against the background of a century i.e. 1917-2017. The three aspects are identified based on their influence on the local health care system of the region. Wilson (2010) in her study in the Malabar region by examining the commodification of health care, pointed out how these three aspects are contributed to the development of the health care system of the region.

In the development of the country as a knowledge economy, health care has become a leading sector (World Bank, 2005). Furthermore, it gave social and economic mobility to a large section of people, but the social hierarchy persisted in knowledge development too. Wilson's (2010) study on the commodification of health care in an urban city of Malabar region, clearly pointed out how health, as a knowledge industry, influenced the care-seeking behavior of people and as an industry in the market, how it changed the nature of private multi-specialty hospitals in the

city. However, little is known about its effect on rural areas and various social groups from the region. Expanding from Wilson's exploration of health as a knowledge industry and industry in the marketplace, an attempt made to explore its effect on social groups reveals several pathways through which it affects health. As a knowledge industry, its effect on different social groups can be identified as: firstly, medical education as a route to social mobility for the middle classes (Wilson, 2010b) and traditional healers from lower caste and women, and how education perpetuates social roles and inequalities (Navarro, 1976); secondly, over-dependence on allopathic medical knowledge with the subjugation of traditional medical knowledge (Sujatha, 2014); thirdly medicalization of social issues (Waitzkin, 1989); fourthly, constantly changing technological knowledge with hospitals and doctors, upgrading skills and services, with importance to interpersonal communication; and finally, as advertising health care, showing how information and communication technologies become central to health care utilization (Nayar, 2009; Wilson, 2010a).

As an industry in the local economy, the region becomes a local marketplace where the health care system links different technologies, health care professionals, and patients (Wilson, 2010a). As a result of this, what changes it has made to different communities, is something trying to explore, by seeing firstly, how health care is fashioned as a commodity and the way people started shopping for health care in the local market. Secondly, the effect of being a potential investment area and how different social groups benefited from it, like migration of doctors from southern districts to the region (Osella & Osella 2000), investment of Gulf money in health sector (Dilip 2008), start-up of many medical institutions by social and religious groups. Thirdly, how the nature of hospitals started to change, by up-gradation of its interiors, engagement of specialist doctors, and adoption of latest diagnostic technologies (Wilson, 2010b); and fourthly, the development of a heterogeneous private sector to cater to users of different socioeconomic status, and development of heterogeneous knowledge system in medicine. Finally, health care as public provisioning, its effect and reach to different communities are analyzed firstly as organizing a necessary public good by the state with its reach and functioning for different communities and sub-regions; and secondly as changing priorities of the state government.

In the context of the variegated development in the Malabar region, the present study looks into the different domains of development that influence the health status of various social groups,

their temporality, and interconnections. It explores how the socioeconomic structure of the society impacts the development experience to differentially privilege the interests of different sections of the society. How the socioeconomic structure differently privileges various social groups in the development of health and health services system. How the processes of marginalization in society leading to differential ability of different sections of the society to own and use resources necessary for improving health status. Further to explore the resistance of the marginalized and exploited classes, castes, and gender groups that force the ruling classes to make resources available for better health status and well-being. As the variegated development of the region suggests, the study analyzes the development of health and health services system on various aspects across major communities and sub-regions in Malabar to get an inter sub-regional picture. Further to look into details on inter and intra-level experiences of sub-region and social groups, the focus of the study is on the major communities of Malabar from Vythiri taluk of Wayanad district.

Purpose and rationale of the research

Although part of the variation in health status among individuals is biological in origin, disparities in health between nations and between social groups within nations are largely determined, by the way, societies are organized locally and globally along economic, social, and political lines (Mangham, 2009). Moreover, these health disparities are striking reflections of the powerful stratifying forces that differentiate life opportunities within countries (Anand et al., 2001). Rather than linking technological development in the health sector with health care system transformation, accounts linking patterns of social, economic, and political transformation are minimal in government policies (Nayar, 2009; Wilson, 2010b). Since India intensified its programme of economic reform, far-reaching effects happened on the health policy and health service provision like marketisation of public health and gradual withdrawal of state provisioning of public goods (Qadeer, 2000). This led to greater dependence on health care sector especially on the private sector to attain good health.

The major factors that influenced the development of the Malabar region include colonial rule, invasion by Hyder Ali and Tipu Sultan from Mysore during 1766-1792, unique land tenure system and peasant struggle (Radhakrishnan 1989); uprisings of Muslims against the British during 1836-1921, communist movement from 1934, agricultural labourer's movement

(Gopalankutty, 1978); migration of cultivators to highlands from the 1940s (Sreekumar &Parayil, 2012), large scale emigration to Gulf countries (Kannan & Hari, 2002); Adivasi movements with their intellectual resources (Steur 2011); state initiatives and other new social movements like environment movement, decentralization movement, and total literacy movement. While the whole region has benefited from various public actions in the form of social and political movements, certain communities and sub-regions were left outside the ambit of these benefits on account of various social, economic, political, and historical factors. Public action in the form of various movements, backed by different class, caste, and religious organizations along with the nationalist and communist movements, and state intervention backed by political parties in the post-independence period have been the major forces to influence the development of the region. However, while these movements uplifted the region from its historical backwardness, the benefits of this development varied from one sub-region to another and the marginalized communities like Adivasis, Dalits, agricultural workers, women, and fishing community were left out to a large extent (Kurien 1995; Mencher 1980; Omvedt 2006; Tharamangalam 2006).

Over a period, opportunities for health have grown through the availability of food, health care facilities, education, employment, drinking water, and other determinants of health. However, inequalities to access those opportunities existed in one way or another. The influence of complex environmental factors is not just limited to the health of the people, it also affects the health services. Thus, the inequality in access to opportunities persists in health care services too. The marginalized communities are not entirely excluded from all the benefits which the region acquired during the last century. Instead, the benefits received by the disadvantaged communities are marginal or are shaped by dominant groups, compared to the benefits received by other social groups. This indicates the fact that benefits of growth are not distributed to disadvantaged groups through employment, education, gender equity, food security, and good health. Their health status remains unequally distributed and many socially disadvantaged were unable to attain the biologically possible good health comparable to the better-off communities. The health system of the region developed in a way in which disadvantaged communities cannot gain substantially from the development in education, financial status, employment, and leading a lower health status compared to other communities in the region. In brief, rather than cultural maladjustment and availability of health care facilities; the poor socioeconomic and political status, low income

is the contributors to the ecology of the low health status of Dalits and Adivasis in the region. On the other hand, the progress of the earlier untouchable community, Thiyya and minority community, Muslims from the region, through becoming political and economic stronghold lead to achieving a higher socioeconomic and health status.

Even though the movements and struggles that happened in the region have sympathizers and supports from all over the region, its activities were mainly concentrated in the town areas of Kozhikode, Kannur, and Palakkad (Gopalankutty 1978). Further, such attempts of other marginalized communities to become socioeconomical and political stronghold in the region did not succeed. For example, such an exclusive movement or organization of Adivasis in Kerala materialized only in 2001, which started in the form of a movement and came to known as Adivasi Gothra Maha Sabha (AGMS). Steur (2011) observes the emergence of AGMS and the attitude of other political parties towards AGMS at different times. He observes many workers of AGMS were earlier with the Naxalite movements and many others were with the Communist Party of India (Marxist) (CPIM). And when the Adivasi activists started articulating an autonomous Adivasi agenda in their movements, disagreement and opposition emerged from the left parties. Steur (2011) further points out the critique of left parties that there were imperialist forces behind the AGMS who are out to destroy communism. During 2006 AGMS allied with the Congress party against communists in the state and later quit when the Congress failed to address tribal issues. During the 2014 election, the AGMS leader CK Janu come up with a new political party in alliance with the Bharthiya Janatha Party (BJP) led National Democratic Alliance (NDA) in the state, but in the election, she got defeated by the Congress candidate (Election Commission Kerala, 2016). Such a move of CK Janu to create an alliance with a right-wing political party created conflicts within AGMS and made the organization more unstable (The Hindu, 2016). In sum, even when alone or in collision with other political parties, the organizations of Adivasis were not so successful as to influence the governance of the state, and their movements faced criticism from several other political formations in the state.

The continued multiple disadvantages faced by certain communities & sub-regions and the multiple advantages faced by some other communities & sub-regions were the base of variegated development of the region. This community disparity is coupled with the sub-regional disparity; the backward sub-regions are the rural areas where the marginalized communities have a

numerically better representation compared to other parts of the state. The disparity in socioeconomic and health status of three regions of Kerala and the disparity within the Malabar region between sub-regions and social groups hints at the role of social structures and systems of the region that shapes people's chances to be healthy. However, the response of the state government to overcome this was mainly focused on the expansion of public health care facilities (Kutty 2000). In fact, health services cannot control all diseases that could have been prevented, because the health services themselves cannot control all the factors that influence health (Varkevisser et al., 2003). Thus, the focus of the government remains on the expansion of health service facilities that too with the help of the private sector, instead of looking into the broader aspects of the health system.

There are studies from the state which looked into the health outcomes (Panikar, 1975b; K. C. Zachariah & Patel, 1983; Soman et al., 2017) , public policy (Cleetus, 2007;Nayar, 2009), health care provisioning (Kutty, 2000;Wilson, 2010a), socioeconomic factors influencing utilization and access (Sankar, 2001; Gangadharan, 2003; Simon, 2007). However, studies have minimally explored the responses of local actors in the organization of various elements of the health system in the state, and little is known about the engagements of various communities in the organization of health care resources. The responsiveness of the health care system towards various communities in the region influences the health status of different communities. The present study will be the first attempt to explore the engagements of various communities in the organization of resources for the health and health care system of the region; the social process through which certain communities successfully influence the organization of resources and the continued marginalization of certain communities in their attempt to influence the health care resources. Within the marginalized communities, how certain communities (Thiyya and Muslim community) were able to catch-up with the dominant communities in terms of socioeconomic and political status, and how does it influence their capacity to create and access health care resources.

The study analyzes how the provision and consumption of health system resources is reconfiguring the social, economic, and political developments that have occurred in the region throughout the period. It explores the intensifying / weakening linkages between various communities and the way in which transformations have happened in the local health care

system of the region as a result of changes in the social organization and hierarchy, economic environment, politics, and governance of the state. It analyzes the impact of changing patterns of social stratification on the local health care system; and its effects on the uneven development trajectories that have resulted in the health disparities.

Study population and their context

All the major social groups in the region are included in the study population, namely Hindus, Christians, Muslims, Dalits, and Adivasis. However, for an in-depth analysis, the study group is narrowed down to Adivasis, Dalits, Muslims, other backward castes, and forward caste Hindus from Vythiri taluk of Wayanad district. By focusing on marginalized communities, the attempt is made to do an in-depth analysis of the marginalization, which is one of the major reasons for differential health status among the communities. Even though the focus of the study is on marginalized communities, the inclusion of other backward caste and forward caste Hindus empowers to understand the differences in opportunity available to different social groups, which leads to health inequality. As already mentioned, the other backward castes from the backward districts of the Malabar region were found facing greater deprivation compared to their counterparts in the better-off districts. Their inclusion in the study population thus helps to understand different layers of disparity within the region and; empowers to compare and contrast the differential development among all major social groups in the study area.

Even though all the marginalized communities selected are the victims of structural marginalization, the political, economic, and social advantages they enjoy differ from each other. The Muslims, Thiyyas, and Dalits started to organize politically well before Adivasis; Muslims mainly organized along the religious line and Thiyyas and Dalits were largely part of the communist movement. Besides, there were socio-religious reform movements among Thiyyas, Dalits, and Muslims in the region and all over the state. Whereas Adivasis attempt to politically organize first with the help of Christian missionaries, later with communists, then with right-wing and finally alone does not help them to become a political stronghold in the state (Steur, 2011). Over the years when Muslims largely organized under Indian Union Muslim League as a political stronghold in state politics (Menon, 1995), such an attempt of Adivasis failed several time and they remain politically powerless. In the case of Dalits, even though they were with the communists they were never well represented in the leadership and never become a political

stronghold as a community (Gopalankutty, 1978). The larger advantages which benefitted the region after state formation can be identified as land reform and large-scale emigration to Gulf countries. When land reform does not bring any benefit to Adivasis, a lesser number of Dalits and Muslims benefitted piece of homestead land (Mukunthan, 2012). As a result, Adivasis and Dalits got little mobility in their social and economic status compared to other backward communities (Osella & Osella, 2000a) and always do not enjoy the benefit of improvement in wage due to absolute reduction in employment days. However, during the Gulf boom of the 1970s, a large section of Muslim families enjoyed affluence through emigration to the Gulf countries but very few among the Dalits and Adivasis were able to take advantage of this (Kannan & Hari, 2002; Zachariah et al., 2000).

In terms of health care, there is a difference among the communities in their views on health and medicine. There is evidence for wider use and practice of Unani medicine by traditional healers from the Muslim community in Malabar and all over the state well before state formation. In a response to an application to the colonial government for the grant by an Unani practitioner, the Inspector of Ayurveda writes that the Unani system of treatment forms part of the indigenous systems of medicine and this system is more widely practiced by physicians who belong chiefly to the Mohammedan community[11]. The same report also states that

> *There is no doubt that in any scheme for the encouragement of the indigenous systems of medicine in Travancore the Siddha and Unani systems are also to be included. Recently several Siddha Vaidyans in south Travancore were given encouragement either by grant-in aid or state recognition. But in the case of the Unani Vaidyans, it is to be admitted, that they have had no adequate encouragement, in spite of the fact that representations were made in the previous session of the SMP assembly urging for the award of grant-in-aid to Unani Vaidyans as well*

During 2004, after Allopathy, Ayurveda, and Homeopathic medical institutions in the private sector, Unani medical institutes constitute the highest in the state. A survey on private health care

[11] Award of Grant to Sheikh Moideen Unani Vaidyan till the end of 1106. M.E, Bundle. No. 153, File No. 149 of 31/LGB, Ayurveda Department, p.18-19. Kerala State Archives, Thiruvananthapuram cited in Cleetus 2007.

institutions (DES Kerala, 2004) shows that, out of the 109 private medical institutions under Unani, 69 are in the Malabar region with the highest in Malappuram district (29 institutions) during 2004. Similarly, the number of outpatients visited per year is highest in Malappuram (around one-third of total outpatients of private Unani institutions in the state) and the Malabar region. The only Unani medical college in the state is started by a private university called Jamia Markaz (meaning Sunni Cultural Centre) with an intention to bring back the tradition of Unani health care. The university stated one of its objectives is to reduce difficulties in the higher educational attainment of Muslim community. This is one of the organizations from Muslim community which provides higher education in various arts and science subjects including medicine.

Among the Muslims in the state, there are several groups, which see that modern medicine is not compliant with the Islamic canonical law. The recent campaign by some orthodox Muslim community leaders and alternative medical practitioners that vaccination is un-Islamic is a recent example (Rajeev, 2016). When one of the religious organizations has denied taking a stand on the issue, another opined that both science and spirituality should be given equal importance and that medicine and vaccination should not be overruled by orthodox belief (John, 2015). However, such groups are small compared to few other groups among Muslims that strongly believe in modern medicine and build up several health care facilities throughout the state. Organizations like the Muslim Education Society, Jamaat e Islami hind, Kerala, and Kuwait-Kerala Muslim Association are some among them which establish and support allopathic medical institutions to support the health needs of Muslims.

However, there was no such conflict found to have been articulated among Dalits and Adivasis as in Muslims; but in many cases, they face non-availability of modern health facilities (Sadanandan, 2001). Among Adivasis, health is the perception and conception in their own cultural system with less awareness of the modern health care and health sources (Mishra, 2012). The non-availability of modern health care facilities for Adivasis from the region is also because of the least importance given to cultural acceptance, lack of integration of local beliefs, and exclusion of community voices in the establishment of health services. In Malabar for many persons, especially the poor lower caste has implicit faith in traditional medicine and found the poor widely using the cheap cost treatment from several distinguished native physicians during

the earlier decades of the 20th century (Aiyar 1925). As a continuation to this, even after almost a century-long support to use of Allopathic rather than traditional systems by colonial and post-independence governments; about 47 percent of OPD in the public sector prefer Ayurveda and Homeopathy during 2003 in the state (see table 1.10).

Thiyya community, the second biggest community in the state comes under the category 'Other Backward Classes'; and they are numerically dominant among the lower castes. Sri Narayana Guru, who was the leader of the social reform movements of the Thiyyas was himself an Ayurvedic physician. Cleetus (2007) in his study on subalterns in medicine found Thiyya as a social group that had been practicing medicine as early as the sixteenth century. During the colonial period, they also demanded employment and grant from the government to the members of the community who acquired Ayurvedic education (SNDP Yogam 1956 cited in Cleetus, 2007). Cleetus (2007) further states that for Thiyyas medicine became an important aspect of negotiation with the dominant caste Hindu tradition and many among them made alternative claims to Sanskrit-based indigenous medicine. However, they succeeded in showing that their tradition regarding medicine was not outside but within the stream of Ayurvedic medical knowledge (Cleetus 2007). After the wide expansion of Allopathic medicine, the middle class from the state sees the medical profession as prestigious and sees it as a route to upward social mobility. The rich, middle class and forward castes become the major stakeholders (users, medical professionals, and owners) of Allopathic medical institutions in the state (Dilip, 2010; Wilson, 2010b; Wilson, 2011). Previously, the medical profession was generally opened to affluent communities like Nayar and Christians only. However, the emergence of formerly excluded groups like Muslims and Thiyyas into the middle-class status opened the opportunity for them to become doctors, nurses, and other health professionals (Wilson 2011).

In brief among the communities selected, all experienced differential socioeconomic developmental trajectory, and there are differences in their view of health and medicine in certain aspects. When the socioeconomic and political development happened in the region are advantageous to some, it serves disadvantages to some other social groups. Thus, the developmental history of the region resulted in the progress of certain communities including lower caste and minority communities in developing traditional and modern lines. On the other

hand, the attempts of most marginalized to develop their cultural, social, economic, and political status remain unaccomplished.

A brief history of various social groups in the district

Wayanad has been called tribal land. Narayanan (1995) infers that the indigenous people are the original inhabitants of Wayanad and the first in-migration to this region might have occurred in pre-historic times. Though in Malabar the Adivasis are mainly concentrated in the Wayanad district they were linked to their kinsmen in the nearby districts like Kozhikode and Kannur. To the early 15th century, this land was ruled by the Rajas of the Veda tribe as a tribal self-governing kingdom. In the medieval period, the *Vedar* king of Wayanad was defeated by the Malabar Kshatriya Rajas of the '*Kottayam Kurumbarnad*' principalities. This paved way for a long period of feudalistic rule of Wayanad by the upper caste Nayar gentry of Malabar. Under the feudal administration, the entire land was the property of the King and their Nayar Janmis. Below that the cultivators were the tenants of Janmmis and the Adivasis were bonded labour under various ownership categories (Munster &Vishnudas, 2012). Later through the invasion of Tipu Sultan leads to a brief ruling of the region by the Mysore regime from 1766 to 1792. The Mysore regime focused on extracting large revenues from the lands by tying up with the Muslims and other lower caste peasants in the area. (Varghese 1970 cited in Kjosavik & Shanmugaratnam, 2007). During the period, Muslim migration to the area got accelerated, they came mostly as timber traders and contractors and acquired large tracts of land from the landlords, a large extent of the forest was even mortgaged to them by the landlords. This on the other hand further infringes the access to and control over both agriculture and forest lands by the indigenous communities (Kjosavik & Shanmugaratnam, 2007).

By 1792 British conquered the rest of Malabar, but under the leadership of *Pazhassi Raja*, the upper caste Nayar along with indigenous communities of Wayanad fought with the British until 1805. After the defeat of *Pazhassi Raja*, the British East India Company decided to rent out the area on a long-term lease to leading landlords. As a result, Wayanad was divided into different revenue divisions and each division was auctioned out for the cultivation of export-oriented crops by diverting the land from rice crop. The British recognize Janmmis as the absolute proprietors of the land. However, there were influential families of Muslims too, who had taken large tract of land on lease from the Namboothiris and Nayars. Earlier the Muslim traders had to

give some rent to the Janmmis who keeps control over the land. However gradually royal families lost control over these areas and it had become the property of local Muslim traders. This in turn leads many of such families to settle down in these areas (Santhosh, 2008). In about the 1950s, under government regulation, Muslim traders could no longer hold large tract of land under them. They eventually sold patches of land to other non-tribal settlers mainly from the southern part of the state. These immigrant settlers were mainly Christians, Muslims, and Thiyya communities who were better equipped than Adivasis in cultivation as well as in the managing market. At the same time, Adivasi families were mainly controlled by the Nayar landlords. They were attached to the houses (*Idam*) or temple property (*Devaswam*) of the landlords. Later the migrant *Chettiyars* and merchant Muslims and other settlers also started hiring Adivasis from the Janmmi (Santhosh, 2008).

By the early 20th century Wayanad witnessed a rapid peasant in-migration from south Travancore and other areas of Malabar mainly by Christians and Thiyyas. They were mainly farming communities, and the then prevailed tenure system in Wayanad helped them to take possession of a large tract of land and bring them under intensive cultivation of cash crops. This had changed the lifestyle and livelihood of native Adivasis. The Adivasis become daily wage labourers when the demand for labour increased in the agricultural plantations of immigrants. The fast-growing cash crop production leads to the emergence of small markets in interior villages (Kulirani, 2003) and naturally, Adivasis become dependent on such markets for their day-to-day needs. In sum, the native traditional farming communities become landless agricultural labourers under the settlers by living in overcrowded colonies (Prasad 2003 cited in Munster &Vishnudas, 2012).

Different from Christian migrants, many Thiyya who migrated to the village are poor without much resource to own agricultural land. Thus, many among them are engaged as agricultural and other daily wage labour in the plantations and timber trading sites. Thiyyas are the biggest single community in Kerala, who were until recently considered as untouchable by the upper castes. Traditionally, Thiyyas were toddy tapers, however over the period they have mainly engaged in agriculture and other daily wage labour and entered into all other occupations. The Thiyyas entered into diversified occupations by taking advantage of the opportunities that arose under the impact of colonization - changes in land relations, commercialization, and the rise of an educated

middle class. Some among them in Pozhuthana become small-scale cultivators and traders, and over time a small educated middle class emerged among them, but the masses remained as daily wage labourers. In fact, at present, no one in the village is engaged in the traditional toddy taping and there exists not a single toddy shop. Similar to occupation another noticeable shift that happened among Thiyyas in the region is a shift from Matriliny to patriliny. One of the studies which discussed the decline of matriliny and its impact on Thiyyas, stated that women in 1944 enjoyed less freedom of movement than their mothers had as a result of the shift in matriliny (Aiyappan, 1944). Even though Thiyya women faced hardship in the joint family system under patriarchy for a long period, in the present-day under the nuclear family set up many women reclaim the freedom and authority to manage their own and their family's affairs. In addition to the freedom and wellbeing of women, the greater role of women in the family helped their children to attain better health and education.

As an untouchable and unapproachable caste under the caste system prevailed in the region, the Thiyyas were subjected to large-scale discrimination based on ritual pollution. The reform movements under the leadership of reformers like Sree Narayana Guru enabled the Thiyyas to develop in traditional and modern lines by showcasing Thiyya cultural tradition. A vigorous campaign for changes in the plight of Thiyyas through criticizing social evils and promoting education, occupational and social mobility had a wider impact on the community. Internal reform within the Thiyya community, which was affected on a mass scale with tremendous speed and zeal through reformers and reform organizations, set the stage ready for them to receive the benefits of external reforms (Chopra, 1979). From their earlier status of the untouchable caste, Thiyyas gradually took up *a Vedic* form of worship and built their own temples and worship places in the region, which later becomes locally well-known worship places. Thiyya men from the region are well known for their martial skills, they have built up the *Chekavan* tradition in *Kalarippayattu* though it was mainly the upper caste Nayar who had the privilege of carrying arms and joining the military according to the caste system prevailed in the region. As many Thiyyas who are experts in the martial arts were enjoyed the status of *Gurukkal* in the region, many experienced traditional healers and their families were well known as *Vaidyans*. In fact, such traditions among Thiyyas in the village and all over the region became an important channel for attaining caste mobilization and social mobility.

Data required

To document the differences in the development trajectories of different sub-regions and communities; and to document the social, economic, and political process responsible for the variegated development, a majour focus is made on secondary data. Several micro studies and some macro-level studies have already looked into the social, economic, political, and health status of different communities and regions in the state. Along with inputs from such studies conducted on particular communities, data were also collected from key respondents to document the process of change, the forms of disparity, the processes of marginalization, and its effects on health. Data regarding economic resources collected includes resources that directly enhance the purchasing power of the household/individual. These include ownership of resources such as land, farm animals and poultry, sources of employment; other movable and immovable property such as a house, bank balance, ornaments, etc. On the other hand, social resources include community organizations, cultural organizations, and educational resources.

To explore the engagement of various social groups, Adivasis, Dalits, Muslims, other backward castes, and forward caste Hindus towards the organization of various elements of health care resource, data were collected through detailed interviews with the respondents mainly from the mentioned communities and all other major communities in the region. To obtain data about the experience of various social groups with health services, the responsiveness elements point out by WHO for assessing health system responsiveness were found useful (Darby et al., 2000), and the same is collected. This includes aspects related to patient's dignity, autonomy, confidentiality, prompt attention, provision of social needs, basic amenities, and choice of provider and facility. Data relating to factors influencing treatment behavior pattern; nature of the illness, forms of treatment that were accessible and degree of access, individual and collective experience of treatment and belief about treatment systems and providers are important factors (Priya, 2012), thus they were also collected. Further type of resources that directly influence health like availability of food, safe drinking water, good sanitation, and good health care needed across different social groups are also explored. Besides, details about various providers and facilities available in the region both public and private provisioning under various systems of medicine were gathered. Data regarding public provisioning were availed from year-wise Economic Review published by the State Planning Commission. For detail of private health

care facilities, the major source depended on is the latest surveys on private medical institutions conducted by the Economic and Statistical Department, the government of Kerala. The other major sources of secondary data are Census of India, 2001 and 2011, General Population Tables and district census handbooks, Economics and Statistics Department, Government of Kerala; District Gazetteer of Kozhikode district for 1965; Electoral list and other relevant documents from Pozhuthana Grama Panchayat; District Medical Office of study districts; Other published books and unpublished research papers.

Purposive selection of study area

The differences in the developmental trajectories of different sub-regions and communities; and the processes through which uneven developmental trajectories resulted in health disparities are analyzed by looking to all six districts in the Malabar region. For an in-depth analysis of the marginalization process, in which certain communities have been marginalized in the development of health care facilities, the study focuses on Vythiri taluk of Wayanad district. The taluk is selected based on the comparatively good share of all social groups in the population, and its development as a marginalized sub-region. In Vythiri taluk there are 17 village panchayats with an average population of 13519 in each during 2011 (Census of India, 2011). Further to take samples for data collection, out of the 17 village panchayats, one village is selected based on the representation of different social groups.

Tools and Plan of data collection

A two-stage data collection process is done to get the required data. At the first stage, general information about social, economic, political, and health conditions of all major communities (the five selected social groups) is collected through interviews with key respondents supplemented by secondary materials and office records. In the next stage, detailed fieldwork is conducted in the villages of Vythiri taluk. For this, a preliminary analysis of the already collected data is done, based on the findings from the primary analysis a semi-structured interview schedule is designed. Based on the schedule interviews are conducted with the heads of 30 households each from the five communities selected. The detailed fieldwork is done in Vythiri taluk from January 2018 to March 2019 to gain an in-depth understanding of the effect of marginalization on health, through observations, informal conversation, schedule-based

interviews, and guided group discussions. As comparison across different social groups is the purpose, a fixed number of samples (30) from all five social groups is taken by ensuring representation of poor and better-off households in each social group. In the first stage of the interview with key informants in the village criteria to classify poor and better-off households in each social group is also prepared.

While taking sample households from five social groups in the selected taluk, it is important to know the population composition of villages in the taluk. Religious wise population data is available up to sub-regional level from the Indian census data. However, below that at the village level, religious-wise census data is not available. Sample surveys like National Sample Survey (NSS) and National Family Health Survey (NFHS) give information regarding three religious groups and for OBC, Dalits, and Adivasis. However, such surveys are sample-based and do not provide the total number or share of different religious or caste groups in a particular region. However, Pozhuthana panchayat within Vythiri taluk found collected religious data with the help of the Economics and Statistical Department (see table.2.1).

Table 2.1 Religion wise population in Wayanad district, Vythiri taluk and Pozhuthana Panchayat

Social group	Wayanad District* 2011	Per cent share	Vythiri Taluk* 2011	Percent share	Pozhuthana Panchayath# 2015	Percent share
Hindu	220439	26.96	57264	21.91	4200	22.82
Muslim	234185	28.64	108122	41.36	6822	37.06
Christian	174453	21.34	40096	15.34	2900	15.75
Dalit	32578	3.98	16,127	6.17	1220	6.62
Adivasi	151443	18.5	38,213	14.62	3262	17.72
Total	817420	100	261417	100.00	18404	100

*Census of India 2011; # Data collected by Economic and statistical Department for Pozhuthana Panchayat during 2015. Availed from Pozhuthana Panchayat office.

Similar to the Wayanad district and Vythiri taluk, in Pozhuthana panchayat also Muslims records the highest population followed by Hindus. But in Pozhuthana panchayat Adivasis recorded third place compared to Christians in Vythiri taluk and Wayanad district. In both taluk and panchayat, Dalits record fourth place with more than six percent share in the total population. Besides, the Pozhuthana village, which constitutes only 50.7 sq km records the highest share of Adivasis

among the villages in Vythiri taluk is a part of the Pozhuthana panchayat which accounts for 71.3 sq km.

As the panchayat has 13 villages (the panchayat is divided into thirteen wards by the election commission of India) with a total population of 18404, it is not feasible in terms of time to do a baseline survey in all households within a short period of data collection. Even though the electoral roll 2016 published by the election commission includes individuals from almost all households in the panchayat, the details are given in them are limited to name, father name, house name, age, and gender. An interaction with elected representatives of ward numbers one, seven and eight; and inputs from the electoral roll for each ward gave some ideas about the settlement pattern of various social groups in the panchayat. It is understood that ward numbers seven and eight are mainly inhabited by Hindus including upper-caste Hindus; eleven and twelve are mainly inhabited by Muslims; ward numbers three, nine, and ten are mainly inhabited by Adivasis, and; thirteen is mainly inhabited by Dalits. However, some households were not included in the electoral list, with the help of elected members and key informants details of such households were included in the list. This will be done during the first stage of fieldwork, which is envisaged for a month.

To select households for the interview, one ward for each social group is selected based on their highest population in the ward. Further with the help of respective ward members and key informants each household in the electoral roll is marked with their religion and caste or ethnicity. Based on that, a list of households in a particular social group for a ward in which the social group is numerically dominant is prepared. For example, in ward number thirteen Dalits are the dominant group, from the electoral list of ward thirteen only households from Dalits are taken to prepare the list. Likewise, the same is done for all other four social groups. After this exercise, there was a list of households for each social group in a particular ward, like the list of Dalit households for Ward number thirteen and list of households of Hindu for Ward number eight. After this, to ensure the presence of both poor and better-off households in each social group, the wards selected were further divided into hamlets. Two hamlets were formed in each ward one by ensuring the presence of better-off households and the other by ensuring the presence of poor households. To classify hamlet, criteria are developed in the first stage of fieldwork with the inputs from ward members and key informants. Further, households in the

already prepared list were classified into better-off and comparatively poor hamlet based on the criteria developed. After this exercise, there were two lists of households for each social group in a particular ward, one with the presence of better-off and another with the presence of poor households. From the final 10 lists prepared, 15 households each were randomly selected to constitute a total of 150 sample households as given in table 2.2.

Table 2.2 Number of sample households from each social group

Ward no.	Social group	Hamlet – with better-off/ poor households	Number of sample households
7	Upper caste Hindu	with better-off households	15
		with poor households	15
8	OBC	with better-off households	15
		with poor households	15
10	Adivasi	with better-off households	15
		with poor households	15
12	Muslim	with better-off households	15
		with poor households	15
13	Dalits	with better-off households	15
		with poor households	15
Total			150

Local criteria developed to identify better-off and comparatively poor households.

The criteria to demarcate better-off households and comparatively poor households have developed through detailed discussions with elected members from five wards selected, panchayat president, and some of the key informants along with inputs from data collected during the pilot study. It was clear from the literature itself that the criteria to demarcate better-off and comparatively poor households within each social group will not be the same for all five social groups. Inputs from the field also show the necessity to evolve social group-specific criteria for a justifiable demarcation of better-off and comparatively poor households within each social group. It has been observed that the gap between better-off and poor households within upper-caste Hindu, Muslims, and OBC are much wider than that in Dalits and Adivasis.

In the discussions 'the total earnings of a household' is evolved as a major determinant of deciding the economic status of a household. However, the discussants also strongly pointed out

the insecurity which poor households face concerning their occupation. This lack of steady income and secure means of livelihood indicates 'livelihood security' as the key determinant in deciding the economic status of a household. Accordingly, the poor households include agricultural labour households, daily wage labourers, and other casual workers. The comparatively better-off includes households of farmers with substantial agriculture, Gulf migrants, government employees, businesspeople with substantial earnings, and traditionally rich families. In the case of Adivasi and poor Dalit households, very few have government employment, gulf emigrants, or any other occupations of the better-off class. Thus, among these two social groups, poor households are identified as those households that experienced insufficiency of food in any period during last year. Similarly, within the category of Thiyya, the highly organized Toddy tapers (traditional local beer brewers) are considered under the better-off category due to their permanent nature of employment and income.

The second key indicator highlighted in the discussion is the area of land owned by each household. Poor households have been identified as with no land or with very little homestead land. The households with large tracts of cultivated land are considered as comparatively better-off households. In addition to this, irrespective of the area of land any substantial return from the land in the form of rent from the land or any building in the land; uncultivated lands with high market value are treated as part of better-off households. On the other hand, some poor Adivasi households have large tracts of land given by the government without full rights to transfer or sell it. Besides, the majority of such lands are not feasible for agriculture due to low fertility, non-availability of irrigation facility and its proximity with forest make them vulnerable to attacks from wild animals. Thus, households who own such tracts of land were not included in the better-off category just because of the large area of the land in their possession.

The third important indicator derived from the discussion is 'type of house and household amenities available'. Big houses like two-storied houses, costly materials like marble, tiles used for the floor; and availability of appliances like refrigerator, washing machine, etc are considered as characteristics of better-off households. However, such amenities are rare among the better-off households of Adivasi and Dalit groups, thus they are not fit for this categorization. Pukka house built with own resources or with government support, availability of the sufficient number of rooms for the family members and having cemented floors are treated as houses of better-off

households among them. Availability of household amenities like LPG (Liquid Petroleum Gas) connection, television, dining table, etc are also used to categories better-off households among these two categories.

The fourth key indicator discussed is 'other assets owned' by the households. Households with stable availability of liquid cash for day-to-day needs, substantial savings in financial institutions, stock of gold ornaments, ownership of four-wheeler vehicles, etc are categorized as indicators of better-off households. In the case of Adivasi and Dalits having arrangements to meet day-to-day expenses without compromising basic needs (food, shelter, clothing, health, education of children), and having a two-wheeler, cattle farm, or any other similar assets are termed as better-off households.

In addition to these four key indicators, few more indicators suggested were also counted.

a) Type of ration card possessed – The discussants elaborated the fair procedures followed to identify priority and non-priority households based on their socioeconomic status in the village. Based on that four types of ration cards were issued to households. Yellow and pink cardholders are below the poverty line and among them, yellow cardholders are economically most backward. Blue and white card holders are above the poverty line, where blue cardholders are comparatively less affluent. Thus, yellow and pink holders are also considered to include in comparatively poor households.

b) School or college where the students are studying - among the households of Muslims, Thiyya, Adivasi, and Dalits, students studying in private schools or colleges by paying substantial fees are termed as better-off households.

In the case of data on caste-wise population, they are also not available from the population censuses. An estimate done by Zachariah (2016) using data from Kerala Migration Survey gives an idea about the share of various caste groups within the Hindu religion for 2008-14. According to his estimation, forward caste Hindu in Wayanad district accounts for 19.1 percent of the total Hindu population (total Hindu population includes Dalits and Adivasis). However, Panchayat level data for various caste groups are not available for the region. Hence, interaction with elected representatives and Panchayat officials reveals that a small number of the forward caste

Hindu families live in the Panchayat. Concerning to OBC, almost the entire Muslim population (99.1 percent) in the state belongs to the OBC category (Kabir, 2010). We have already included Muslims as one category in the five social groups selected. Thus, the remaining OBC population in the state is the backward class Hindu population excluding Dalits and Adivasis. The major castes that come under this category are Thiyya, Nader, and Viswakarma. The backward caste Hindus in Wayanad districts account for 29.3 percent (OBC) of total Hindu population (total Hindu population includes Dalits and Adivasis) during 2008-14 (Zachariah, 2016). The 22.82 percent Hindu population in Pozhuthana panchayat is majorly constituted by OBC (mainly Thiyya) and forward caste Hindus.

Ethical considerations

The study does not impose any risks on the participants, and no medical interventions are carried out at any stage. The proposal of the study was presented at the Institutional Ethics Review Board of Jawaharlal Nehru University and got approval with IERB Ref. No. 208/Student/181. During the fieldwork, informed verbal consent was taken from all the respondents after providing sufficient information regarding the study. Respondents were also informed that there is no direct risk and benefit involved in this study, and their participation is purely voluntary. The participation does not ensure any direct benefit to the respondents but in the long run findings of the study may influence policy changes. The confidentiality of the data collected was maintained throughout the work and will maintain confidentiality even after the study. Information leading to the identification of respondents was anonymized in the study report to protect confidentiality. The data collected will be kept with the researcher and will be solely used for academic purposes only.

Chapter III

Social History of major Social Groups in Pozhuthana Panchayat: Summarizing the Relevant Social History of the Village as a whole

It was in 1972, Pozhuthana panchayat came into existence by departing from Vythiri Panchayat. Pozhuthana panchayat has two main villages; one is Achooranam village with an area of 2,032 hectares and the other is Pozhuthana village with an area of 5,019 hectares. During 2011 the former had a population of 11,998 living in 2,684 households, and the latter, which is more than double in its area, has a population of 6,406 living in 1,571 households. In the total population, during 2015[12], Muslims constitute 37.06 percent, followed by 22.82 percent of Hindus, 17.72 percent of Adivasis, 5.75 percent of Christians, and 6.62 percent of Dalits. Prior to the British, Wayanad was divided into *Nads* (smaller divisions), and each was entrusted with a *Nayar* chieftain for administrative purposes. *Edanataskur* was the *Nadu* which includes present-day *Vythiri* and *Pozhuthana*. *Edanataskur* comprises of three *Amshams*[13], namely *Kottapadi, Kalpetta* and *Vythiri,* and was placed under *Kalpetta Nayar* and *Kanthamangalath Nayar* as chieftains. Under these chieftains, the present-day villages under Pozhuthana panchayat were ruled by the head of *Pozhuthanayidam Nayar* family. The chieftain of *Pozhuthanayidam* was holding the whole of this land until the second half of the twentieth century.

Even after several land distribution efforts, the land is unequally distributed among the villagers. In the plain lands of the village, upper caste Hindus and Muslims have large tracts of land along with other social groups like Thiyya and Christians. Only some Adivasis have agricultural land in the village, and most of them are on the hill side near to the forest. The non-availability of irrigation facilities and attack from wild animals makes cultivation difficult in such areas. In the case of Dalits, very few among them have additional land than a small piece of homestead land.

[12] Religious wise data at Panchayat level is not available for 2011. 2015 data is collected by Economic and Statistical Department Kerala for Pozhuthana Panchayat

[13] Smaller segment or part of an administrative territory below Nadu. For example *Edanataskur* was the *Nadu* which includes present-day *Vythiri* and *Pozhuthana*. *Edanataskur* comprises of three *Amshams*[13], namely *Kottapadi, Kalpetta* and *Vythir.*

Over the period, the land becomes a commodity which is more frequently sold and bought and steadily went in to the hands of newly better-offs. Land became increasingly concentrated in the hands of those who see it as an investment, contrary to those who held it earlier by cultivating and building a life based on agriculture. When land is being denied to the native inhabitants of the village, it is important to note that large tracts of land in the village are in possession of plantation companies. The lands in the hands of plantation companies are provided to them by the *Pozhuthanayidam* landlords on a long-term lease agreement for 99 years. Even after the completion of the lease period, efforts to retake land from private plantation companies remain unattained.

The economic life of the village inherent to the development process changed over the years, from a traditional agrarian economy based on food crops, shifted to a more organized agrarian economy focused on cash crops. By the second half of the twentieth century itself plantations of coffee, tea, and pepper had been established in the village. Plantation agriculture had led to changes in the traditional economy, and the fast-growing cash crop production has lead to the emergence of small markets in the village. By the 1950s, cash-oriented agriculture became widespread in the village, and it became unavoidable for anyone to be part of it to continue in agriculture. Further, while remaining as an agrarian economy, other types of economic activities have also started mainly through the support of remittance from Gulf countries. In this process of change, some were able to take multiple advantages, and some others face multiple disadvantages. While the upper caste Hindus dominated and gained multiple benefits for an extended period, the Muslims, Christians, and Thiyyas were also able to take advantage in various aspects. When Muslims were able to integrate and develop a new belief and culture based on Islam; the Thiyyas could make substantial social progress to develop in modern and traditional line. The least benefitted are the marginalized Dalits and Adivasis. In the social process of development experienced by the village, both the marginalized communities got subjugated and alienated from the benefits of development experienced.

Upper caste Hindus of Pozhuthana - The Nayar dominance and its decline in the village

The upper caste Hindus in the village constitute *Namboothiri Brahmins*, *Nayars,* and their sub-castes like *Menon* and *Kurup*. The Brahmins of Malabar generally are known as *Namboothiris*, until recently they were very rich, orthodox, and to a greater degree, opposed to change and resistant to western influence in relation to any other community. The *Namboothiris* were, in fact, immigrants settled in the region, but they had acquired a superior social status and ability to keep their Brahminic culture as superior over the native culture. However, in number, they are one of the smallest communities in the village as well as in the whole of Malabar. The *Nayars,* who are the largest upper caste in the village, are recognized only as *Sudras* under the Hindu caste system. Thereby, they are considered inferior in ritual status to the small number of *Namboothri Brahmins* in the village and whole Malabar. They were the only caste so close to the Brahmins through their act as the servants and bodyguards of the *Namboothiris*, by holding the position of local rulers and officials who carries out the wishes of the Brahmins and kept the lower castes in order. In addition, Brahmin men kept the *sambantham* relation with the *Nayar* women. This is a form of morganatic marriage, in which the younger male members of Namboothiri families freely mate with Nayar women. The *Nayar*s do not treat it as anything bad instead believed relation with a member of upper caste and a noble family would bring them a social and religious status similar to *Namboothiris*. To a large extent, this was true; being the local rulers and their close relationship with the Brahmins gave them fairly high ritual, social and economic status over other lower castes and non-Hindus in the village.

Brahmins believed in the *Kana-janma-maryada* which means the god has presented the whole Kerala land to the Brahmins. Accordingly, they believed that they have right over the entire land, and they were called as *Janmmi*. They indirectly ruled all the land and the people living on it through the *Nayar* landlords known as *Deshavasi*. The *desham* was the primary political and administrative unit of Malabar up to the arrival of Britishers in power. The head of the *desham* was the *Nayar deshavasi*, who had the functions of directing religious ceremonies of the village and temples, maintenance of law and order, and management of the estates of the Brahmins. Over the period when the king was least involved in day-to-day matters of the village, the *Nayar* rulers gained authority and power similar to that of a king.

Even though over the period *Nayars* lost their ruling authority as landlords and were alienated from most of the lands in their ownership, they still own lands, and hold power in the governance of the village greater than any other community. Even after independence, the dominance of *Nayars* continued in village administration through local governments. But it is not the same as the earlier orthodox ruling *Nayar* families; now a group of newly educated young politicians from among them are in the forefront. When the first democratic form of election of representatives for Pozhuthana area into Vythiri panchayat happened in 1963 (during the period Pozhuthana was part of Vythiri panchayat), three Nayars were elected along with a Muslim member. When Pozhuthana became an independent panchayat in 1972, a Nayar called *Nanu Nayar* became the president. Since then up to 2019, out of the eight elected presidents, except for two Muslims, all other six times a Nayar either from Communist party or from Congress party became the president. Even though they are small in number, the political party of *Nayar*s called the National Democratic Party (NDP) won the panchayat president post with the support of the Congress party during 1988. However, this does not mean the existence of earlier political dominance of *Nayar* on other social groups in the village. Instead, it shows, the resources and atmosphere are more suitable for individual *Nayar* to become political leaders and members of the local government than any other community except Muslims in the village. However, through the strong functioning of the local self-governance system and the recent reservation of seats in local self-government, many among the marginalized section got the opportunity to take part in village administration. Nevertheless, the power gained by the lower caste in the village governance was not enough to question the new form of political and ruling power maintained by the educated Nayar in contemporary times.

In fact, from the time of the Britishers itself, most of the local politicians who worked for the upliftment of labourers and plantation workers are from *Nayar* community. There was a genuine concern among a few newly educated *Nayars* towards the sufferings of lower caste labourers. Political activities of the first generation of college-educated *Nayars* in the village were focused on the grievances of the labouring class, and the freedom struggle. As a result, educated Nayars like K Govindan from the village participated in the freedom struggle and the fight of labourers for better and safe working conditions. Such local Nayar leaders then joined different political parties, including NDP, CPI (M), and Indian National Congress (INC). Through their leadership, the earlier labour collectives took the form of trade unions in the village during the time of

independence. They stood with the trade unions for the rights of labourers, including their struggles for getting the barren lands of *Achoor and Mutharikkunnu* for agricultural use from the private plantation and government. In sum, the political and labour movements of the poor that happened in the village got extensive support from a section of the newly educated Nayar community.

The social, economic, political, and religious atmosphere of the village continued to remain enabling for an extended period for a *Nayar* to lead a life with new form of education, social status, and authority in the village. This can be understood from the life history of any of the better-off households of the Nayars in the village.

One such example is the case of a well-known politician of the village, whose father migrated to the village in the early decades of the twentieth century with no possessions. His father, the fifth son of a middle-class *Nayar* family of Kozhikode district, migrated to Pozhuthana after a brief fight with his parents. He lived in the Pozhuthana village and met the head of *Pozhuthanayidam*[14] and conveyed his wish to settle in the village. The *Pozhuthanayidam* chieftain told him to take land in the *sixth mile* to do agriculture and build a house. Then he cleared five acres of forest land and made it cultivable. Even though the land is near to the main road, it is not suitable for rice cultivation as it is on the slope of a hill. He started to cultivate vegetables, bananas, tapioca and planted coffee and pepper in the land. Later he resolved the issues with his family and reunited with them but settled in Pozhuthana village with his wife and children. He got married to a *Nayar* woman from his native district Kozhikode. As he was having five acres of land and cultivation in it, he was able to build a much better two storied house with a tiled roof with four bedrooms and a kitchen. As similar to other upper caste houses of that period, he also built a well near to the kitchen and a bathroom adjacent to it. He got all the support of *Pozhuthanayidam* chieftain in availing the land, making it cultivable, building his own house, which is generally not available to any other castes in the village. As he is able to manage his agriculture well with the cheap labour of lower-caste workers, he was able to make some

[14] Family name of the local chieftain. Phozhuthanayidam chieftain owned and controlled the whole land of present day Pozhuthana panchayath until the second half of the twentieth century.

financial resources. He sent both of his sons to school and then to college, and later the elder one became a teacher and got settled in the nearby village with his wife and children.

The younger one, during his college days itself, aligned with the communists and fought for the welfare of the working class. Later with the recommendation of a communist leader, his son got a job as a supervisor in the plantation. He worked there for thirteen years and later resigned from the job to engage in the work of communists for the upliftment of labours in plantation and agriculture. Further, he became one of the main leaders of the CPI (M) in the village and elected to the local self-government twice. He played a major role in the local governance in almost all times when CPIM led LDF won the election, and continued to hold higher social status in the village.

Occupation and economic status

Not all *Nayar*s are equally wealthy, from very large landlords they ranged through moderate landholders down to the poorest daily labourers. All Nayars in the village are not settled together in a particular area; rather, one could find a Nayar family settled on the hill side with the head of the household engaged in transport service with his own vehicle. Another one settled in the plain terrain but in the interior of village engaged in own agriculture activities and elder son running a shop in the market. Another one settled near to the main road with a large tract of land and doing agriculture by employing *Pulaya* workers, or a family with one or two members in government employment. However, irrespective of their financial status and place of living in the village they possess the higher ritual status among the Hindus. The drastic changes in the customs and certain laws relating to matrilineal joint families lead to a large rate of land transfer from *Nayar* to Muslim and lower caste Hindus in the village. However, *Nayar* had not lost all their advantage or been swept from social power. Many of them steadily alienated their land, but still, many among them held more land than anyone else in the village. Similarly, their dominance on ritual status was questioned at several occasions but continue to maintain a superior position in the society. For *Nayar*s, the changes do not vanish their dominance; rather, they only loosed the unquestioned dominance which they enjoyed in the traditional village.

In the yesteryears, there were caste-linked occupations among *Nayar* like they were the officials of Kottayam raja, and even before that, many among them were the soldiers of the Raja. Over the

period, occupational mobility takes place among Nayars and at present, one could see members of *Nayar* caste working in various fields. But it does not mean that they are willing to do any kind of work, rather there are still some reservations in doing certain jobs. For example, working as daily wage labour in agriculture, working as a fish or meat merchant in the village are least preferred by them. In the case of the comparatively poor *Nayar* family, there are cases of individuals working in an automobile workshop in the nearby town, another one running an own auto-rickshaw in the nearby Vythiri town. It is also notable that both are working away from their village as they do not prefer to do such works in their own village and the other reason is, they have some hold to do their business in a bigger town than their village.

During the period of drastic changes in the economic sphere of the traditional village towards trade and commerce, *Nayar*s were least interested in acquiring the skills to do that. Even though they saw some of the Christians and Muslims who successfully made a profit out of trade and business, *Nayar* does not consider such businesses in the village as an occupation of reputed to engage. During the time of such changes majority of *Nayar*'s maintained the position of higher socioeconomic status and dominance over others in the village. Thus, they were largely involved in acquiring education and thereby getting employed as government officials and professionals like advocates and teachers. At the same time *Nayars* continue to hold traditional land and assets. Their pride in traditional status based on caste authority is not removed completely; to an extent, it prevents them from taking advantage of new commercial opportunities. On the other hand, instead of engaging in trade and commerce, they invested in the education of family members. As a result, the first among the college-educated generation in the village came from Nayars, and many among them become government officials of higher posts. The dominance by Nayars in all major government offices established a new form of ruling authority by keeping other social groups away from the ruling circle for few decades.

Rituals and beliefs

In religious and ritual matters, Brahmins who ruled the village with the help of *Nayar*s are similar to their counter parts elsewhere in the country, following the same *Vedas* and *puranas*. However, different from this, the non-Brahmin villagers, including *Nayar*s have their own distinctive beliefs and culture. Over time, in many aspects, non-Brahmins have accepted and

followed the elements of Brahmin culture but still, largely stick to their own culture and belief. But *Nayar*s who are close to the Brahmins, to a greater degree, accepted the beliefs, rituals, and caste practices of Brahmins. As a result, in the present-day village, two different dominant belief systems and culture exist among Hindus, along with other lower caste and Adivasi beliefs.

As the new Brahminic belief spread among all social groups, it started to reflect in the day-to-day life of people in various ways. All the temples of goddess *Devi* and god *Shiva* in the village are built on the lands of Pozhuthanayidam landlord, and are the major temples of Nayar community. Over the time when the temples of upper castes were opened to all Hindus irrespective of their caste, they become the major temples of Hindus in the village. The *Kavu* and devotional places of *Thiyyas* and other lower castes were never represented as a general temple of all Hindus. Even though the *Kavus* and temples of the lower caste are open to all Hindu castes; generally, upper castes do not visit them. In the temples of the upper caste, offerings to the deity are generally bananas, milk, and sweets. Whereas in the lower caste *Kavu* and temple, offerings include toddy, raw rice, and dried fish, some of which are treated as ritually polluting by the upper castes. Such differences based on beliefs are not just limited in the religious practice but can be seen in various aspects of life, like the differences in the traditional medicine of *Thiyyas* and text-based Ayurveda practiced by upper castes.

As all the major temples in the village were once owned and managed by the upper castes only, now some changes have happened in this. Now all the temples are managed by committees formed by villagers (temple committees) in which members from lower castes are also active. But no major changes happened in the rituals practiced in the temples that are wholly based on the upper caste Hindu beliefs. Similarly, no changes have happened in the exclusive rights of the Brahmins to become the priests of these temples. Unlike Muslims in the village, there is no such religious authority among the upper caste Hindus to supervise and inspect the day-to-day life for the ideal functioning of religious matters. However, there is a social control on the Brahmins, especially those who are engaged in temple activities, to remain strict to the way of life based on the belief system of the temple and their caste. Such Brahmins are expected to follow the purity concept by strictly being vegetarian, not consuming alcohol, and not performing any activities which are treated as sinful. Such informal monitoring is done by the temple committees, and anyone who violates the rules is removed from their roles in the temple.

In the case of *Nayar* community, as similar to other lower castes, it is not compulsory to follow the customary practices and ritual activities of their caste or religion in order to be a member and follower of the caste. However, one could find two types of Nayar families in the village, one with more orthodox beliefs and the other with newly educated and globalized families with no rigorous religious beliefs.

Different from other lower caste in the village, *Nayars* are less in the practice of giving offerings to the spirits of their ancestors during the special occasions and death anniversary in a ceremonial way. Earlier *Nayars* also gave importance to veneration of ancestral spirits, but it gradually changed when they become closer and closer to the beliefs of *Namboothiri* Brahmins. For the lower castes, their beliefs and rituals are uniquely aligned to their local environment, whereas in the case of *Nayar* it is more aligned to the Brahminic belief as elsewhere in the country.

Family and kinship sentiment

*Nayar*s followed the matrilineal *Marumakkathayam* system of inheritance, based on the matrilocal joint family called *tharavad*. All members of a *taravad* descended from a common female ancestor, but the management of *taravad* affairs was vested in the eldest male member, the *karanavan*. Thus, the system was matrilineal not matriarchal. The property and assets of the *taravad* were held in common by all members, but no one can individually claim his or her share of the joint property. The *Karanavar* acts as the manager and head of the property of *tharavad* and makes decisions in an autocratic way as he was not accountable to or questioned by any others in the family. All day-to-day matters of the family are managed by the *Karanavar* by delegating duties to other members, and he heads and manages all the functions like marriages and rituals in the family. His words are the final decisions in case of any disputes in the family and his sanction is important in fixing any marriage alliances for members of the family.

However, over the period, the matrilineal joint family proved to be ill-suited to the increasing individualism and to the demands of a cash economy, which developed through reform in education and administration. Kinship sentiments in the form of the joint family gradually give way to individual families. In the village, the earlier large joint family system is not prevailing today. Generally, it is usual for the eldest son to separate first from the family by building a new

house, and then the next eldest will go out when they have a growing family. While separating, it is usual to give them their share in the ancestral property. The result is that the youngest son is very often left with the ancestral home.

The earlier *tharavads* generally had large tracts of land and other resources like livestock. They produced most of the things needed for their day-to-day use, and the remaining are bought in bulk and distributed to the members. Thus, in most cases the *tharavads* are self-sufficient in resources in meeting their needs and hold some wealth even in the form of cash. Their engagements with the neighbors and villagers are minimal in terms of mutual help for day-to-day needs and family functions.

When cash and salaries gained wider use among different social groups, land was made more easily available to many, western style education became more important. Individual *Nayars* and their immediate families found *tharavad* system is not suitable for the maintenance of *Nayars'* position in the society. Under *tharavad* system, the younger brothers found it is difficult to give individual attention to their children, and the *karanavar* had a general tendency to be biased towards his own children in terms of spending over education, health, etc. When the matrilineal system became burdensome, and their increasing desire for change, the *Nayars* faced difficulties compared to any other community in changing it to a patrilineal system. Nevertheless, they changed to m*akkathyam* (patriarchy), as the earlier system proved unsuitable to the values imparted through newly established education and to the emerging economic conditions.

Even though many changes followed the changes in *tharavad* system, still in many aspects the attributes of matriliny and authority of *karanavar* remain among the family setup of *Nayar*'s. One example is the fixing of marriage proposals and the way they organize marriages. While fixing a marriage proposal, the reputation of the erstwhile *tharavad* of the bride and bridegroom is the first thing matched for suitability. While organizing the marriage function, different from other communities in the village, the whole function is generally managed and headed by *karanavar* of the family. Whereas in the case of other communities the role of family will be minimal, and the neighbors, relatives and the local headman will be the one who manages the function and direct the rituals. Further, as similar to earlier, they strictly follow endogamy and the common way is marrying a man or woman from the nearby villages outside the panchayat.

While arranging marriage alliances the reputation of the family is highly considered, descendants of well-known *tharavad* always prefer relation with members of similarly well-known *tharavadu* only.

The traditional medical practice among Nayars

In Malabar *Vydhyam* or traditional medical practice was never an exclusive occupation of any particular caste. When Ayurveda developed as a unique medical practice based in text distinct from folk medicine, the literates among the upper caste *variyar's* and immediate lower castes like *Nayars* were in the best position to become Ayurveda *vydhyans*. There were some locally well-known Ayurvedic Vaidya's in Pozhuthana from *Nayar* community like Karunakaran vaidyan. Along with the practice of traditional medicine, education and high ritual status of Nayar Vydyans made them well respected in the village. However, at present, no such Ayurvedic v*aidhyan*'s are practicing in the village; instead, there are some aged people in the *Nayar* community who have knowledge in folk medicine. As similar to other caste groups, among *Nayars* also there were some folk medical practitioners in the village without much difference in their practice of traditional medicine. In the past, as similar to other lower castes, Nayars also widely believed in magico-religious practices in curing certain diseases. *Panikkars* are the higher caste astrologers so close to *Nayars* who pronounce the specific religious reason behind an illness or misfortune, and what offerings one should do to get relief from it. Over the period, many changes happened in the beliefs of *Nayars;* at present, only a few among them follow such practices to cure any illness.

*Thiyya*s of Pozhuthana – the backward class attempts for social mobility in the village

As like other parts of Malabar, Thiyyas in the panchayat was once considered as untouchable caste, and in the last several decades they have achieved remarkable progress in social, economic, political aspect and have actively contributed to the reforming changes in the social and religious institutions in the village. Presently Thiyyas are on an equal footing with the higher caste Hindus, Christians, and Muslims, at least socially and politically. Their condition, however, has not been this good until recently. Orthodox higher caste considered themselves polluted if a

Thiyya came within ten or fifteen meters near to them. As elsewhere in the state, Thiyyas in Pozhuthana also attempted to overcome their earlier untouchable caste identity and to embrace modernity. For a large middle class among them, struggling to improve cash and culture holdings, consolidating or conserving enough to pass on to their offspring becomes an unavoidable responsibility. Thiyya have carefully converted newly made cash and other resources, which they gained through improvement in education, occupational mobility and political activism, into power. Hence they have come into competition with upper castes and other dominant social groups. The socioeconomic advancements achieved by them in the late nineteenth and early twentieth century's provided an opportunity to negotiate with the dominant groups, and attain a higher social position (Jeffrey 1994). In the suitable atmosphere created by the social reform movements within Thiyyas, in recent years, two major paths led *Thiyyas* in the village towards greater prosperity and power.

First which influenced only some of the better-off among them by gaining the education and becoming officials and professionals, and by utilizing opportunities like emigration to Gulf countries. They used their resources and relationships with upper caste and Britishers to acquire formal education. A small section among *Thiyyas* in the village thus became professionals, government officials, and Gulf emigrants. The second path was open to a larger number of people. The changes in agriculture to cash-crops gave the low caste men and women the opportunity to gain wealth out of emerged employment opportunities in the village. The coconut business, employment in plantations of tea, coffee, and pepper were some such avenues. *Thiyyas* are upwardly mobile people in social, economic, and religious matters, mostly imitating the caste group immediately above them in the caste hierarchy*Nayar* community. *Thiyyas* adopt from time to time what appears to them best and followed some of the customs prevalent among the dominant caste, religious, class, and political groups in their immediate vicinity. In fact, reformers, reform organizations, nationalists, leftists, and legislative measures helped the Thiyya community to experience feelings of self-respect and self-confidence, which ultimately enabled them to fight for socio-religious and economic equality in the future.

In Malabar and all over Kerala, the reform movement of lower castes was led by the lower caste itself, which spread its influence from below to the higher orders in contrast to the reform organizations like Brahmasamaj, and others which are upper caste social organizations, which

directed the reform from above the social pyramid (Chopra 1979). Sree Narayana Guru (1855–1928) was one such prominent social reformer and the organization Sree Narayana Dharma Paripalana Yogam (S.N.D.P, literally the society for the propagation of moral teaching of Shri Narayana), which he inspired, was greatly influential among Thiyyas. The significance of Narayana Guru's teaching and services of the S.N.D.P. Yogam lies in the fact that it created a feeling of self-reliance and self-confidence among the backward caste Thiyya. In fact, Narayana Guru's teachings with its emancipatory potential, were habituated by the lower castes while engaging with other ideological influences in the region, including the struggle for National Liberation, socialism, and communism, and translated it into action for securing social Justice (Ismael 2013). Among the many castes in Hindus, including several lower castes, it was the Thiyya who first began to break out of the restrictions of orthodoxy in the state (Nossiter 1988). The social reformers and organizations among Thiyya not only questioned the orthodox higher caste for caste restrictions but tried to bring radical changes in the community through influencing the mind of lower caste people. Such an initiation got momentum among Thiyyas mainly because of two reasons, firstly that their social customs were less irksome than those of higher castes, and as low castes, they had little to lose and much to gain by joining in the socioeconomic change (Nossiter 1988).

In addition to the SNDP and Sree Narayana Guru, there existed other reformers among Thiyyas in Malabar to influence the social mobility of lower caste from rural villages. Vagbhadananda, who established the Atma VidyaSangham (AVS) in 1917, and launched campaigns against untouchability, alcoholism, and denial of the right to temple entry, is an example. Reformers like Vagbhadananda opposed many rituals observed by Thiyyas and argued that such practices economically impoverished people and undermined their wellbeing. They also initiated struggles in parts of Malabar for women's rights and advocated for women's education. The efforts of Vagbhadananda were intended to improve the socioeconomic status of Thiyyas and other lower castes. He strongly opposed the practice of untouchability and writes, 'What is this religion that allows cats, dogs and even donkeys to come near humans, but does not allow another human being' (Abhinava Keralam 1921 cited in Kannan 2012). Vagbhadananda did not disassociate himself from the political developments occurring in Malabar at the time and played a substantial role in extending his support for peasants and worker's struggle. The reform movements and reformers from Thiyya did not function in isolation but joined hands with the agricultural

farmer's movement, wage labours protest, nationalist movements, reformers, and activists belonging to different backgrounds to promote similar causes. They were also active in engaging with the opening of schools, libraries, credit societies, and wage labourers' co-operative societies etc.

The social reform efforts among Thiyyas in the villages of Malabar got momentum when they started to work with the political organization. From the early decades of the twentieth century onwards, the activities of the Kerala Congress Socialist Party and the emergence of Kerala Communist Party initiated many agitations against social issues in the villages of Malabar on a class basis. The social reformers and organizations among Thiyya supported such fights for equality; in fact S.N.D.P Yogam in Malabar passed resolutions to support such political organizations (Mathrubhumi 1946 cited in Biju 2017). A large number of working-class Thiyyas started to organize under political parties and fight against the local landlords to protect the rights of labouring class. In fact, there are incidents to show the power gained by the lower castes to influence the political parties and other organizations.

During the early decades of the 20th century[15], when the government removed the restriction on access to public roads and the Thiyyas walked through the Kalpathy streets, they were welcomed with stone-pelting. But the Thiyyas resisted and influenced the politicians leading to get unanimous support in favour of them in the Madras Legislative Council[16]. The social reform movements and political parties initiated a renaissance in the region, and among Thiyyas were oriented with traditional knowledge, and their ideology had been merged with the ideology of nationalism, socialism, and communism, which influenced the region over the period. This oriented Thiyyas of Malabar to develop, as self-respecting community through reforms in internal caste practices, challenging higher-caste discriminations, actions for access to education and employment.

The family structure and cultural beliefs of Thiyyas

Like in other parts of Malabar, in *Pozhuthana* village also the earlier *Thiyya* family setup was a joint family where several married brothers lived in peace and concord in one house, with the

[15] G.O No.782 L & M Dated, 14.06.1893, KRA Kozhikode.
[16] D.O Letter No. 9525/25 dated, 9.11.1925, KRA,Kohikode.

father or eldest brother as the head. Many of the respondents interviewed recollected their childhood of living in such joint families. Now the earlier joint family is rare in the village and found married couples separate from their joint family and living in their own house, even though it is smaller in size or under construction. However, their connection with parents and siblings is always maintained and found living not too far away from each other.

The new change, according to the villagers, is because of the wish of the newlywed to live more comfortably and happily without the interference of other relatives in their day-to-day life. In such a case, each family can also ensure that whatever income they are getting could completely be used for the wellbeing of their new family, which includes spending on food, own house, better education for children etc. This shows the aspiration of the young members of *Thiyya* to build their family along the modern line according to the general trend in the village, even though they did not have ready resources with them. This shift from joint family to nuclear family changed the social role and status of many young *Thiyya* women in the village. In their new houses, they become the *veetukari,* female head of house who looks after the day to day activities of the house. (They are different from the head of the house, which in most cases holds by the elder male member of the family). In the joint family, they were highly dependent and subordinated under the parents-in-law, then under husband, and then under other elder members of the family. In addition, the burden of work for women in a joint family of *Thiyya* was so great that the women got only some days at the end of a year for leisure and to promote their health. Generally, it was only once in a year, a woman returned to her parents' house to have a break from the daily heavy work and to gain weight through good food and Ayurvedic preparations made at home.

In the past, the gender differences in cultural matters and in social life among *Thiyyas* debarred women even to come and talk in front of elderly male members of the family. Thiyya women are now active in public life through involvement in self-help groups, public functions, activities of political parties, and in meetings of local self-government. However, participation in such public activities by the women from the better-off who could afford to run the family is minimal. What enabled the Thiyya women to actively participate in public life is their aspiration to come out from the disadvantages faced by earlier generations and build their family along the modern line.

Earlier caste restrictions in Malabar were one of the severest to an extent that even informally forced what kind of house each caste could have, particularly what kind of materials could be used for the roof, and accordingly different terms are formed to refer to the houses of each social groups. Accordingly, in Pozhuthana also a *Thiyya* house was referred to as a *pura*, distinct from the Nayar *veedu* or *tharavad*, a Nambudiri *Illam* or *Idam*. The *Thiyya* houses were built with coconut leaves and coconut wood for the roof, mud bricks for wall and floor smeared with cow dung. Generally, with two or more bedrooms, a hall, a long veranda in the front, and a small kitchen on the other side. The thatch is annually renewed with new coconut leaves from the landlord. Renewing the thatch is the occasion for a grand feast to all the persons who assist in the work. Only comparatively better-off households have a well available within their premises. However, for the poor *Thiyya* families, single room huts built with coconut leaves and woods are their house. However, presently, no *Thiyya* family lives in thatched houses or in single room houses. As the room on the south side of the house is considered with special ritual status, earlier the houses are built by considering such religious aspects. However, now a day's building big houses with modern style is the trend in the village, and the earlier importance of ritual matters in building house is less strictly followed. Most of the *Thiyya*s now have better houses built with stone walls, tiled or concrete roofs, and cement smeared floors. The few better-off *Thiyya*s were also having double storied houses built in the modern style with all household amenities.

The worship place of *Thiyyas* is known as *Kavu*, where they worship their own Dravidian god and goddesses. Different from temples there will not be daily rituals in the *kavu*, except daily lighting up of lamps in the evening. Even though, there are no daily rituals, on special occasions and on demand from the devotees, rituals are performed sometimes by the devotee themselves or by the one who have assigned to do that. This *kavu* do not have a temple like building rather, it is the traditional natural sacred groves. Brahmans had no role in this *kavu, a*ll rituals are performed by *Thiyyas* only. Every year on the days of the festival *Theyyams* in these *Kavu* is performed by the communities lower in caste status to *Thiyyas,* namely *Malayar* and *Vannan*.Offering food and toddy to ancestors'spirits and the god *Muthappan* is common among *Thiyya*s. Just two decades back, the offering of a rooster's blood and sometimes goats was usual among them. But as the law restricts it now, it is rarely practiced but not completely gone. During the field work Tamil settlers in the Suganthagiri found offering the blood of a goat to the *vanadevatha,* the god

of jungle. The function was held inside the forest on the shore of a river, and it has been attended by members of *Thiyya* caste also.

The daily life of a *Thiyya* involves the elements of rituals and beliefs. Every evening during sunset *Thiyya* family lights a lamp called *nilavilakk* in the middle of the front verandah of their house and prays to the god. The contact taboo earlier exited in the village in the form of untouchability does not exist today. However, members of the same caste or even the same family observe contact taboos for certain ceremonial purposes. Like other Hindu castes in the village, Thiyya also observes contact taboo when they are visiting a temple, during childbirth, and during the menstruation period. In the present days, Thiyya convinced of the retrogressiveness of earlier practiced contact taboos. The young members of the *Thiyya* family, especially men, do not follow such taboos, and even in some cases, educated young criticize their elder mother for following such taboos. The educated young find it as an uncultured act and will bring defame to them in the society.

The death rituals among Thiyyas generally stand for three or five or seven days based on the decisions of the close relatives of the diseased. During these days' distant relatives, friends, villagers, and all other well-wishers will visit the close relatives of the diseased. The fixing up of the number of days is generally based on the convenience of relatives to reach from faraway villages, but now having five or seven days is considered as the improved status of the family. By fixing five or seven days it is expressed that the family have extended connection in the society with large number of families and individuals thus require enough time for everyone to visit during the ritual period. *Thiyya*s follows burial within their house premises, but in the recent days, they started to cremate the dead in their house premises. This change is in order to avoid the creation of idle land within house premises due to burial. This shows even in matters of beliefs, they are not reluctant in change if such changes will give them more desirable benefits.

There are many changes happened in the marriage functions among *Thiyyas*, they had adopted simple marriage ceremonies in terms of ritually and economically as propagated by Sree Narayana Guru. Even though it is a gradual change in rituals and other practices, there were not much resistance against such changes from the village; instead, found more and more *Thiyyas* adopting such new changes. In all the ceremonies, the father's group, the mother's group, and the villagers are represented and at every stage, the formal permission of all is asked for and given.

Inter-marriage between members of different caste is not normal in the village. However, there are old cases in the *Pozhuthana* village where *Thiyya* women of the nearby village were marrying an *Adivasi* men and new cases of *Thiyya* men from far away villages marrying *Adivasi* woman from this village. However, villagers told that there are no cases of a *Thiyya* and *Adivasi* man or woman from the village marrying to a member of another caste within the village.

Generally, marriage is conducted at their own houses by inviting around a thousand people, including family, friends, neighbors, and villagers. People from all castes will be invited, and a grand vegetarian and non-vegetarian feast will be given. Those who are invited from the marriage bring gifts, and close relatives give valuable gifts like gold ornaments, household utilities, etc. All others will give an amount of cash on a sealed cover with their and their family name written on that. This amount received from everyone will be recorded in a book after the marriage in order to repay at the time of any function in their family. For poor households of *Thiyyas* such an amount received during the marriage is a great help to meet the expenses of marriage functions. In addition to such financial help, on the direction of the *moonnaman*[17]it is the neighbors and villagers who do all arrangements, including preparation and serving of food to guests, arrangement, and decoration of the marriage venue, etc. On the days of marriage, the family members will be involved only in ritual-related matters; they were not supposed to involve in the matters of the reception, which will be under the purview of villagers. Thus, for *Thiyyas* conducting a marriage or, for that matter, any ceremonies are not possible without the involvement of villagers in each step.

Education

The first school started in the village was in 1926 as a lower primary school. This gave an opportunity for *Thiyya* community to attend school, but during the time, only some of the better-off families from *Thiyya* send their children to the school. As a result, literates among *Thiyyas* remain low. Those who are now in their 40s and 50s, born in between 1950 and 1960, found attended school only up to 2nd and 3rd standard only. Many of the respondents of this age responded that the low financial status of their family made them work in the agricultural fields

[17] It is the *Onnaman, Randaman*and *Moonnaman* who supervise marriage ceremonies of the *Thiyyas*. In most cases they will be the local leaders from same caste only but now a day some from upper castes *Nayars* also do this for *Thiyyas*. However, they do not hold any ritual status; they do these functions in their nearby areas as a local leader.

with their parents instead of attending schools. However, over the period, along with the establishment of more schools in the village and improvement in the economic status of *Thiyya*s helped their children to attend schools. Those who are born between 1970 and 1980 found acquired an education level of matriculation and above. The next generations show tremendous improvement in education, with many graduates, postgraduates, and professional degree holders among the *Thiyya*s in the village. The educational attainment of *Thiyya*s in the village now reaches a position to shows remarkable progress compared to any other community in the village.

Generally, young boys and girls are sent to the nearby *Anganwadis* at the age of three until they reach the school-going age of six. The *Thiyya* families living in the Kurichiarmala (which is a tribal area but few families of *Thiyya* and Nayar also lives) found sending their children to faraway aganwadis even though they have an anganwadi near to their house. They do this because in the nearby anganwadi only Adivasi children are enrolled, and they express the fear that their child may acquire the behavior of the Adivasi children if they send their child to this Anganwadi. This shows that, when the Thiyya community was able to improve their socioeconomic status, now the concern is not with contact taboos or other religious aspects of purity but with the behavior of Adivasi child, which they see of a lower standard. In another way, the aspiring *Thiyya* families see education and behavior forming of children are important factors to become a more civilized citizen in a modern way, which they believe essential for attaining a socially and economically respectful life in the society.

After Anganwadi or LKG, at the age of six the children are enrolled in the village schools. Most of the *Thiyya*s, except few better-off households, send their child to the nearby government schools. Malayalam is the general medium of language in schools, but parents prefer their child to learn English as early as possible, and it is found some *Thiyya*s send their child to English medium schools if there a possibility for that. Dropouts among *Thiyya* pupils are very low in the village, and immediately after schooling they try to get admission to colleges. Graduation is seen as the minimum level of education required and those who have not got admission to government colleges join private colleges and tutorials. Those who have educated parents further send their children for higher education. In general, it is found after graduation *Thiyya* children

start searching for jobs or start preparation for acquiring a government job or try to migrate to Gulf countries.

Occupation

The *Thiyya*s in the village followed diversified occupation, small-scale trading, agricultural labouring, small-scale farming, and daily wage labouring other than agriculture like in construction sector. There is also some better-off businessman, Gulf migrants, and professionals among them in the village including schoolteacher, nurse, and lawyer working both in the public and private sector. With regard to employment *Thiyya* in the village got the advantage of the new opportunities that arose in the region through colonization, state, and central governments affirmative actions, changes in land relation, commercialization, emigration opportunities to Gulf countries, and development in education. The traditional occupation of the *Thiyyas*, toddy tapping, is not popular in the village and there is not a single toddy shop in the Panchayath. A few decades before, there was a toddy shop, and few members from the *Thiyya* community were engaged in their traditional occupation. However, as in the other parts of Malabar, it was never a major occupation for the majority of *Thiyyas* at any particular time in the village.

Further, traditionally majority of *Thiyyas* in the village were agricultural labourers working in the rice fields of upper caste *Nayar* and *Nambuthhiris*. However, in the present day, we can see a diversification in the occupations in which *Thiyyas* from the village are engaged. Even though this is part of their attempt to give upward social mobility, while choosing an occupation, their primary concern is not social status attached to it but economic benefit from that. This is clear from the occupational preference of young *Thiyyas* in the village who are in the age group of twenty to thirty. There are only a very few among them working as agricultural labour rather they prefer daily wage work in construction and other sectors which is more remunerative. Similarly, for the poor *Thiyya* women to work in the field or in construction site meant no less prestige. However, in almost all daily wage occupations in which women engaged in the village they get the work of helping a skilled male worker, which will always be less remunerative than the male worker.

Traditional medical practice of Thiyyas

*Thiyya*s have a long tradition of practicing folk medical practice, which is non-textual and mainly based on the local plant-based medication. They have a good knowledge of medicinal power of almost all plant varieties grown surrounding them. The folk practitioners' service and medical properties of plants that used by them are all well accepted by the villagers at large. A few decades before, many male and female members from the caste were having knowledge in folk medicine, and some were well-known practitioners in the area. Even today, there are some members from the community in the village who have knowledge of traditional medicine, but only very few among them are practicing. Those who are practicing include men and women who treat only on demands of patients those who visit them at their house. Few young men among them are primarily engaged in different works as agricultural labourers, plantation workers, and one among them is a politician. These traditional healers treat a variety of illnesses but only occasionally when patients visit them. A *vydhyan* in Pozhuthana village works as daily wage labour has knowledge in treating patients with diabetes, blood pressure, cholesterol, and kidney problems. He learned this from his father and not reluctant to reveal what medicines he uses to treat illness. He uses the plant *venga* (Indian Kino Tree) to treat diabetic patients, *maamam* to treat cholesterol, *Kaasini cheera* (Chicory plant) to treat cholesterol and kidney diseases. *Parvathi amma*, a 70 year old woman in *Athimoola* village have the knowledge in treatments for pregnant women and a new born child. Earlier, women in the early months of pregnancy and relatives of pregnant and lactating women visit her for particular health issues during pregnancy and after childbirth and also for general advice. She generally gave advice regarding the type of foods to be eaten, on specific household works which can be done to get the effect of exercises, etc. Similarly, other *vydhyans* among *Thiyyas* in the village also have knowledge in treatment for snake bite, headaches, body pain, stomach pain, wound, back pain, arthritis, burns, vomiting, etc. Patients from the village occasionally visit them mainly to treat back pain, arthritis, stomach pain, fever, etc.

As we have already seen, there were attempts from the *Thiyya*s to shift from their traditional practices and engage in newer forms of occupations, which are considered superior in the hierarchy of social and economic position. Acquiring knowledge in traditional medicine and its practice was one among them, which gave them a reputation in the village. As similar to the

changes that happened in the beliefs and practices of *Thiyyas,* we can also see changes in their traditional medical practices. Over the period within their indigenous medical tradition, many aspects from textual and Ayurvedic medical knowledge were incorporated by the *Thiyya* vydhyans. This process of incorporating imputes from Ayurvedic texts in the folk practice of *Thiyya* happened throughout the Malabar when *Thiyya Vydhayans* attempted to gain social status and reputation similar to that of Ayurveda *Vydhyans*. This gained momentum during the British period when education becomes more accessible. Some of the folk healers in the village were in active contact with their counterparts in the other villages of Malabar. And in fact, their ancestors were the one migrated from the mainlands of Malabar only. Thus, the changes which took place in traditional medical practices of *Thiyya in* other parts of the Malabar influenced the *vydyans* in the village also. It is also found that some of the young members from families of medical practitioners learned Ayurvedic medicine from colleges. A young *Thiyya,* who is the son of an earlier *vydhyan* found attended a short-term course in Ayurveda in order to get more credibility to his folk medical knowledge among the villagers. After some years of service in the institute where he studied, he is now working in one of the Ayurvedic clinic in Mumbai.

It is noted that in the process of caste mobilization and the augmentation of social aspirations, the revival of the indigenous medical tradition was important among Thiyya (Cleetus 2007). Even though upper caste Vaidyans enjoy special status and privileges, there were Thiyya Vaidyans who were highly trained and skilled in Sanskrit and Ayurvedic medicine. In fact, the preparation of "Hortus Malabaricus"(on medicinal plants) in the seventeenth century by the Dutch governor Henry Vaan Rheede was completed with the help of a Thiyya Vaidyan called Itty Achuthan. The great social reformer among Thiyya, Sree Narayana Guru himself, was a Vyadyan who have knowledge in traditional medical practice. In addition to the influence of Guru's teachings on socio-religious reforms, his teaching had a positive impact on child health and infant mortality, particularly in coastal and other low-lying villages of the State (Tharakan 2018).

Almost all *Thiyya* houses has some medicinal plants in their surroundings like *thulasi, brammi etc* which they use for self-medication. In case of a minor illness, the immediate response is self-medication through their knowledge of folk medicine and now a day's also with allopathic medicine. They also have a great belief in modern medicine and its practitioners. *Thiyya*s follow modern medicine for all major health issues and minor health issues after self-medication based

on their local health tradition. It is also common among them to avail both modern medical care and get treatment from a traditional *vydhyan or* perform self-medication based on their local knowledge in parallel for certain illnesses like jaundice. This is mainly because some of them believe that even though modern medicine cures the illness, it cannot completely remove the illness as some of the elements of the illness will still remain in the patient's blood. They believe, in order to completely remove the elements of the illness from the blood sometimes, one has to take medicine prepared through the traditional way using the medicinal plants near to them. In some other case, the patient has to take a bath in water boiled with medicinal plants or have to provide offerings to god or ancestral spirits to completely get rid of the disease. Some of the folk healers among Thiyyas in the village also believe that the best suitable medicine for a patient is a medicine prepared using plants surrounding to the patients living environment. Practices of Matravada, the practice of spells, are also closely connected with the folk healing of *Thiyya*s. Even today, occasionally, some patient gets treated by a modern medical practitioner and a 'practitioner of spells' simultaneously.

Muslims of Pozhuthana- Integration and development of a new belief and culture in the village

The migration of Muslims towards the village mainly took place during the rule of Kottayam Raja itself, and movement at a greater pace occurred later under Mysorean rule and the British period. The horror of the frequent fight between Muslims and Britishers aligned with Hindu landlords in the mainland of Malabar, culminating in the Malabar Mappila Revolt of 1921, pained the Mappilas from the early twentieth century itself. During the *Malabar Lahala,* many Mappila soldiers were forced to leave from present day Malappuram and other parts of Malabar; and many of them arrived in the village and settled down. Most of them then worked in the village as agricultural labourers and some in the plantations along with the labourers recruited by plantations from Karnataka and Tamil Nadu. Many of the Muslim families who migrated from Malappuram during the early 1920s to Wayanad also settled in the village, especially in the hillside called *Settukkunnu*. In the present day Pozhuthana panchayat, Muslims constitute more than one-third of the total population with substantial social, economic, and political power.

By the beginning of the twentieth century, Muslims had their presence in almost all the areas in the village except in the settlements of Adivasis. By that time, there were some landlords and businessmen among them in the village who were mainly engaged in the timber trade. Such rich Muslims with their family names were well known in the village and enjoyed greater social and political status even under the rule of upper-caste Hindus under Britishers. During the time, the main road which connects the village with other villages was constructed only up to the house of a Muslim chieftain called *Kalenthan Mesthiri*. Another rich landlord in the village was *Nagji Settu,* who owned large tracts of land in the village. He was well known by his act of distributing large tract of land to the poor Muslim migrants coming into the village. This was done by Ali haji, another rich Muslim man of a nearby village who bought and distributed this land to Muslim agricultural labouring families at a low price. This large hillside later came to be known as *Settukkunnu* (*Settu* hill) and thereafter mainly inhabited by Muslims who have migrated from the main lands of Malabar during the time of Malabar Mappila riots in 1921. Presently the hillside village is inhabited by more than 80 families, who are mainly daily wage labourers, plantation workers, and Gulf emigrants. The help that brought land in the hands of agricultural labourers without much financial hardship brought drastic improvements in their social life.

During the 1970s, similar changes also happened among many more Muslim families by reaching land in their hands through land reforms and individual purchase. During the early 1970s, as a part of the agricultural labour's agitation in the state, the village also witnessed agitation in the form of encroachment of barren land owned by the estate companies. As a result of the agitation, parts of the paddy cultivable areas like *Achoor* were given to encroachers for cultivation. In addition, the hilly terrain called *Mutharikunnu* was retained by the agitators and later became the settlements of mainly Muslims and other social groups including Adivasis. During the period when the land reform was implemented in 1970, the agricultural labourers who usually took land on lease from the landlords for cultivation got full ownership of a portion of such lands. In addition to this, those Muslims who migrated with some resources bought land in the village by knowing that there are established settlements of fellow community members in the village. By this time, the earlier land ownership structure changed, and now a large number of labouring Muslims in the village got ownership in their homestead and cultivating land. This change happened among other communities as well; Adivasis, Christians, and *Thiyya* also got land. This ultimately allowed them to build their own thatched or tiled houses with burnt bricks.

From the 1970s onwards, many young Muslims in the village lived under a reasonably sound house in their own plot of land and managed to support their family. By this time, substantial rise also came into the economic condition of a large number of Muslim families in the village through the affluence of remittance received through Gulf migration. This not only changed the lives of few, but it changed the face of *Pozhuthana* and the *sixth mile* market through the emergence of more shops and small-scale businesses funded by emigrants. Many large double storied houses with beautiful structures were built, many got employment not just in agriculture but in many other sectors too. From earlier comparatively poor status, many Muslim families now became comparatively better-off, rising to the status of a middle class.

Rituals and belief of Muslims

Even though there are interactions in the day-to-day life of Hindus and Muslims in the village, they live as entirely separate communities with two dominant belief systems and cultures. Even though both the groups have borrowed many aspects from each other's culture they remain as two distinctive groups. While more and more Muslims were migrating to the village, the village was under the rule of upper caste Hindu landlords. Under their rule, the upper caste Hindu religious life based in caste system dominates the cultural life of the village, in which the life of lower castes and Adivasis were controlled by the upper caste and subjugated them to lead a distressful life. However, Muslims found some space for progress within that tradition, which was not available to the lower caste Hindus who were even restricted in their movement through the caste system under the physical and spiritual power of the upper caste.

As the Muslims come to the village with the intention of a safe life, in the initial days they lived in compliance with the dominant upper-caste Hindu cultural tradition. It is well visible through their acceptance of many of the customary practices of Hindus, even though some among them were contradictory to the social norms of Islam. However, it is not new for them as there are many examples from throughout the Malabar which show the acceptance of Hindu beliefs and rituals by the Muslims. The belief in evil spirit, the veneration of saints and offerings at their tomb, the faith in divination and magic are some among them. To some extent, the Islam belief of Muslims in the village and whole Malabar is embedded in the indigenous social and religious order of the region which is primarily based on Hindu beliefs.

Over the period, out of the advantage from trade Muslims and a few Christians gained advantage in economic and social life. As a result, a new Muslim religious culture with some resources gained from trade & commerce and from employment in plantations developed and spread across the village. It further progressed and spread out of the bound of caste-janmi-ruling authority and its upper caste Hindu culture in the village, not only in terms of ritual matters but also in terms of economic activity. As a result, in many matters, they stood far ahead of the native lower caste Hindus and Adivasis in the village. Some of the rich Muslim landlords in the village acquired social status and lifestyle on equal foot with that of upper caste *Nayars*. Along with the upper caste Nambbothiri-*Nayar*, lower caste Hindu's and Adivasi's cultural tradition, a new culture and social life of Muslims based in Islam expanded in the village. Some of the old centers of markets were shifted, and new were buildup around the habitation and religious places (mosques) of Muslims.

For the Friday congregation, all Muslim men meet at the common mosque. To attend Friday prayers at Mosque is compulsory for Muslim men and young boys, and the deserted view of *sixth mile* market during the time of Friday prayers is a usual sight. Earlier in a greater sense and even today, in some sense, special respects were given to the *karanavars* (elder members) of well-known families in the mosque in general and during Friday prayers in particular. The *Imam* of the mosque is the one who led the prayers in the mosque, and along with him, a committee of members from the village manages the day-to-day activities. The committee is known as the *Mosque committee*, which holds substantial power among the Muslims or, in other words, it governs the religious matters of the Muslims under them. In addition to the supervision of day-to-day functions of the mosque and the Madrasa run by them, the committee is also powerful to have religious authority. The religious authority includes giving approvals to marriage proposals, taking decisions on religious matters, and even sometimes giving religious sanctions on those who have violated the Islamic rules. For its smooth functioning, demographically, Muslims are divided into Mohalla units, which is the group of people living around a Mosque. Similarly, each mosque in the village consists of an Imam and *mosque committee* to look after the social activities of their *Mohalla*. As the *mosque committee* is an important organization among Muslims, the members of well-known families and a person with some holds among the villagers in the form of education and social status comes into the committee.

The yearly *Nerchas* are the largest public festivals of Muslims in the region in which the anniversaries of *Auliya* were celebrated. *Auliya's* are a variety of holy men worshiped by Muslims. By continuing their old rituals, ear-piercing of girls, circumcision of boys, and rituals related to puberty are also celebrated by the Muslims in the village with religious rigor and celebration. The circumcision is performed by *Ossan,* and the ceremony is the sign of the boy's formal admission to the fold of Islam. It is performed with rejoicing and small feasting where the rich and well-known *taravad* celebrate it with elaborate feasting by inviting close relatives. These practices were done much strictly during the past when they lived in the matrilineal joint families. Even though most families have shifted to a patrilineal system, the spirit of matrilineal *tharavad* exists even today. For example, even today, the status of *tharavad* is one of the most important considerations for marriage alliances. A *tharavad* is formed from several generations of families of a single descent.

Muslims are relatively free from the caste-based differentiation compared to Hindus in the village, but still, the spirit of caste differentiation can be observed among them in the form of hierarchical categorization of individuals. At the top are the *Thangals,* ranked highest who hold high power in religious organizations of Muslims. The *Ossan*, the barber among the Muslims, was ranked the lowest by their low-status occupation. In between the two are the majority of Muslims in the village characterized by great extremes of wealth and poverty. The traditional families with substantial land holdings and some Gulf emigrants households comes under the wealthy and the daily wage labours comes under the poor in the village. The *Thangals*, in addition to their religious roles, also engaged in the work of healing through religious sayings and practice. Some of them were also found engaged in teaching and business but not in any manual labour. In the present days, there are only very few among the *Ossan* in the village, and they are engaged in their traditional occupation as barber and in manual works. In the old days, the women from *Ossans*, perform the job of midwives. Caste prejudices towards these sections still exist among the Muslims, especially among the elder members of them in the village.

Clothing and fashion

Up to the early twentieth century, the customary Muslim style for men was to wear a skullcap or *talakettu* (white turban), white *mundu* or *lungi* with check design, and having beards. However,

the religious scholars (the ulema) in public always wear a white *mundu*, a white shirt with a white shall over the shoulder, and an elegant round skull cap. While the *lungi* and shirt combination is the common everyday attire of all working class in the village, there are differences among the religious groups in terms of their preference of colour, way of wearing etc. On formal occasions, Muslim men, except some educated young, wear white *mundus* and white shirts. The specific *mundu*-wearing styles of Muslim men mark out religious identity; unlike Hindu and Christian men, they never use gold colour borders (cassava) in their *mundu*. Moreover, they normally fold the *mundu* to the left and wear it only up to ankle-length. The young Muslim men wear trousers, shirts, and footwear of different colours and styles according to the new trends. Even with such styles, many among them found folding up the trousers to make them ankle-length to align with their religious way of dressing.

For the women, the earlier common and widely used blouse and *pavada* combination, which reveal a strip of midriff now avoided and changed with churidar, through which the body is almost fully covered from neck to ankle. Even today, some of the elderly women continue using them. But among the young Muslims who are in their thirties and above prefer sari, and the younger than them prefer churidar. Within the two decades, many changes happened in the dressing styles of Muslim women in the village; one among them is the increasing use of purdah. Now a day's most Muslim women wear purdah when they are out in public, and it started to appear among some of the young girls of school-going age too.

To an extent, the idea of dress restrictions as an aspect of one's Muslim identity remains in the village among all sections, including the working class, better-off, Gulf-emigrants, educated, and professionals. However, none of these sections have found completely rejecting the new trends and fashions in favour of dress restrictions, rather find combining both fashion and belief to move forward with the general trends of the larger society. On the other hand, the increasing use of purdah, wearing of trousers up to ankle-length, use of headscarf with churidar, refrain from wearing certain color styles of dhotis and saris undoubtedly shows their attachment to an Islamic identity in dressing even at the time of increasing influence of modern fashion. In general, there is a consciousness among the Muslims of the village to align with the general style of Islamic 'decent dresses'. The use of typically more expensive dresses and its frequent buying even among comparatively poor families also shows the willingness to spend on personal

consumption items among the Muslims in the village. In sum, in terms of dressing and for that matter the social life among the Muslims in the village, earlier developed a composite culture while retaining a distinct Islamic identity, and in later times there was more identity assertion.

Education

Similar to other labouring classes, in the past Muslims in the village also had lower enthusiasm towards education, as they saw little economic benefits in being educated. However, the maturing generation of 1930 had got the opportunities for a modest education that was unavailable to earlier Muslim children in the village. The first generation of those who had migrated at the beginning of the twentieth century and before it was mainly illiterates and their next generation born in the village were able to attain lower primary education at the newly started school in the village. It is the third generation among them who got opportunities and showed interest in education at a large scale and become literates, professionals, and government employees. The first and second generations among the migrants were having a lower rate of literacy and especially a lower rate of female literacy. From the third generation onwards, the education of girls gave them the opportunity to venture into higher education and employment outside the village, this in turn gradually rose the age of marriage among them, which was less than sixteen in the past. Primary education among young Muslim men enabled them to learn about and follow up possibilities elsewhere in India and overseas. The wealth gained by emigrant young Muslim men in the village further attracted many more among them to gain basic education, which could facilitate them in attaining employment in Gulf.

During the early decades of the twentieth century, itself Muslim politicians were engaged in building a lower primary school in the village. By recognizing the importance of education for the overall upliftment of Muslims in the village, the local leaders, with help from the Madras District Board Member Musthapha Pookoya Thangal, a primary school was started in the village. As a result, this first school was started in 1926 at the Muslim majority Achooranam as a *Mappila school* (literally *Muslim School*). During this time under Malabar District board schools were named like Hindu elementary school or Mappila elementary school. In the Muslim majority areas, *Mappila schools* are established with a Muslim academic calendar, which opts for vacation during *Ramzan* instead of April as in the general academic calendar. Even though no

religious instructions were taught in such schools', stories and learning materials were primarily used from the religious books of the Muslims. This makes Muslims from the area interested in education and avoids their reluctance towards modern education. Later with the establishment of more schools under the local self-government in different parts of the village and gaining of some financial resources by a large section, education becomes a matter of social status. Almost all families started to send their children to school, at least up to the age they were able to tack up some employment opportunities. Over the period when educational qualification became the sole criteria for getting a government job, and the government's recognition of Muslims as backward class leading to get a reservation in government appointments, schools, and college admission, gave impetus to education among Muslims in the village. In addition to the general schools, the literacy campaign run by the state government, also helped many illiterate aged among Muslims in the village to gain basic literacy.

Economic activities and occupations

As already mentioned, mainly from Malabar and other parts of the state, Muslims migrated to the village with the intention of a safe and better life. The opportunities generated from the timber trade, large-scale agriculture, and plantation further attracted them towards the village. By around 1860 itself, tea and coffee cultivation was started in the village by individual businessmen and Britishers. In addition to this, during the time, the cultivation of vegetables and fruits also existed along with large-scale cultivation of rice. This gave employment opportunities for labouring classes from other parts of Malabar, Karnataka, and Tamil Nadu. Thus, those Muslims who migrated to the village during the time were employed as labourer's in the agricultural fields, plantations, and timber trade. By the early decades of the twentieth century, large-scale plantations started to establish in the village, the increasing substitution of cash for kind in employment widened the scope for merchant activities in the village. This attracted Muslims traders who were doing trade in the competitive markets of Malabar towards the village. At the same time some of the wealthy Muslims were also able to keep their hold on the large timber business in the village. The Muslims also started to engage in a less explored area of shop keeping trade in the village, and gradually it becomes largely in the hands of Muslims. Even today, in one of the towns, *sixth mile* except for Muslims, no others have a shop or business. In the markets of Pozhuthana and Achoor also they have greater number of shops and

businesses. In addition to the experience of Muslims in trade, the factor which made them to have a strong hold in the sector is the less interest of other wealthy communities in such businesses. Similar to maintaining the caste-*Janmi*-ruling power on land, the *janmis* (Brahmins and *Nayar*) were not interested in other sectors like trade and commerce. Muslims and some Christians made use of it by taking up trade and commerce in the village, which was outside the clutches of caste-*janmi*-ruling authority and control.

The other thing which made remarkable progress in the financial status of Muslims and thereby their social status in the village was the emerging employment opportunities in the Gulf countries. From the second half of the twentieth century through the establishment of a *Mappila* school in the Muslim-majority area and later in some more interior areas helped many of them to attain primary education. Education helped them to learn about the growing opportunities in the Gulf countries, and through their relatives and contacts in the rest of Malabar they were able to gain employment opportunities in the Gulf countries. By knowing the possibilities of a prosperous future through Gulf emigration, more and more young literates started to ensure their Gulf employment at a young age before getting married. To an extent, even the educated among them migrated to engage in any kind of work by overcoming prejudices about what constitutes a fitting job. Over the period, Gulf emigration becomes a success path for Muslim youth to gain money and social status. And it ensured financial stability among a large section of Muslims in the village. Through this affluence of Gulf remittance, many families invested in local trade and business, which further helped Muslims to strengthen their hold on trade and business in the village.

Political affiliation

The majority of the Muslims in the village are the supporters of Indian Union Muslim League (IUML), and the rest are aligned under the Communist Party of India- Marxist (CPI (M)) and Indian National Congress. Politically, Muslims showed more unanimity compared to other social groups in the village. As the mosque acts as a regular communal gathering place, it helped the Muslim politicians to have a hold on their followers and ensure a vote in their elections. They retained the support of their followers through constant reiteration that substantial benefits of welfare programmes would come to the Muslim community only through the efforts of elected

members who represent the political party of Muslims. Above it, the exploitation of a religious vote-bank is common through getting a vote by convincing the community that IUML is the party that is based on the faith of Islam.

The IUML, as elsewhere in the state emerged as a successful communal organization in the village. Presently IUML is an important force in the local politics of the village. In fact, even at the time of Britishers itself this part of Malabar that include the village was represented by a Muslim in the Malabar district Board. In the present local self-government, IUML has two elected members out of the total thirteen. In the previous election of 2010-2015, they were elected in five seats, and with the support of the Congress party, they won the president post for the second time since the formation of the panchayat. The first time when Muslim League won the post of Panchayat president in Pozhuthana was in 1995. In all other elections they got elected at least in two seats of ward members. As one of the major communities in the village, the Communist party also did everything they could to draw Muslims to their party. As a result few young Muslims moved towards the Communist party, but none of them held a major positions in the party or in the local government formed by the communists.

Traditional medical practices among Muslims

There were traditional folk healers in the village from the Muslim community who practice folk medicine which is similar to that of other folk healers like *Thiyyas* in the village. There is only one traditional practitioner of the Unani system of medicine in the village, who caters to patients occasionally at his residents on demand from the patients without regular daily service. In the past also there were not many practitioners exclusively served under the Unani system in the village. Unani does not spread or advocate in the village like the traditional medical practice of Adivasis or Thiyyas. However, members of the Muslim community believe that Unani is a distinctively Islamic medicine, and some of them who have a preference towards Unani found visiting private Unani providers in the nearby town. There were also some women traditional practitioners among Muslims in the village. At present, a seventy-year-old *Ummathakkutti* is the only known woman among them in the village with substantial knowledge of traditional medicine. At present, she is not treating anyone; she has the knowledge in treatment for attrition of bone, skin issues, back pain, ear pain, and knowledge in medicines for pregnant women. As

similar to other *vydhyans* in the village she also used medicinal plants and materials like *Kalluvazha* (cliff banana), wild tobacco, Jimsonweed, coconut, and milk to treat illness.

Among the Muslims in the village, earlier, the women from *Ossans* performed the job of midwives. They were primarily knowledgeable in caring for the mother and newborn child. They are knowledgeable in caring the newborn and their mother, which include bathing newborn babies and their mothers and washing of cloths used by mothers of newborn babies. The Muslims consider such acts of washing the clothes for mothers of newborn babies as impure; thus the barber women who are ritually lower are considered for doing such works. Even today, some of the better-off households avail the service of *Ossan* midwives to take care of the mother and newborn child. At present, only very few *Ossan* women from nearby villages are engaged in such works because of the lower status attached to it. Due to the high demand for such traditional midwives, over the time, the low-paid work now gets a remuneration of more than twenty thousand per month. Some of the *Ossan* women even demanded more money, and the better-off generally hire them because of their health concern over the young mother and newborn child.

The belief in evil spirits as a cause of illness, especially psychiatric disorders, exists among Muslims in the village. They found attending the yearly festival of *Idiyangara* Mosque in the nearby district Kozhikode to get relief from illness. The belief is that if there any ailment in any part of the body, by offering bread prepared in the shape of an ailing body part will cure the illness. In addition, they also visit the *Musaliyar or Thangal* to cure illness. The *Thangal* is the caste functionary among them, they pretend to cure illness by writing texts from Quran on a plate with ink and then consuming the ink mixed with water by the patient. This was widely followed in the past and occasionally by some among the villagers still follows such acts. A fifty-year-old Muslim woman from *Achoor* suffering from mental illness for around last ten years found visited more than one *Thangal* to follow such practices. Her daughter mentioned that she is under the treatment of a psychiatrist in a private hospital in the nearby town. But, still, they give regular offerings during the *Nercha* in well-known mosques in the area. They found doing this gave some relaxation to her mother. They also gave offerings to some Hindu temples in the nearby area through some neighbours when they came to know about the temple from a patient to whom they met at the hospital.

Dalits of Pozhuthana - The ghettoization of Pulayas into caste colonies

Dalits in the village are mainly constituted by *Pulayas* and a few *parayars* who are considered as lower castes below Nayar and Thiyya. All over Malabar, they were slaves of upper caste *Nayar* and *Brahmins* right up to the end of the eighteenth century. Some of their present settlements, like Anoth and Kurichiarmala in the village are older than the settlements of any other communities in the village except Adivasis. Their settlements are seen both in the lower plain land and in the hilly terrain near to the agricultural fields. The *Pulayas* were the agricultural labourers of the *Nayar's* and later of other social groups like Muslims, *Thiyyas,* and Christians. The *Pulayas,* as agricultural labourers stood at the bottom of the socioeconomic hierarchy without any control or right over the land in which they work and live. In fact, till the beginning of the twentieth century, they were not having any control over their own life as in all aspects, it was controlled by the *Janmmies*. From that state, under the provisions of law *Pulayas* in the village today become free individuals enjoying the same freedom, same rights, and protections available to others. But in the villages Pulayas still remains under the ritual superiority of upper caste Hindus. During 2015 the total number of Dalits in Pozhuthana Panchayat was 1220, settled in different parts of the village with around 250 families. They are mainly settled in Anoth, Kurichiarmala, and Suganthagiri, with around thirty to fifty families together in each settlement. The remaining Dalit families are settled in different parts of the panchayat with other communities.

Significant changes came into the life of *Pulayas* in the village was during the decades that followed independence, marked by reform and trade union movements in the village. During this period, they got accelerated access to public spheres of life, including public places like schools, markets and temples, which were once denied to them. Further, when the government introduced reservations in education, employment and local self-government, they gained some economic and political power in the village. In addition to this, the land reforms and fixation of minimum wage of agricultural labours bring much more autonomy in the life of poor *Pulaya*. Some of the *Pulayas* have been able to make more effective use of the government's affirmative policies and able to get education, job in the government sector, and become small traders. But, still for the poor *Pulayas,* the ability to uplift themselves is very limited in the village, and they largely remain as less paid agricultural labourers. Even though they are very badly positioned in the

social hierarchy of the village, to reach this position their community has made some improvements in their earlier status. Earlier, they lived without any control over their lives, their socio-religious life and day-to-day activities were regulated under the wish of the upper castes in the village. None of them got little chance to move away from this control according to their wish, and those who have tried for that or showed disobedience to the orders of their upper caste masters had met with severe punishments and further deprivation of their means of livelihood. Up to the early decades of the twentieth century, in return for their work they received only occasional allowances in the form of paddy, tapioca, etc. They were employed only in the agricultural fields, not in the houses or nearby estates of upper caste, as they were unapproachable because of the ritual pollution maintained by the upper caste through touch, approach and sight.

Rituals and beliefs of Pulayas

There is a *kavu* of Pulayas in the corner of *Anoth SC colony,* which is as old as their settlement in the area. During the first day of every Malayalam month, there will be ritual offerings in the *kavu*, but during the last three years, it has been stopped as the one who performs this ritual passed away. Not all *Pulaya* will perform these rituals, but this is done only by the *Karanavar* of a joint family *Pulaya*, and the right to do this is transferred only hereditarily. Presently none of the members from the descendants who have the right to do rituals is present in the settlement. The members of the house, which is near to the *kavu* maintain and clean the surroundings of the *kavu*. In addition to the monthly rituals, the yearly festival (*thira*) was celebrated in the *kavu*, but it also got stopped for several years. The last festival was celebrated more than ten years before, and attempts to do them again are rarely made mainly because of the huge cost incurred.

On the other hand, when the upper caste temples are open to all castes, *Pulayas* found visiting them frequently as similar to other upper caste Hindus. Similarly, like other Hindu castes, *Pulayas* also light up *Nilavilakk* in the evening at their house. They also worshipped ancestral spirit, especially by giving offerings on the death anniversaries of relatives and on all other special occasions. Their offerings in the house and even in their *Kavu* include toddy and arrack, which are ritually polluting for the upper caste Nayars. Thus, such offerings of *Pulayas* are not allowed in the upper caste temples in the village, and in such cases, *Pulayas* follow the rituals of

upper caste Hindu temples. In the day-to-day life of Pulaya both their own traditional beliefs and the dominant Hindu upper caste beliefs are simultaneously followed. Some of the better-off *Pulayas* in the village found increasingly giving importance to the rituals based in dominant upper caste beliefs in their attempts to get away from the ritual subordination by other castes. Such attempts are usually made by individual *Pulayas* to effectively utilize their improved standard of living to gain a higher social and ritual status. However, other than a few better-off households, the majority of *Pulayas* as a community do not succeed in seeking recognition for an improved social status as like what *Thiyyas* gained. Only those who were able to gain some new resources from the socioeconomic changes that happened in the village and thereby improvements in their economic status were able to succeed at least on par with *Thiyyas*. In their attempts to reforming themselves towards higher social and ritual status, their reference category was the caste group immediately above them in the caste hierarchy ie *Thiyyas*, never the upper caste Brahmins or *Nayar*, who treat *Pulayas* as untouchable and unapproachable until recently.

In the houses of *Pulaya*, women play a major role; they were found having more power to make decisions, manage the little money and goods they have. This they have gained mainly through their continuous employment in the agricultural field and the return they gained. The little return they got from labouring gave them freedom to spend on household needs at their will. In the recent past through the Self Help Groups (SHG), many among them developed the habit of thriftiness and collective farming. They were also found, more freely interacting with others irrespective of gender, even in public places like Pozhuthana town, when such acts are not usual among women from other social groups. In addition, there is no caste restriction on the women to present themselves in public in a certain way as it informally exists among the *Nayar* and Muslim communities. In other words, there is no such burden on the *Pulaya* women as it is among the Nayar and Muslim women to present themselves as a woman of particular caste or religion.

Practice of caste discrimination

Even the mere sight of a *Pulaya* within a prescribed distance was enough for a Nambudiri and *Nayar* to consider them polluted until the later decades of the nineteenth century. The social norm in those days restricted the lower castes access to public places, when the upper caste is out

in the public roads it is the responsibility of the lower caste not to pollute them by coming within the prohibited distance. If the lower castes violated the pollution rules, they were given severe punishments. In addition to the upper caste Hindus, the other lower castes like *Thiyya,* who themselves were untouchable for the upper caste, practiced caste discrimination in their engagements with the *Pulayas*. The public roads in the village were not freely accessible to them as there was always the fear of causing pollution to higher caste people by their presence. Not just roads, the temples, public ponds, main markets, education, occupations other than labouring all are restricted for them until the beginning of the last century.

Even though untouchability and un-approachability have changed over the period largely through the enforcement of law and social reform movements, still in the day-to-day engagements, many of its aspects remnants. Even today, some among higher caste do not have food cooked by *Pulaya*, do not build houses inside their settlements or colonies, do not engage in marriage alliances with them, do not recognize their devotional places as similar to that of all Hindus, and still consider them as inferior in caste and ritual status. Even though intermingling and inter-dinning are common, an issue raised by young *Pulaya* is framing of their children in classrooms as backbenchers and differences in the attitude of teachers towards them. The students who dropout from Achoor government higher secondary school and their parents claimed that it is the insensitive behaviour of the teachers towards the difficulty of *Pulaya* and Adivasi students to cope with the pedagogy as the reason for high dropout among them.

Even though the political parties and trade unions fought against caste discrimination in the village, they only had beaten those aspects of castes which are necessary to fight for better wage and working conditions in general, but less so in daily life. They gave the least attention to the caste connection of occupations within the members of trade unions rather they focused on mobilizing workers of all caste to fight against plantation owners. By the time trade unions emerged as organized political groups to fight against the oppression of labour, large landlords had already ruined their *janmi* status in the village, and owners of plantations become the new oppressors. Thus, the fight of trade unions and political parties in the village was a fight by the lower caste against the capital owning plantations, not against the caste power of upper caste *janmi*. Even the attempts of left parties, who ruled the panchayat more than anyone else and said to be committed to the cause of the marginalized were limited to attacking those aspects of caste

that are necessary to maintain a labouring class that support their party. As a result, in addition to the persisting caste division of labour, *Pulayas* settlements in the village are still labeled as 'SC colony' to reflect a way of living inferior to upper caste culture.

Pulayas who live in the Anoth found using honorific words while addressing or even while referring to a member of higher caste *Nayar*. Even though age is an important factor ascribing status to persons in the village, the younger member of the *Nayar* also get the same treatment from the *Pulayas*. Similarly, it is common among the younger *Nayar* to call an elder *Pulaya* agriculture labour just by their name without adding any salutations of respect like brother or sister, which is generally seen as a degrading way of addressing someone. Even though such acts are changing among the younger generations, the elder generation is found strictly following them.

Many of the caste restrictions on the *Pulayas* and other lower castes were removed in the course of time through the enactment of laws, but it did not annihilate the spirit of the caste system that existed among the villagers and do not bring an immediate substantial improvement in the socioeconomic status of the *Pulayas*. This means that the practice of untouchability has disappeared, at least in public places. However, the disappearance of traditional caste-based discrimination from public places cannot be treated as evidence of the annihilation of caste culture in the village. For example, the respect shown towards elder member or a woman from *Nayar* and *Pulaya* in a stationary shop or in the panchayat office or in the PHC or in a tea shop or in a marriage function in the village is strongly influenced by their caste status.

Settlements of Pualayas in the village

Coming to other forms of resources, dwelling is one of the most important. Even though major changes have happened over the period, even today the houses of *Pulayas* could be easily identified as different from that of other social groups in the village. Some of their houses are small in size and built with less expensive materials and without many household facilities. The remaining families are ghettoized in two crowded colonies with the least household facilities. In the yesteryears they lived in the corner of the agricultural field of the upper caste *Janmmis*. Their settlements in the Anoth and Kurichairmala are examples of settlements established adjacent to the earlier agricultural fields. Earlier, they lived in the kutcha houses of one or two rooms, walls,

and roof made of palm or coconut leaf and floor smeared with cow-dung. Their houses are very close to each other and near to the small canal through which water flows to the agricultural filed. Without bathrooms and latrines, depending on a public well for drinking water and the water flows through the canal for all other purposes. They were also had some banana and tapioca plants within the small piece of homestead land along with one or two bullock living near to their thatched hut. This altogether makes their dwelling area filled or smeared with unhygienic matters like water logging, mud, cow dung, food wastes of livestock etc., which made their surrounding less clean and unhygienic to that of other social groups. As a result, the other social groups in the village labeled Pulayas as unclean in their appearance and uncultured in their behavior.

Presently several *Pulayas* have single or double room houses with plastered walls and tiled or concrete roofs in the colonies built with the support of the government. In their settlement, each small house is crowded by family members, and each new generation adds similar new houses in the already crowded colony. They built new houses with bathrooms and toilets during the last few decades with financial support from the government. But instead of ensuring social progress, the colonies isolated the poor from the mainstream and labeled them as the colonies of the lower caste. It led to the ghettoization of *Pulayas* to two main caste colonies in the village. Such colonies remain indicators for the inferior social status of *Pulayas*, and it distances them from the mainstream of society and helps others to appropriate their labour at a cheap rate. No families from other social groups built houses in their settlement because of the lower caste status of the *Pulayas*. In the village, it is only the Dalits who are living in the caste colonies except for one Adivasi colony.

As the major part of the earlier agricultural lands have been converted and occupied by other social groups for settlements, many changes happened in the surroundings of *Pulayas* settlements too. For example, their settlements in Anoth now become a colony known as *Anoth SC colony*, the north side of it separated by main road with agricultural field , and the west side separated by a sub road with houses of Muslims and *Nayar*s on the other side of the road. On both other ends it is the agricultural field of upper castes and Muslims, where the *Pulayas* get work occasionally. As the agricultural labour become irregular, having a cow or oxen become difficult, and the number of houses within the settlement increased; in line with the perceptions

of other social groups the concept of cleanliness among Pulayas also changed. However, the labeling of colonies where *Pulayas* live as unhygienic continues even today. Even some of the local health care professionals and local self-government officials have the opinion that they are reluctant in changing health-damaging behaviors like alcohol and tobacco consumption, living in filthy and unhygienic condition, and least interested in health promotive aspects.

Occupation

For the *Pulaya* men in the Anoth SC colony, regular employment was available only during the first three months of each year from January to March in the coffee plantations. Throughout the other months, they have to depend on the small-scale farmers in the village to get some work in their agricultural field. However, such works are not regular, and they get only ten to fifteen days of work in a month. Even though with a low wage in the past, they used to get work throughout the month, but over the years the number of employment days available to them got reduced because the owners of agricultural land reduce their cultivation. The labours have the opinion that even the land-owning upper caste farmers do not have enough financial resources to do large-scale cultivation as they practiced earlier. When the earlier land relation had changed, and land reforms were enacted, agriculture in the village got reduced, and workdays available to labourer's become irregular.

To escape from unemployment, many among *Pulayas* went for other works, many in the settlements of Kurichyarmala and Suganthagiri were found engaged in daily wage works other than agriculture. *Pulayas* are traditionally agricultural labours and do not have much expertise in other fields of daily wage labour. Instead of recognizing their lack of expertise in labour other than agriculture, in the village they are generally labeled as less able-bodied to perform heavy physical works. Further, lack of own land and lesser employment days kept them unemployed for several days in a month, this in fact leads to label them as lazy workers. In a society that treats Dalits lower in the social order, the more laborious and less remunerative are the other employment opportunities they got. Some of the elder members opined, as almost all of them were agricultural labourer's nothing other than having their own agricultural land could bring financial security to them in the short and long run.

Even though the state government provided homestead land to Dalits by forming SC colonies, Dalits, the real tillers of the land, denied land as a productive resource. For the caste group immediately above them in the caste hierarchy, *Thiyya* and higher caste *Nayar* inheritance is the way through which most of the younger generation got land in the village. But for *Pulayas* government's distribution of homestead land is the major means as their older generation were not given land in the village. Instead of land, government regulations and political activism focused on improvement in working conditions and a minimum wage, but it really does not help them to make substantial improvements as, over the years, the village witnessed a decline in agriculture and therefore decline in employment.

On the other hand, some of the better-off *Pulayas* were able to gain employment as clerks, teachers and other higher posts in the government institutions of nearby villages and towns. The reservation and affirmative action's by the state and central governments helped many *Pulayas* to achieve education and government jobs. There are also some small-scale traders among them who have shops in the Pozhuthana town. However, among the comparatively poor most of them continue to be agricultural labourers and other daily wage labours like construction workers. The *Pulayas* from the village who got government jobs are working as primary school teachers, lower division clerk and other low paid positions under class IV category like peons, security guard etc. Their presence in highest positions of government employment as like other communities is nil in the village. Even though there are government employees under *Pulayas* in the village they are mainly employed in the lowest strata of government employment. Hence, the better-off among *Pulayas* in the village are not as rich as other higher castes in the hierarchy or other social groups like Muslims. However those with government employment or engaged in small scale trading are far better in terms of possession of own land, house, savings and other assets like gold ornaments compared to comparatively poor *Pulayas*.

Participation of *Pulayas* in political activities of the village

Earlier the work and life of *Pulayas* were fully dependent on their upper caste masters in such a way where they were not even able to build a life of their own. Even after having a common occupation of agricultural labour, the strong control of landlords does not promote any fellow-feeling with respect to work as a collective action among *Pulayas.* The strategy followed by

other social groups like Muslims in acquiring political power in the village after independence was to strengthen their own political party IUML, and to an extend *Nayars* in the village also tried to build their political party NDP. The emergent *Thiyyas* in the village also used this strategy and got varying degrees of success by largely align with communists. In the case of *Pulayas*, lack of educational and economic resources along with the continued social discrimination becomes the major hurdle in having any political hand within any political party in the village. However, even before independence, especially during the time of freedom struggles in the region, the lower caste workers especially *Pulayas* in large joined trade union struggles along with *Thiyyas* and Muslims under the leadership of some educated *Nayars* and Muslim politicians of Communist and Congress party. They together fought several fights in the village for a better wage, better working environment, and even for the ownership of agricultural land. However, such togetherness does not change some of the caste-based reservations maintained by the upper castes towards the *Pulayas*. They retained their caste rigidness to the extent that endogamy and other practices that were crucial for maintaining caste differences. On the political side, it does not bring many *Pulayas* into the leadership of the political parties or trade unions. The leadership of trade unions and political parties was maintained by the *Nayars* and Muslims and later from members of *Thiyya*s. The recent reservation in local self-government elections is what brings some leaders of *Pulayas* and other schedule castes to all political parties.

The extension of welfare and public services and improvements in working conditions through the functioning of political parties was crucial in preventing the worse condition of the poor *Pulaya*. In that sense, the political parties and trade unions in the village achieved indisputable success during the second half of the twentieth century. However, the incomplete alienation of traditional caste practices in the village also maintained a new form of educated upper caste ruling power, in which leaders of political parties from upper castes exercise a form of power on the lower castes. This observance of such a new form of power is visible within political parties and in the governance of the village by political parties. Thus, the emerged politics in the village not only failed to bring *Pulayas* in the leadership of political parties and governance, kept control over them through the new form of power, but they also failed to meet the felt need of *Pulayas* to gain land as a productive resource. The subjugation of *Pulayas* in the politics and local self-government of the village is thus not just happened by chance but as a result of political development shaped advantageous to the upper caste Hindus and Muslim elites in the village.

Adivasis of *Pozhuthana* –The alienation of native inhabitance in the process of development in the village

Adivasis in the village are the earliest native inhabitance in this area, and before the invasion of others, they were ruled by the Rajas of the Veda tribe as a tribal self-governing kingdom. It was during the later centuries of the medieval period, the Malabar Kshatriya Rajas of the Kottayam *Kurumbarnad* principalities conquered areas, including this village. This pave the way for a long period of feudalistic rule of the area by the upper caste *Nayar* gentry of Malabar. Under the feudal administration, the entire land freely owned by the Adivasis became the property of the King and his *Nayar Janmmis*. The *Nayar Janmmis* become the custodians of the whole land, and below that, the cultivators were the tenants of *Janmmis,* and at the lowest level the Adivasis become bonded labour. But, even at the time some Adivasis mainly *Katunayakar* remained in the forest without much interaction with the new ruling *Janmmis*. The rest of the Adivasi families was remained attached to the *Pozuthanayidam* landlord working as bonded labour in their agricultural fields. Over the years, when some more small *Nayar* landlords emerged in the village under *Pozhuthanayidam*, Adivasi families got distributed among them but without any changes in their status of bonded labour. The *Chettiyars* community and the Muslims who become merchants and cultivators in the village also employed Adivasis by hiring them generally for a year from the owner *Janmmis*. The changes happened in the administration of land, coming of new cultures and beliefs had changed the lifestyle and livelihood of native Adivasis. The Adivasis become daily wage labourers when the demand for labour increased, in turn with the emergence of agricultural plantations. Later, when plantations in large scale started in the village, in its beginning the large-scale requirement of labours was mainly met with the Adivasi labourers with minimum wage. The growing plantation and agriculture mainly based on cash crop production naturally leads to the emergence of small towns and markets in the village. However, Adivasis were not able to gain from the developments in agriculture, plantations, or in the local market. The native Adivasis who were once engaged in their own agriculture later become landless agricultural labourers first under the Nayar Janmmis, then under plantations and later mainly under Muslim and Christian settlers. The better access of village resources to other communities like *Thiyyas*, Muslims, and *Pulayas*, and the living of Adivasis as an alien in the village gradually lead to labeling Adivasis labours as poor performers compared to labours from

other communities who have gained skills in modern agriculture and construction. As a result, when the efforts of trade unions resulted in better wages and working conditions for daily wage labours in the village; and large requirements for labour in the plantations, agriculture, and other sectors like construction were generated, the least benefited was Adivasis.

Rituals and beliefs of Paniyas

Even though Adivasis in the village are the least influenced by dominant Hindu Brahmanical religious beliefs, in many spheres like marriage functions, beliefs in deities, and offerings to god are found accepting elements of the upper caste Hindu beliefs. However, this is not similar to the assimilation of higher caste beliefs by the lower caste *Thiyyas*, instead, Adivasis incorporated the aspects of upper caste Hindu beliefs in parallel to their traditional beliefs and rituals. *Paniyas* and *Kurichyar* in the village, in many aspects, now observe two parallel beliefs and rituals with greater importance and priority to their traditional belief and rituals. Changes in the marriage rituals, materials of offerings to the god, visits to upper caste temples, daily lighting of *Nilavilakku* etc. are some examples of this. Through the traditional belief of the *Paniyas*, every *Paniya* joint family will be having a *Kavu* devoted to the main gods *Maladhayivam, Gulikan, and Maariyamma* in their ancestral house. In addition to this, when the upper caste temples are open to the Adivasis, now, they have another additional group of gods and temples to worship, which is different and new to their traditional belief. *Paniya* worships their gods and sprites of ancestors together in practice as their *Kavu* are still not public, but each joint family has their own *Kavu* of same god. Even though the joint family does not exist today as it exists earlier, in case of any special occasions, they come together at the *Kavu* to observe rituals. The rituals in the *Kavu* are done by the head of the joint family or by any other elder member in the family, the right to do rituals are not restricted to any sub-castes as it is in the upper caste Hindu temples. In addition to the offerings like coconut oil, flowers, which are similar to offerings of upper caste Hindus, *Paniyas* also give row rice, rice cooked in sweets, and traditional arrack as offerings to the god. Among this the arrack, and for that matter, any alcohol is treated as impure to offer in upper caste temples. In addition to the daily lighting up of lamp annual festival along with ritual, offerings are made on special days in the *Kavu* of *Paniyas*.

The offerings to the spirits of ancestors is another important ritual they do on almost all special occasions like marriage, childbirth, at the beginning of agriculture, etc. Generally, the spirits of the dead are housed inside in the corner of the house, and every time, offerings are made in this place only. The spirit of the deceased is housed on the seventh day, and rigorous practices of offerings are followed annually for three years. For the first three years on the anniversary women members in the house took *Vratham* (austerity with prayers) for seven days. During those days, they rarely come out of the house, never cross a river or a road, took a bath every day in the morning, only have food cooked by them. On the seventh day, offerings will be given inside the house, and rituals will be performed in the *Kavu* also. All members from the joint family and some neighbors from the settlements are also present in the function, which will be done in the night and ends with a feast. After three years, on every anniversary, also offerings are provided by the family members.

On the yearly festivals in own *Kavu* all family members will come together and engage in the rituals, which last for around two days. Throughout the time, all members, even those who are staying away from the area will remain in the *Kavu* and leave only after completing the rituals. Similarly, in some of the famous *Kavu* like *Valliyoorkavu* in the nearby village also many *Paniyas* attend the festive and return only after the completion of all rituals. This is different from the festive in the upper caste temples in the village, where people generally visit for a few hours and come back during festivals. But, the *Paniyas,* even in the festivals of upper caste temples, are present in the ground near the temple up to the completion of two days festival. There are changes in this among the younger generations, educated and those who are residing in the settlements where various social groups live together, they found visiting the temple for the main functions of the festival only.

Marriage among Paniyas

There are 24 settlements of *Paniyas* spread across the Panchayat. Many of the *Paniyas* have relatives in other settlements and those who are migrated to the Panchayat in the recent decades have their relatives in nearby villages and other parts of the districts. Even though matrilineal system has changed among them, it is usual for the young *Paniya* boys to visit and stay in their uncle's house for long days. This usually happens after completing or discontinuing their studies

and around at the age of 20 when they are matured enough to go for agriculture or any other works. During such stays, it is usual to find a suitable marriage alliance from the settlement or, in many cases, to build a relationship with the daughter of his uncle by knowing her willingness to marry him. Generally, *Paniyas* in the village has a preference to marry the daughter of their uncle. In such a way, during their stay in their uncle's house, they find a suitable alliance, and once the girl expresses her willingness to marriage, it will be conveyed to the *Karanavars* (father or uncle). Then it is the duty of the parents of the boy and his uncle to conduct the engagement at the bride's house. Along with the parents of the boy, few relatives will visit the girl's house and begin marriage talks by giving betel leaves, areca nuts, rice, dresses for the bride, and a bundle of firewoods to the bride's father. Along with that, some money decided by the brides *Karanavar* is also handed over as *brides'money*. This is now done only for ceremonial purposes, and generally the money amounts to a hundred rupees only. Earlier, this was practiced rigorously and on every festive day's groom gives some money to the bride's father for giving her daughter to him. During the function, they will decide the date of marriage, which is usually a close date within a month. The dates decided are already consulted with a *Kaniyan* of upper caste Hindu, who usually find the auspicious dates and time for marriages. Earlier, this was done by elderly members of *Paniya* only, but now those who are knowledgeable in such matters are rare among *Paniyas*. There will be a feast after fixing the date, in addition to the bridegroom and his relatives, a few neighbors and relatives of the bride constitutes the whole guests.

Members from other settlements and members of other social groups are not often invited for the engagement and even for marriage. Only very close friends from other social groups are invited, even though they are settled in the nearby area. The marriage function usually starts in the evening and lasts up to the night. The marriage ritual consists of tying a neck-chain by the groom to the bride. The chain will be made of some beautiful stones and rupee coins which is usually made by some elderly family members of the groom. In addition to this chain nowadays an additional gold chain or cotton yarns depending on the financial condition of the groom is also used.

However, among the few better-off *Paniya,* there are many changes that started to notice in the marriage functions by doing them in the ways of upper caste Hindus. Functions in the daytime, use of *malgalsutra* made of gold, decorations with hired goods, elaborated feast are some

examples. Some of the better-off among them also give some dowry in the form of gold ornaments to girls, but it will not be more than one or two small chains or bangle. Nothing other than this is given as dowry, and also no talks are made regarding it. Until recently, before the implementation of The Protection of Children from Sexual Offences Act (POSCO Act) in 2012, child marriage was high among them, mainly marriage of bride below eighteen years of age. This was mainly because, they treat a *Paniya* girl matured after her first menstruation and for the boy when he start going for agricultural work around at the age of twenty. By their custom, such matured girls and boys are allowed to be in a relation and get married. However, this has been changed and those who are willing to marry but below the age, now wait up to their legal age to get married.

As a new trend, the marriages alliance of *Paniya* girls in the village with *Thiyya* men from faraway villages found increasing. The parents of the *Paniya* bride have the opinion that even though the bridegroom is from far away villages and of other ethnicities, their daughters can lead a much comfortable life in the groom's house as it is big and built in the modern style. The *Thiyya* from far away villages, mainly from nearby Kozhikode district, are comparatively better-off than the *Paniyas*. The *Paniyas* observes that the families of bridegroom from such areas have continuous employment, no shortage of food, better public facilities in their village, and grooms are good in behaviour. By good behaviour, they mean that the young men from these faraway villages are less addicted to alcohol and regular in their employment as compared to the young Paniya men in the village. When enquired about such qualities of *Thiyyas* from their own village, it is understood that the *Thiyyas* from the village are least interested in marrying a *Paniya* woman as they treat the others as lower in status to have a marriage relationship with them. Even though the families of bridegroom from far away villages also treat *Paniya* girls as lower in status to have a relation with them, but the difficulty in getting bride of their own caste or of any other caste in their own villages are the reason for approaching *Paniya* women from Pozhuthana and other villages of Wayanad. It has been observed that those bridegrooms married from Pozhuthana made several years of attempt to find a bride from their own villages. There are cases where more than ten years of search had failed to find a suitable bride. However, it is found such a crisis is not due to the shortage of young women in *Thiyya* caste rather because of the newly educated young girls 'preference to marry an educated or government employee. All those

who married paniya girls of the village from the far way villages are daily wage labourers having education level below matriculation.

Alienation of land, forest, and related resources

The expansion of the administrative system of erstwhile Kottayam to Wayanad resulted in a far-reaching transition of land relations. Until then, the Adivasis were depending on the forest for their livelihood and freely doing cultivations in the lands around their dwellings. However, after the conquering of the land by Kottayam Raja, the ownership of land was transferred to the hands of high caste *Nayars* who were appointed by the Raja as administrators of the region. Under their regimen, *Paniyas* and all other *Adiyasis* became bonded labourers under the upper-caste landlords (*janmis*) of Wayanad. During the beginning of the second half of the eighteenth century when the Mysore ruler Hyder Ali conquered Malabar, this area also came under their rule. It led Muslim landlords to have some hand in the agriculture and trade, especially in the timber trade in the region and village. Subsequently, the forests become managed largely on commercial lines and the customary community rights of the Adivasis to the forest started disrupted. Later, when the British made this land under their control, utilization of forest land for timber and plantations made Adivasis to largely lose their hold in the forest lands. As a result of the changes in land relation, Adivasis continue to lose their earlier privileges to freely cultivate agricultural land and avail livelihood from forest.

From 1920 onwards, a further alienation of *Adivasis* from their land took place in the villages because of the large inward migration from the mainland of Malabar. Through encroachments and illegal transfers, many of the lands owned by the Adivasis then went to the hands of Muslims, Christians, and others who migrated to the village. As a result, Adivasis become predominately landless labourers in their own land which they lost to the new cultivators. Later some got small pieces of land for dwelling under various government schemes, a few others got agricultural lands too, but still, many among them remain without any agricultural land.

When the land reform was enacted in 1963 in the state, Adivasis and *Paniya* in particular were largely excluded from its benefits in the village. This happened mainly because the act recognized the land rights of tenants, but the Adivasis who were bonded labours under the landlords were not considered as tenants. As a result, Adivasi bonded labours failed to retain

their rights to the land on which they lived, instead, many among them were evacuated by the *janmis*. Such Adivasis in the village then settled in different parts of the village, some on the fringes of the forest and others by encroaching revenue lands in the plain.

Over the period, landlessness among Adivasis become a political issue in the state and governments were forced to implement some of the acts and programmes. One thing which benefited at least some Adivasis in the village was the distribution of land after the closure of the Suganthagiri cardamom project due to its failure. This led some Adivasi families in the village to receive land of different sizes up to five acres for a family and later a house with financial support from the government. Later, an important way through which some Adivasis in Pozhuthana and allover Wayanad got land is through the implementation of the Forest Right Act (FRA) of 2006. However, the state continues to be hostile to the land rights of Adivasis, as a result flaws and injustice win through the implementation of individual rights over forest. During this period, many Adivasis has encroached lands near to the main roads in the village, mostly Adivasis from other parts of the district with the direction and support of the CPI (M), which the party did to gain political benefit from the issue. When some of these encroachments were legalized, the benefitted were mainly Adivasis of nearby villages. The *sixth mile* ST colony is one among them, which was encroached by Adivasis and later title deeds were provided by the government. Some of them in the colony were also able to build houses with the support of the state government and some are still in construction. They were given title deeds as *kaivasharekha* which in effect is just a possession certificate. In a sense, what they get is not land, but it is the possession, certain rights and privileges to the individuals who are living in a particular land. They cannot sell the land, cannot cut trees in the land but can cultivate, dig well, built a house, and take revenue from the land. Thus, it will be untrue to say that Adivasis are the real owners of such lands. For those who have land without full rights, only they could do was to live and cultivate on it, the land where they lived had no money value.

At present, except for some Adivasi households, the majority of them do not have cultivable land in the village. When some among them in the *sixth mile* ST colony and *Sugandhagiri* got agricultural lands along with homestead land, Adivasis in other parts of the Panchayat only have a small piece of homestead land. In the past, Adivasis in the village were largely dependent on the forest for their livelihood, but when the forest went on to use in commercial line and later

come under the strict protection of the government, Adivasis not only alienated from their livelihood from the forest but also their customary rights over the forest. The Community Right over land and Community Forest Right are completely neglected in Pozhuthana. With the loss of access to forest and land, Adivasis not only lost their resources for livelihood but also their symbolic and cultural capital as well as their wealth of knowledge. In a way, through the alienation of Adivasis from their earlier resources, they are displaced from their own cultures, community and knowledge systems and informally pressurized them to align with the values of the present society which is being controlled by other dominant communities.

Settlements of Adivasis

Mainly two types of settlement are observed among Adivasis in Pozhuthana, first, households with some agricultural land settled in the corner of their farming land. In such settlements, each house are surrounded by its own agricultural land, houses are thus built at some distance. However, only some households from Suganthagiri, Anoth ST colony, and Kurichyarmala are living in such settlements. The majority of Adivasis from the panchayat is living in another type of settlements, where the houses are built close to each other without any agricultural land to the households. Such households only have homestead land, and they live in such crowded colonies with minimal household facilities. In addition to this, some of the better-off Adivasis have houses in various parts of the panchayat along with other communities.

Among the Adivasis in the Pozhuthana some of them have houses with machine-made tile or concrete roofs mostly built through financial support from government housing projects. All such houses are of similar design with two bedrooms, a hall, a small verandah, kitchen, and toilet. Such houses are built near to each other, and the plans of the houses are centrally approved without any intervention of the beneficiaries in it. For the rest of the poor among them have kutcha houses built with grass, coconut leaf or plastic sheets for roof and mud bricks or bamboo for walls and floor smeared with cow dung. These types of houses have only one room and a small verandah in the front. The majority of such houses have kitchens closer to the veranda, and some of them have a cooking area within the limited space of a single room. In addition, some such houses do not have toilets or bathrooms, but the majority have electricity connection. Only better-off among them have an own well. Those who are living in the ST colony in the *sixth mile*

have public taps near to their house, rests are mainly depending on the far away public taps, wells of others, and small natural ditches in the hilltops. The majority of the poor with some resources managed to get drinking water in their premises through self-managed pipe connections from the natural ditches of the hilltop. The river is the other main source of water for all other purposes other than drinking, for those who are living near to the river. In the case of better-off among them, some have big two-storied houses built with modern architecture. Such households have all household amenities similar to that of better-off households from other social groups. However, majority of better-off among them have only two-bedroom houses with minimal household facilities like electricity, drinking water, and toilet.

The daily life of Paniya in the village

Food grains from the PDS shops are major source of food for *Paniyas* in the village, along with tubers, jackfruit, papaya etc. grown in own or neighbours garden and vegetables from their own cultivation, if any. They also depend on the private shops when they have some money in their hand to buy vegetables, rice, fish, etc. However, lack of money restricts this, and insufficiency of food received from PDS shops occasionally puts them in hunger. As comparatively poor among them do not have enough money in their hand, they are not regular in purchasing from the nearby market. Different from other social groups a regular breakfast is not always affordable to them, and children occasionally go to the school with an empty stomach or having left out food from previous day's dinner.

In addition to the insufficiency of food from PDS shops, some of the Adivasi households do not have a ration card. The new families who have departed from the joint family are the one who does not possess the ration card. As it involves paper works to get a house number and then a ration card, they are less skilled to do this and have to go to Kalpetta town and need to seek the help of others. However, such families who do not have ration cards found sharing the grains purchased from PDS shops between relatives. It is during the rainy season in the months of June and July they suffer more from the shortage of food because of the unavailability of work. The use of alcohol and chewing tobacco is found high among them, especially among the elderly labouring men. Chewing betel nuts is common among women and even among young girls without any restrictions from their parents. However, among the young men compared to their

counterparts in other villages in Wayanad, alcohol consumption is low because of the non-existence of toddy shops in the nearby areas.

Even today, to an extent, comparatively poor Adivasis in the village lives like an alien, for an outsider their engagements in the markets of Pozhuthana seems like they do not belong to the area. Their presence itself is rare in the town as they do not run any shops or business in the *sixth mile*, Achoor or Pozhuthana town of the village. They come to these towns to buy food grains from PDS and other shops in the market, to go to the PHC, and to get buses towards other towns like Vythiri and Kalpetta. It is an occasional site to see some elderly Adivasi men and women in a tea shop in the village having some food on their way back to the village from the nearby town, taluk hospital or from any other places. The way they sit in the chairs near the dining table, mostly on the one in the corner of the tea shop, shows their discomfort and the difficulties they face in their engagements with others in the village. Different from others, it is also found in their visit to the market that they only interact with a very few people, and their social contacts in the market are minimal. Similarly, they were found least involved in the activities of established arts, and sports clubs in the village, and their young men were even not found in the village playgrounds with others who used to play every day.

Over the time when many among them were alienated from the land and forced to settle in colonies, it in a way destroyed their close connectedness with relatives. In addition, their colonies were labeled as alien sites from the mainstream of the society, characterized as a place where people of lower ritual status, illiterate, and not modernized, live close to each other with quarreling. This not only degraded their status among other social groups, but it further created a distinction in the village in their status between *Paniyas* living in colonies and *Paniyas* residing in other parts of the village. In the present day, *Paniyas* living in the colonies becomes lower in status even for the other *Paniyas* in the village. As *Paniyas* from different families and settlements were together brought into the colonies in the village, they face the problems of lack of a common leader, familial *Kavu* where they worshiped, and their caste functionaries who performed the rituals. Now it becomes a necessity to find some *Paniyas* who are knowledgeable in ritual matters from outside their settlements to get help in ritual matters.

The engagements of Adivasis into the activities of local self-government and political parties are restricted in a few leaders. For the majority of them, their engagements in political parties are limited to their mere presence in the rallies and protests organized by the political parties for the cause of Adivasis. The political leaders from the village express that they make all attempts to involve Adivasis in all public functions in the village, and they proudly mention that when the building for the Panchayat office was built, to inaugurate it they have selected a common Adivasi man. However, even today, for the majority of Adivasis Panchayat office and its services are not freely accessible as similar to others. Even though they have two elected ward members in the reserved seats of panchayat, the participation of Adivasis in the *Gramasba* is nominal.

Kurichyars of Pozhuthana

Kurichyar is the other important Adivasi group in the village. They claim higher ritual status among the Adivasis, and some among them still did not eat food cooked by anyone lower in ritual status like *Paniya*. Even though the majority of them in the village are poor, in general, they are socioeconomically better equipped than *Paniyas,* and a few among them in the village are as well-off as an average *Thiyya* or Muslim. Even though changes had happened in the concept of purity over the period, they still consider ritual superiority over *Paniyas*. From the earlier period itself, they are agriculturalists who used to have their own lands. They were well known in the history of Wayanad as well-known bow-men who played a part in the Pazhassi Raja's rebellion against Britishers during the beginning of the nineteenth century. This is one way shows that different from other tribal groups *Kurichyars* were not lived as aliens without much interaction with others, but they got greater chances to engage with others.

Traditional medical practices among Adivasis in the village

As elsewhere in the region, Adivasis in the village also has a long tradition of practicing indigenous traditional medicine. As they are the earliest inhabitants in the village, their community from several generations was well aware of the medicinal plants, forest resources, and other natural resources in the village. They were also well aware of the medicinal power of several plants and their use in relation to changes in the environment, as they used certain plants in connection with the changes in weather conditions. A *Kurichya* traditional medical practitioner among them mentioned that certain plants are required in less quantity during

summer compared to the rainy season because during summer the medicinal content in such plants will be higher. Similarly, some plants have to be plucked with extreme care that one should not even talk while plucking them. He also believes medicinal plants should not be collected at night, and some of them only are collected in the early morning. In the past, there were many more elder members in the village who have knowledge of their traditional medicine and its practice. However, presently, very few among them in the village are engaged in traditional medical practice at their home based on the demand from individual patients.

Among the few who practices, Balan, a Paniya male of thirty-five-year-old is specialized in treating kidney stone issues. He has learned this from his mother who earlier gained this knowledge from her father and practiced for several years. He uses plants collected from nearby areas of his house to prepare the medicine. Normally two or three days one has to take the medicine in empty stomach in the morning. Patients even from nearby villages visit him occasionally by knowing from earlier patients. He never gives medicine into the hands of the patient and never discloses details of plants used; they believe that if it is revealed, the medicine may not give desired effect in the future. To avail treatment, patients have to visit him in the morning at his house, and number of day's medicine required depends on the severity of the illness, and generally it lasts for three to seven days. Everyday patient has to visit him and sometimes has to bring a glass of milk in which he mixes the medicine. There is no such fixed fee for his service; generally it is left to the patient's wish. Even though he is known in the village for successfully treating many patients, he continues to work as agriculture labour in the village by occasionally treating patients who visit him.

Even though not practicing there are some *Paniya, Kurichyar, Nayekkar* and *Kadar* among the Adivasis in the village who have knowledge in medicinal plants and its uses. A thirty-three-year-old *Nayekkar* tribe, Achuthan from *Kuruvanthod* village, has knowledge in the medicines for treating eye issues. An eighty-two-year-old man from Kadar tribe from *Ammara* village knows medicines to treat snake bites. Another eighty-five-year-old *Paniya* woman is knowledgeable in medicinal plants to treat stomach pain, sleeplessness, and minor wounds. Similarly, many among them are knowledgeable not only in medicine but also in many other matters relating to the village. By observing the presence and growth of certain plants, they usually predict the availability of groundwater in the area. In the old days, before the migration of other social

groups, when they have more freedom in their life, they were more engaged in the use of their traditional knowledge and medicine. However, the changes happened in the village after the migration of other social groups denied their right to collect forest resources, alienated their agricultural lands and they become less self-reliant and more dependent on other villagers.

Conclusion

Summarizing relevant social histories of different social groups in Pozhuthana helps to understand where each community stands socially, economically, educationally, culturally, and politically in relation to each other. What are the portends of the situation for their health and wellbeing. Malabar region of Kerala is distinguished from the central and southern parts of the state because of the fact that the former were under the direct British rule as Malabar district of Madras presidency. Hence the British had a role in shaping the social status of various social groups in the region. When the Britishers favored the Bhramnins and upper caste Nayar landlords they were in frequent fight with Muslim community. In fact the frequent fight between Muslims and Britishers aligned with Hindu landlords in the mainland of Malabar, culminating in the Malabar Mappila Revolt of 1921, forced many Muslims to migrate.

However despite their lower status of lower caste in the Hindu caste hierarchy the Thiyya community was favoured by the British in many aspects. A large number of Thiyyas had built up considerable fortunes in all major colonial towns under the British or French rule like Calicut, Mahe, Thalassery and Kannur. What helped them gain access to such fortunes was their proximity to the British/French colonial administrations and members of the European community (Chekkutty, 2019). Many among the community had received English education and also managed to start own businesses and possess lucrative positions in these administrations. The favorable atmosphere enabled the community gave birth to a great number of distinguished men and women in the field of literature, art, culture, Ayurveda treatment, statesmanship, administration, martial art, education, sports and science.

But for the lower castes below the Thiyyas in the Hindu caste hierarchy, Pulaya and Adivasis the feudal social customs were oppressive. The social taboos imposed by the rigid caste system on the lower-caste communities prevent them access to public places. Even under the colonial rule the social ostracism was pervasive and the Pulaya and Adivasi community had to bear much of

the brunt. When jobs in army and administration and access to schools, hospitals, courts, and markets became available even to lower caste Thiyya. Access to these spaces and other spheres of development was restricted for lower caste Pulaya and Adivasis.

Even though Nayars are one of the Sudra castes, by the time they come to Pozhuthana as local rulers of the king, they had acquired the religious status similar to upper caste Brahmins. The Namboothiris or Brahmins, who were the big landlords, employed Nayar to manage their agriculture and other activities. Over the period Nayars become owners of sizable lands were they employed other lower caste for cultivation. The absence of a strong Brahmin presence in all villages of the panchayat made the Nayar as the dominant higher caste in the village. Their upper caste culture made them individually self-reliant families with the least dependence on other villagers in their day-to-day life. Such a behaviour is visible in their attitude of reluctance to engage neighbours and villagers in the organization of family functions like marriages. In the ceremonies of upper caste Hindus in the village, the role of relatives, neighbours, and villagers is minimal compared to other lower castes. All decisions relating to the family are taken by the head of the family without much discussion with members outside the family. However, they were not reluctant to the social changes, as they acquired education and modern trends of public life at the earliest compared to other communities in the village. Their comparatively good financial background further facilitated access to all facilities and services necessary for a better life. Even though the dominance of Nayar has declined and some of their traditional resources are alienated in the social changes that happened in the village, it never reached a level to restrict their access to basic necessities of day-to-day life.

As one of the oldest caste groups in the village, it can be observed that Thiyyas have changed a lot in their general outlook on life in the modern line compared to any other caste group in the village. They found some of their old customs increasingly inappropriate and refined it through alternative ways of organizing family life. Unlike upper caste Hindus, the lower caste Thiyyas had not much privileges to give up, which made their transition to new practices on the model of upper castes relatively an easy task. Reform movements that took place among Thiyyas throughout the state under the leadership of Sree Narayana Guru and later under SNDP also influenced the thoughts of Thiyyas even though SNDP does not have any organizational hold in the village. Many of the beliefs and rituals among them got changed in line with the larger

reform movement, which includes bringing Thiyyas festivals in line with the practice of higher caste Hindus and encouraging simple and economical marriage ceremonies. Through ritual ties and the ways of organizing ceremonies, Thiyyas gave greater role and importance to members beyond their close family in their day-to-day life. Rituals and invitation of distant family members, neighbors, and villagers in the functions of birth of a child, marriage, those related to the treatment of illness, and with death among Thiyyas, illustrate how they are social concerns of a group of people and how importantly as a community they are socially connected.

With the aspiration to see their children in government employment, they enthusiastically sent their children into schools, and it further led them to challenge the control and nepotism of upper castes and other dominant religious groups in government employments. They had some resources to take advantage of the socio-economic changes that happened in the village, and they were not restricted by their ritual status or beliefs in entering new arenas of social life. Among them, many developed diversified interests in trade, employment, and land mainly through their growing close connection with the Nayars, Muslims, and Christians. Thus, from an untouchable lower caste status, the Thiyyas in the village now emerged into a ritually respectable community with a hold in almost all spheres of village life.

By the time Muslims come to the village, they were very much in interaction with the dominant Hindu culture in the region, and to an extent they have even assimilated many of its values into their beliefs and culture. It was not much difficult for them to survive and further progress in the village as the majority among them migrated to the village with the hope of a safe life from their difficult living condition in the mainland of Malabar. The well known and better-off among the Muslim community helped large number of community members from different parts of the state to get settled in the village. When the better-off among them helped many to acquire land in the village the well known politician among them helped to start special schools for the community. Similarly through the collective efforts of the community members more facilities like public road, religious places and livelihood opportunities were developed in the village. Their experience in trade and commerce helps them to progress by investing in small-scale businesses in the village, which remained out of the bounds and interests of dominant upper caste Hindus. Compared to any other social group, within a short period, they made substantial progress in economic, social, religious, and political life in the village. In fact, the Muslim lives based on

Islamic belief were less restricted in the village by dominant upper caste Hindus at the same time when the lower caste Hindus were restricted all public resources due to caste restrictions. On the other hand, throughout the period, Muslims lived as an entirely separate religious group with their own beliefs and culture in the village. In the present day, Pozhuthana Muslims hold a dominant religious, social, economic, and political status par with that of upper caste Hindus.

Over the period Muslims as a community brought substantial changes in the economic life of the village, mainly through the affluence of remittance received from emigration. The inflow of remittance from the Gulf boosted the growth and development of local markets, the construction sector, individual private plantations, and other businesses in the village. This, in turn, produced more employment opportunities in the village, not just in agriculture but also in other sectors. In one- or another-way Muslims as a community touched the life of every family from different social groups in the village. Different from the reform process happened among Thiyyas, instead of completely reforming their beliefs based on new values and ideas, Muslims incorporated modern values and ideas into their lives without disturbing their beliefs. The economic progress attained by households and changes in the lifestyle made Muslims to redefine their day-to-day life to showcase their superior religious and economic status. In the new context, with more resources in hand, there is a growing popularity for an Islamic way of life by aligning with the trends and values of modern society.

The lower castes of the village, primarily Pulayas, to a large extend accepted their condition in many aspects of daily life because they had no many alternatives. Without external help, the low castes were unable to make a change in social, economic, political, and religious status. On the other side, the dominant upper castes and other religious groups like Muslims and Christians found less likely in their attempt to make any changes in the life of Pulayas in the village. One can observe an association between the lower caste and their inability to protect old productive resources and inability to gain new resources during the development process. Those who gained from the developmental process through the possession of more productive resources were the upper castes, Thiyyas, Muslims and Christians; they now become the dominant players in the village and also in the position to use the expansion of state infrastructure and services for their desired functioning. On the other hand, for the lower castes like Pulaya, the expansion of state infrastructure had not produced much expected implications.

When the Thiyya community gained substantial progress through close relation with Bitishers while bearing their "untouchables," status in the Hindu caste system, the Pulayas never benefitted. The community remained "polluted" and "slaves" in the eyes of the higher castes, and not allowed entry into the public roads and other public places, hence not able to develop any fruitful contacts with the Britishers. Further among Thiyyas agricultural labour and political organization under communist party was important in bringing about desirable socioeconomic change. Whereas, Pulaya community fails to organize as agricultural labours and least recognized by political parties to support them in achieving a better socioeconomic condition.

We can identify this change has not happened similarly among all Pulayas, but differently among the comparatively poor Pulayas and the comparatively better-off Pulayas. There has been some degree of change in the interaction of higher castes in favour of poor Pulayas, who continue to be only agricultural labourer's and are economically dependent on other social groups. On the other hand, there has been substantial change in the engagements of higher castes in favour of better-off Pulayas who are employed in white-collar occupations and are economically independent. It shows that it would be possible for Pulayas to improve their position in the village and get accepted as social equals by persons from higher castes. But for that, they have to achieve economic independence and accept some of the culture and values of the dominant groups like what Thiyyas did. However, it is difficult to happen such changes without outside help.

The social history of Adivasis in Pozhuthana panchayat depicts the story of alienation of native inhabitance from their land, forest, and other resources. From an Adivasi self-governing kingdom in which their indigenous culture thrives, Adivasis in Pozhuthana now become subjugated from the mainstream public life. They become bonded farm labours, then labourer's in the coffee and tea plantations, and now daily wage labours mainly in agriculture with irregular workdays available. Throughout the period, their positions in the village remained as subjugated and bring little progress through the social, economic, and political changes that happened in the village. At the same time, other social groups who have migrated to the area at different points in time gained substantial new resources in varying degrees. Adivasis as a community was very badly positioned in the village that there was little they could do to take advantage of changes. They are strict in their traditional beliefs, rituals, occupations, folk medicine, and way of living, but at the same time, by maintaining the superiority of their beliefs they also incorporated many

aspects of modern life and dominant upper caste Hindu beliefs to cope with the changing social life in the village. Over the time, as part of the changes that happened in the village when the majority among them lost their old resources, some were able to gain new resources like homestead land, house, literacy, and employment in government service. However, the new resources they gained as a community were not capable of preserving and developing their indigenous knowledge and traditions.

Chapter IV

Wayanad District and Pozhuthana Panchayat: New Resources for All

Geography and ecosystem

The Wayanad plateau is filled with hills and dales situated at a height between 700 meters and 2100 meters above the mean sea level along the Western Ghats on the eastern portion of north Kerala. The total area of the district is 2131 sq. km constituting 5.48 percent of the total geographical area of the state. Forest area in the district constitutes 36.97 percent (787.87 sq. km) and the total urban area is only 1.91 percent (40.74 sq.km). The district came into existence on 1st November 1980 consisting of three Taluks Vythiri, Sulthan Bathery, and Mananthavady. At present Wayanad has 25 grama panchayat and three municipalities in three taluks.

Figure 4.1: Location of district Wayanad in the map of Kerala

Wayanad is primarily an agrarian economy with perennial plantation crops and spices playing a major role. The major plantation crops include coffee, tea, pepper, cardamom, and rubber. Coffee is grown both as a pure crop and as a mixed crop along with pepper. Pepper is grown largely along with coffee in the north-eastern parts of the district. During 2016-17, Coffee in Wayanad (67426 ha.) shares 40.4 percent of the total cropped area of the district, and 79.34 percent of the total area under coffee is produced in the state. Other major crops sharing the cropped areas are Arecanut (7.23 percent), rubber (6.47 percent), pepper (6.33 percent), and coconut (6.18 percent) (ECOSTAT, 2017). During the same period, Paddy is cultivated in 7822

hectares of land, which is 4.68 percent of the total cropped area in the district and 4.56 percent of the total paddy area cultivated in the state[18].

While comparing with 1975-76, the area of paddy cultivation has decreased 80.43 percent in the state by 2016-17. Wayanad district also witnessed the reduction of paddy fields, over time most of the paddy fields in the district are filled with plantations of various kinds. While there were 30,000 hectares of paddy fields in the district in 1980, it has shrunk by more than 76 percent to 7822 hectares during 2016-17. During 2016-17 the area under nonfood crop production is 60.63 percent, and in the remaining 39.36 percent of food crop producing area around 18 percent is covered by spices and condiments[19]. In the present days, homestead farming assumes importance in this district and the average size of land holdings is 0.68 hectares. A variety of crops including annuals and perennials are grown in these smallholdings (ECOSTAT, 2017).

Almost the entire Wayanad district is drained by the Kabani river, an important tributary of the Kaveri river, and its three main tributaries viz. Panamaram, Mananthawady, and Tirunelli river. There are no major irrigation projects in the district but have two medium irrigation projects viz. Banasurasagar multipurpose project and Karapuzha irrigation project. Apart from this, there are several tanks and ponds, minor irrigation projects, and lift irrigation projects in the district. Wayanad experiences a salubrious climate with a mean rainfall of 2786 mm. Lakkidi, Vythiri, and Meppady are the high rainfall experiencing areas. It is seen that southern, southwestern, and northeastern areas of the district receive more than double rainfall compared to eastern and northeastern areas bordering with Karnataka district.

As Wayanad is part of the Western Ghats, it comes under one of the UNESCO World Heritage Site, and one of the eight "hottest hot-spots" of biological diversity in the world (UNESCO 2012). Wayanad is now prone to natural calamities in the form of large-scale landslides, landslips and floods. The Western Ghats Ecology Expert Panel (WGEEP) which studied the environmental situation of Western Ghats has categorized all three taluks in Wayanad as regions of highest sensitivity or Ecologically Sensitive Zone 1 (ESZ1) (Gadgil et al. 2011). During the

[18] Figures ccalculated from data available in the report on Agricultural Statistics 2016-17 published by Department of Economics & Statistics, Kerala, Thiruvananthapuram, December 2017

[19] Figures ccalculated from data available in the report on Agricultural Statistics 2016-17 published by Department of Economics & Statistics, Kerala, Thiruvananthapuram, December 2017

colonial period itself and even after independence, forest land in Wayanad has been violently appropriated for intensive cash-cropping. For example, from the 1960s onwards a three-decade-long commercial supply of bamboo to the Gwalior Rayons factory in Kozhikode for the production of pulp and fiber had led to a greater depletion of bamboo forests of Wayanad (Shaji 2019). Over the period as a result of changes in agriculture, the plantations, and the settler cash-crop farmers followed environmentally destructive intensive commercial farming processes in the district and transformed the land into a commodity (Münster and Münster 2012). When agrarian capitalism reached its ecological limits and entered a crisis of accumulation, nature and wildlife tourism appears as a new possibility for accumulation. A study in the aspects of environmental anthropology found that nature tourism is turning a severe challenge not just to the biodiversity and wildlife of Wayanad but also to the indigenous communities (Münster and Münster 2012). Now tourism in the region is leading to the commodification of nature and culture for middle-class consumption. Besides, the extensive use of chemical fertilizers and pesticides in the plantations and farms has resulted in irreversible harm to Wayanad's fragile ecosystem, which in turn results in many issues like health issues due to pollution of water bodies, soil, and air.

Demography: over time and in the present

Wayanad has been called as tribal land, Narayanan (1995) infers that the indigenous people are the original inhabitants of Wayanad and the first in-migration to this region might have occurred in pre-historic times. Though the Adivasis are mainly concentrated in the Wayanad district they were linked to their kinsmen in the nearby districts like Kozhikode. To the early 15th century, this land was ruled by the Rajas of the Veda tribe as a tribal self-governing kingdom. In the medieval period, the Vedar king of Wayanad was defeated by the Malabar Kshatriya Rajas of the Kottayam Kurumbarnad principalities. This paved way for a long period of feudal rule of Wayanad by the upper caste Nayar gentry of Malabar. Under feudal administration, the entire land was the property of the King and the Janmis such as the Nayars. Below that the cultivators were tenants of Janmmis, and the Adivasis were bonded labour under various ownership categories (Munster and Vishnudas 2012). Through the invasion of the region by Tipu Sultan leads to a brief rule of the region by the Mysore regime from 1766 to 1792. The Mysore regime focused on extracting large revenues from the lands, and therefore they made ties with Muslims

and other lower caste peasants who were the real cultivators. Even though the Muslim population was there in Wayanad from the 16th century itself (Johnny 2001) immigration of the Muslim population accelerated during the Mysore regime. During the period they came mostly as timber traders and contractors and acquired large tracts of land from the landlords, a large extent of forests was even mortgaged to them by the landlords. This disturbed the access to and control over both agriculture and forest lands by the indigenous communities (Varghese 1970 cited in Kjosavik & Shanmugaratnam 2007).

The Rajas and other Janmmis[20] of Malabar were in the habit of renting out their lands on lease for a long term period to an inferior. There were influential families of Muslims who had taken large tract of land on lease from the Namboothiris and Nayars. Earlier the Muslim traders had to give some rent to the Janmmis who kept control over the land. However gradually royal families lost control over these areas and it had become the property of local Muslim traders. This in turn lead many of such families to settle down in these areas. In about the 1950s, under government regulation, Muslim traders could no longer hold large tract of land under them. They eventually sold patches of land to other non-tribal settlers from mid-Travancore and southern areas of the state. These immigrant settlers were mainly Christians, Muslims, and Thiyya communities who were better equipped than Adivasis in cultivation as well as in managing market. At the same time, Adivasi families were mainly controlled by the Nayar landlords. They were attached to the houses (Idam) or temple property (Devaswam) of the landlords. From the landlords, they had been hired by the settlers like Chettiyars, normally for a year to work in the agricultural field.

By the early 20th century Wayanad witnessed an onslaught of peasant immigrants from the south Travancore region mainly by the Christians and Thiyyas. During the time of the Second World War, due to food shortage Wayanad and for that matter the whole Malabar witnessed a further large inflow of immigrants. The immigrants were farming communities. Then the prevailing tenurial system in the Wayanad helped the immigrants to take possession of a large tract of land

[20] Historians differ widely over the transfer of land from the original owners to the Brahmin Janmmis. Namboothiri Brahmins who came to acquire the status of wealthy and powerful landlords are called Janmis. Such a state of affairs prevailed in Kerala even in the beginning of the 19th century when the British had begun to establish their political authority over the land (Prakash, 1984).

and bring it under intensive cultivation of cash crops. The settlers had emigrated to Wayanad as agricultural labourers or people who could purchase land from the Janmmis and with an aspiration to improve the quality of their life (Krishnan 2006). This had changed the lifestyle and livelihood of native Adivasis. The Adivasis become daily wage labourers when the demand for labour increases in turn with the intensive agricultural plantations by the immigrants. The fast-growing agricultural production specifically cash crop production naturally leads to the emergence of small towns and markets in interior villages (Kulirani 1996). In sum the traditional farming communities and Adivasis become landless agricultural labourers under the settlers, living in overcrowded colonies (Prasad and IIM cited in Munster and Vishnudas 2012).

Table 4.1 Demographic characteristics of Wayanad district and Pozhuthana Panchayat- 2011

		Kerala State	Wayanad District	Percent of state	Pozhuthana Panchayat	Percent of district
Number of villages	Total	1018	48	4.72	17	35.41
	Inhabited	1017	48	4.72	17	35.41
	Un-inhabited	1	0	0.00	0.00	0.00
Number of households	Normal	7,835,517	190,263	2.43	4255	2.24
	Institutional	12,478	483	3.87	-	-
	Houseless	5,759	148	2.57	-	-
Population	Hindu	14758080	220439	1.49	4200	1.91
	Muslim	8,873,472	234185	2.64	6822	2.91
	Christian	6,141,269	174453	2.84	2900	1.66
	SC	3039573	32578	1.07	1220	3.74
	ST	484839	151443	31.24	3262	2.15
	Total	33,406,061	817,420	2.45	18404	2.25
	Rural	17,471,135	785,840	4.50	18404	2.25
	Urban	15,934,926	31,580	0.20	0	0.00
Sex Ratio	Total	1084	1035	-	1067	-
	Rural	1078	1034	-	-	-
	Urban	1091	1051	-	-	-
Literacy rate	Persons	93.91	89.03	-	86.32	-
	Males	96.02	92.51	-	90.76	-
	Females	91.98	85.70	-	82.29	-

Source: Census of India 2011, District Census Handbook Wayanad

According to 2011 census, out of the total inhabited villages in the state, 4.72 percent are in the Wayanad district. The Wayanad district has 48 inhabited villages, of which seventeen villages are in Pozhuthana panchayat. Among the total households of around seventy-eight lakh in the

state, 2.43 percent are in the Wayanad district. Wayanad district also has 3.87 percent of institutional households and 2.57 percent of houseless households in the state. As given in table 4.1, during 2011, Wayanad district have a population of around eighty-one lakh which accounts to 2.45 percent of the population of Kerala state. During the period Pozhuthana panchayat recorded a population of around eighteen thousand which accounts for 2.25 percent of the population of Wayanad district.

The growth rate of population in Wayanad during 2001-2011 shows that it is slightly behind the state average (4.91 in Kerala and 4.71 in Wayanad), but in the case of female population growth rate, it stands little higher than the state average (6.14 in Kerala and 6.78 in Wayanad). In the total population of the state, ST constitutes only 1.45 percent, however little less than one-third of the total ST population in the state is inhabited in the Wayanad district alone. As already shown in table 2.1 scheduled tribes and scheduled castes constitute 18.5 percent and 3.98 percent respectively to the total population of the district. It is important to keep in mind that tribes were the native inhabitants of this district and migration of others to this area on a large scale is a recent phenomenon that happened in the last century. During 2011, in the total population of the district Muslims constitute 28.64 percent, Christians constitute 21.34 percent, and Hindus excluding SC and ST constitute 26.96 percent. However, concerning their total population in the state, their share in the district is 2.64 percent among Muslims, 2.84 percent among Christians, and 1.49 percent among Hindus.

While the population of Wayanad predominantly lives in rural area, the whole Pozhuthana panchayat comes under the rural area. When 47.7 percent of the population in Kerala lives in the Urban area, only 3.86 percent of the population in Wayanad lives in urban areas. In the case of sex ratio, Wayanad district records a sex ratio of 1035 which is less than the state level sex ratio of 1084. However, the village Pozhuthana recorded a sex ratio of 1067 which is higher than the district average. Concerning literacy rate, the district Wayanad and Pozhuthana Panchayat lag well behind the state-level rates. When the state records a literacy rate of 93.91, the district Wayanad and Pozhuthana panchayat recorded 89.03 and 86.32 respectively. The lowest literacy rate among Adivasis and Dalits is one of the majorcontributors to the lower literacy rate of the panchayat and district.

Economy and livelihoods

The economy of the district is mainly dependent on agriculture, in fact Wayanad is known as the land of paddy fields. A more organized form of agriculture with better farming skills started in Wayanad during the medieval period when the region comes under the control of the Kings of Malabar. Through the migration of farming communities from the rest of Kerala and Mysore in the early centuries of medieval period gave momentum to the development of agriculture in the region, but it also paved way for the subjugation of indigenous communities in the region. By the early decades of the 19th century itself British had identified Wayanad as a suitable area for plantation. Coffee was the first crop planted in Wayanad near Manathavady between 1830 and 1840, then onwards a variety of cash crops being grown. Plantation agriculture had led to changes in the traditional economy, and the fast-growing cash crop production leads to the emergence of small markets in interior villages (Kulirani 2003).

By the early 20th century Wayanad witnessed a rapid in-migration of farming communities from Travancore, and they acquired large tracts of land and brought them under intensive cultivation of cash crops. The emergence of market-based economies in the villages created huge difficulties in the lives of indigenous communities and they were forced to depend on such markets for their day-to-day needs through a process of commoditization and commercialization of their natural resources which they could harness for free hitherto. In other words, the native indigenous communities become landless agricultural labourers under the newly migrated settlers (Munster & Vishnudas, 2012). However, the settlers, mainly Muslims, Christians and Thiyyas were able to take advantage by becoming cultivators, by engaging in the timber trade, and by engaging in daily wage labour when demand for labour increased with the development of a market economy. Even today, hill produce and agriculture produce are the main commodities of trade in the district. The district is industrially backward, but it had Medium Scale Units like Tea / Coffee Processing Units, timber mills, and traditional industry of handicrafts. During 2011, only 1.28 percent of rural households from the Wayanad district earned their income from non-agricultural own account enterprises compared to the state level estimation of 2.1 percent. Similarly, only nine percent of rural households in the district have income from a salaried job, compared to around 14 percent in the state. However, when around ten percent of rural households in the state earn their main source of income from cultivation, in the Wayanad district more than 22 percent

of households earn their main income from cultivation. Similarly, when around fifty percent of rural households in the state earn their main income from manual casual labour, it is 60 percent in the Wayanad district. As this is the case, return from agriculture and manual casual labour shows the financial constraints faced by a large section of households in the district. It is found that the number of households having monthly income of highest earning household member less than Rs.5,000 is around 80 percent in Wayanad compared to around 70 percent in the state.

In the case of Pozhuthana panchayat, in determining better-off and comparatively poor households important parameter is income from employment. Over the period occupational diversification has happened among all social groups in the village, but still, livelihood opportunities available to certain social groups are limited. If we consider the primary occupation of the household as the one through which greater needs of the households are met, we can see the existence of occupational diversification among all social groups through their engagement in different occupations as shown in table 4.2. Data from household level survey among different social groups is presented in table 4.2. Table shows that even though occupational diversification and mobility have happened among all social groups, within comparatively poor households agriculture labor and other daily wage labor remain the major source of income, with greater concentration among Dalits and Adivasis. Among the households of better-off, their primary source of income is mainly from government employment, Gulf emigration, and self-employment. Except for Adivasis, more than fifty percent of better-off households from all other social groups earn their primary income from these occupations.

The data also shows that, Adivasis, the native inhabitants who once cultivated freely in the lands of the village now mainly engaged as agricultural labourers and as other daily wage labours. For the majority of better-off and comparatively poor households among them, agricultural labour and daily wage labour is the major occupation. Among the selected Adivasi households of better-off and comparatively poor, not a single household receives enough income from own farming to consider farming as a primary occupation. However, a large number of them are engaged in own farming (see table A1 in annexure). The case of Dalits, who were the agricultural labours of landlords in the past, is also similar. About 40 percent of comparatively poor households among them earn their primary income from agricultural labouring. About 60 percent of poor and 33.3 percent of better-off households among them earn their main income from daily wage labour

other than the agricultural sector. In sum, the occupational mobility they gained in the village is mainly a movement from agricultural labour to labouring in sectors other than agriculture like construction.

Table 4.2 Primary occupation of sample households from different social groups in Pozhuthana

		Primary occupation of households						
Social Groups	Hamlets	Salaried employment/ Gulf emigrant	Self-employment	Plantation worker	Farmer	Agricultural labour	Daily wage labour	Total
SC	Better off	4 (26.7)	4 (26.7)	0 (.0)	1 (6.7)	1 (6.7)	5 (33.3)	15
	Comparatively Poor	0 (.0)	0 (.0)	0 (.0)	0 (.0)	6 (40)	9 (60)	15
ST	Better off	3 (20)	1 (6.7)	0 (.0)	0 (.0)	6 (40)	5 (33.3)	15
	Comparatively Poor	0(.0)	0 (.0)	0 (.0)	0 (.0)	10 (66.7)	5 (33.3)	15
Thiyya	Better off	6 (40)	5 (33.3)	2 (13.3)	2 (13.3)	0 (.0)	0 (.0)	15
	Comparatively Poor	1 (6.7)	1 (6.7)	0 (.0)	1 (6.7)	2 (13.3)	10 (66.7)	15
Upper caste Hindu	Better off	7 (46.7)	5 (33.3)	0 (.0)	3 (20)	0 (.0)	0 (.0)	15
	Comparatively Poor	5 (33.3)	2 (13.3)	0 (.0)	0 (.0)	0 (.0)	8 (53.3)	15
Muslim	Better off	8 (53.3)	5 (33.3)	0 (.0)	2 (13.3)	0 (.0)	0 (.0)	15
	Comparatively Poor	0 (.0)	0 (.0)	2 (13.3)	1 (6.7)	4 (26.7)	8 (53.3)	15
Total	Better off	28 (37.3)	20 (26.7)	2 (2.7)	8 (10.7)	7 (9.3)	10 (13.3)	75
	Comparatively Poor	6 (8.0)	3 (4.0)	2 (2.7)	2 (2.7)	22(29.3)	40 (53.3)	75

Source: field survey

For largest share of better-off households of Thiyya, upper-caste Hindu, and Muslim, the primary family occupations are salaried employment, Gulf emigration, and self-employment. Around 40 percent of Thiyya, around 47 percent of upper-caste Hindu, and 53 percent of Muslims of better-off households have salaried employment or remittance from Gulf emigration as the primary source of income. Besides, around 33 percent of better-off households each from Thiyyas, upper-caste Hindu, and Muslim households have self-employment as a primary occupation. The share

of salaried employment and Gulf emigrants among Adivasi and Dalit households is minimal. Salaried employment especially in the government sector is highest among upper-caste Hindus, and Gulf emigration is highest among Muslims compared to other social groups. In the case of Dalits and Adivasis, the share of agriculture labour and daily wage labour is the highest. In the case of Thiyya households, even though a comparatively good share among them earns their primary income from agricultural labour and daily wage labour, they also have a good share of households engaged in salaried employment or Gulf emigration, self-employment, plantation work, and farming to meet a major part of their household financial needs.

Even within the category 'daily wage labouring other than agriculture', a large share of Adivasis and Dalits work as unskilled or semi-skilled helpers, the skilled workers are mainly from Muslims and Thiyya community. When the skilled workers get a daily wage between Rs.700 to Rs.900 depending upon the occupation (for example a painter gets a daily wage of Rs.700 and a construction worker gets Rs.900 per day) the helper gets a wage of 500 per day. The workdays available to these helpers also matter in comparison to skilled workers. The demand for helper men from Dalits and especially from Adivasis remains low as women from Dalits, Adivasis and Thiyyas also engage in such works. In recent years, the number of workers who migrated from other states is also largely engaged as helpers in almost all sectors of daily wage labor in the village, leading to a reduction in workdays for native unskilled workers.

The household survey shows that permanent work in the plantation is the major source of income for 2 households of better of Thiyyas and another 2 households of comparatively poor Muslims. Here households with plantation work as a major source of income come under the better-off category among Thiyyas, among Muslims, they come under comparatively poor households. This shows the greater economic difference within better-off households among Muslims than the Thiyyas in the village. The other primary occupation of households is own farming, in which better-off households of Thiyyas, upper-caste Hindus, and Muslims have greater hold than any other socioeconomic group.

Even though own farming as primary occupation is low among Adivasis and Dalits, a large share of land-owning among them are engaged in own farming, but which yields a return much less than their subsistence level. Detailed tabulation of survey data on occupations in which members of households from each social group engaged are given in annexure as table A1 and A2. This

shows that 47.5 percent of Adivasi and 24.6 percent of Dalit among land-owning households are engaged in own farming[21]. Besides, when occupational mobility was limited up to labouring in sectors other than agriculture to Adivasis and Dalits; in the case of Muslims and Thiyyas they were able to have a stronger hold in other occupations too. About 18.21 percent Muslims and 4.9 percent Thiyyas have Gulf emigrants; about 1.8 percent Muslims and 8.2 percent Thiyyas have government or salaried employment; and about 13.1 percent of Thiyyas and 10.9 percent of Muslims have self-employment. Further better-off households from these three social groups have higher Govt/salaried employees, Gulf emigrants, and self-employees (see table A2 in annexure).

Use of natural Resources

The most important natural resources which have made a substantial influence on the socioeconomic and political development in the district and the Pozhuthana village over the period include forest, river, other water bodies, and land. The knowledge about the extent of the natural resource base and local perceptions of various social groups on natural resources is important. Different social groups differently perceive or utilize these resources available in the district and the village. For example, in the past the public lands like roads public water bodies like ponds in the village were not freely accessible to the lower castes, as there was always the fear of causing pollution to higher caste people. Not just natural resources but the roads, temples, public ponds, main markets, education, occupations other than laboring all are restricted for them until the beginning of the last century. However, the situation has changed, and many such earlier restricted resources are now freely available to all, but above mere assurance of access, still different social groups were not able to effectively use such resources to improve their capabilities. In this section, natural resources found in the district and village are discussed based on how they have been used and valued by various social groups from time to time.

Forest

In terms of the percentage of forest cover in the total geographical area, Wayanad has the highest forest cover of 83.3 percent during 2011 in the state (KSCSTE 2020). Even though there was a

[21] Sum of own farming, 'agricultural labor and own farming' and 'daily wage labor and own farming'.

reduction in the forest cover during 2019 compared to the 2011 assessment, forest cover in Wayanad remains the highest in the state. In the case of Pozhuthana panchayat also more than half of its total area (53 percent) is covered by forest. Tribes in the district, from time immemorial, had an integral relationship with the forest and have been dependent on the forest for livelihood. Even today some of the Adivasi households mainly from *Katunayakar* live in the borders of the forest. Over the period with changes in the socio-political structure of the society, the customary rights of Adivasis for living, possessing, and earning livelihood from the forests got questioned. Their rights, especially their right to livelihoods got questioned during the early 19th century itself when the area comes under the rule of the colonial regime. This injustice continued even after the independence in the name of conservation and protection of forests. Through legislative methods like the relatively recent Indian Forest Rights Act, 2006, there are attempts in granting legal entitlement, empowerment, and improvement of livelihood, but due to impediments in the implementation, such attempts become inadequate in addressing the rights of the Adivasis (Mathew and Umesh 2019). Only a few Adivasis are now occasionally engaged in collecting minor forest products for their livelihood in Pozhuthana panchayat. In addition to the reasons mentioned, reduction in the availability of minor forest products, attacks from wild animals, low return from the sale of minor forest products is the reasons which alienate Adivasis from their old livelihood. However, over the period many other communities were able to make economic benefit out of forest resources. The Muslims and upper-caste Hindus along with the British were the groups who gained much wealth through timber trading. During the early decades of the twentieth century itself, there were some landlords and businessmen among Muslims in the village who were mainly engaged in the timber trade. Even though there is no large-scale timber trade in the Pozhuthana village at present, in the past two such timber trading sites in the forests of the village were large enough to be locally well known.

When the forests become managed largely on commercial lines mainly through timber trade and plantation, the customary community rights of the Adivasis to the forest started disrupted. As they continue losing their livelihood from the forest, they were forced to look for other livelihood opportunities outside the forest. Which made them dependent on other powerful social groups in managing their life and livelihood, like dependence on wage labor in the timber trade of Muslims and dependence on the agriculture labor in the fields of *Janmmis*.

River and other water bodies

Kabani River, one of the three east flowing rivers of Kerala, and its tributaries constitute a powerful river system in the landscape of Wayanad. People from the district depend on the river for different purposes, it mainly includes household uses like washing and bathing, for irrigation, fishing, tourism, and also used by small and household industries. Further, the rivers within the district are also used for the floating of timber, more extensively used during the colonial period for the timber trade. In addition to the benefits it serves, during monsoon season the rivers of Wayanad become flooded suddenly. This creates difficulties for the people who live near the river. The Pozhuthana River which flows through the mainland of the Pozhuthana panchayat from south to north finally flows into the Kabani river. The villages in Pozhuthana are mostly drained by this river and the streamlets draining into it. People who live near the river mainly depend on the river water for washing, bathing, and other household needs. They are mainly from Dalits and Adivasis and a few from Muslims and Thiyya who does not have any other arrangements for water. Interestingly it is also found that none from the upper caste Hindu usesriver water for household uses and only a few from comparatively poor Thiyya and Muslims use river water. However, in the case of Dalits and Adivasis, all those who reside near to river depend on it for all their household uses except for drinking. When the river is the unavoidable resource for the household water needs of many, better-off households especially upper-caste Hindus believe that the use of river water will lead to health hazards. Some of them opined that the river water is highly polluted due to the use of chemical spraying in the coffee plantations which is surrounded to the river. While it rains in the area, the chemical sprayed in the plantation travels through the rainwater and the river is getting contaminated. On the other hand, illegal waste dumping and the lack of initiatives to protect the riverbanks aggravate the condition of the river. Interestingly most of those who raised the criticisms are those who are not using river water for any needs and comparatively better-off who have another source of water.

Until recently for some Adivasis and Dalits in Wayanad fishing from the river was a major livelihood option. However, at present very small number of them from the district, and no one from Pozhuthana is engaged in fishing as a full-time livelihood, instead occasionally more people are engaged in fishing in the district. In that sense inland fishing is an occasional source of income for some. An estimation shows that there are only 295 fishermen engaged in inland

fishing in the district during 2007 (Census of India 2011b). The vast reduction in fish availability due to contamination of water is the reason which makes fishing uneconomical and less preferable for people from Pozhuthana. Almost all agricultural land near to river and plantation in the panchayat uses river water for irrigation. While the small farmers near the river use motor pumps to water their agricultural land, the plantation uses water tankers to fetch water into the plantation which is spread out on the panchayat land. The cement brick-making household industry and the coffee plantations uses river water for their business in the panchayat. River rafting with the traditional bamboo raft is one of the attractions for tourists coming to the village. There are few yound men in the village from the Muslim community who finds their income from this. As a livelihood option, earlier some of the Dalits and Adivasis were able to utilize the river by engaging in fishing, but in the present day, they were unable to earn anything from the river. However, people from other communities were able to take economic advantage from the river, like bamboo rafting and the use of river water for household industries.

The other important water bodies in the district include natural lakes, ponds, small natural ditches, streams leading to the river. These were extensively used by households for their day-to-day needs in the past, but now many households are able to have own arrangements within their premises. However, even now for a large number of families living on the hillside small natural ditches in the hilltops is the major source of drinking water. In Pozhuthana panchayat , it is found that the majority of poor with some resources managed to get drinking water in their premises through self-managed pipelines connected to these ditches in the hilltop. Few households of Adivasis who cannot afford the plastic hose fetch water from these ditches/streams generally 1 to 2km away. As this is still a major source of drinking water for many households, still no intervention is taken by the local authority to recognize it and takes preventive measures to avoid contamination. Irrespective of social groups all those who live on the hillside and do not have resources to have own wells, depend on such natural ditches. However, it is also important to note that only a few households of upper-caste Hindus and better-off Muslims live on the hillside. Overall households from Adivasi communities have preponderance towards the use of drinking water from the natural ditches compared to others living near the hillside.

Land

Ownership of land is not only concerned with securing a livelihood for the people, the history of land ownership in the district has led to create and maintain social hierarchy among people in the district. For example, the whole land of Wayanad was owned by the Adivasis at the time when it was a tribal self-governing kingdom, then it comes under the upper caste Hindu king who ruled the princely state, later went into the hands of rulers from Mysore, and then into the hands of colonial rulers. Until the state formation and even after that under different rulers, the lands in Wayanad had been inequitably distributed among various social groups. Those who are socioeconomically, politically, and religiously powerful owned and retained large tracts of land, and the possession of the land, in turn, helped in retaining their higher socioeconomic and religious status in the district. The lands on two sides of the main road are the plain land in Pozhuthana and moving away from the main road hilly terrain begins. Among the households who reside in these plain lands, only a small number are from households of Adivasis and Dalits. Majority of those Dalits and Adivasi households who lives in the plain lands are the one who obtained land through encroachment and later the government granted possession grants. Another group of tribal people living in the plain area is those who live in congested colonies and government-built colonies for the Adivasis. The majority of the Adivasis and some of the Dalits from the panchayat are living on the hillside. The other communities which have many households living on the hillside are the comparatively poor from Thiyya, Muslims, and Christians. Muslims are the highest in the *Settu hills*, which was the area earlier a Muslim chieftain distributed to labourers at a low price. Adivasis are high in *Kurichyarmala*, a hilly terrain on the border of the forest. Even though the majority of upper-caste Hindus lives in the plain terrain of the village, few houses of comparatively poor upper-caste *Nayar* are found in the hillside. In the plain lands of the village upper caste Hindus and Muslims have large tracts of land along with other social groups.

The households from upper-caste Hindus and Muslims are the communities that hold large tracts of land in the village. In addition to agriculture, especially Muslims build buildings in their lands and give for rent in the local market. They were able to make revenue from the land through agriculture and business. Land use practice of individuals from different social groups reflects the choices they make to adjust to the diversity of constraints and opportunities they experience.

The case of Adivasis and Dalits shows that mere possession or even ownership of land is not enough to make revenue out of it, many other societal factors along with public policies, their financial stability are important. The Adivasis who have large tracts of land were given *kaivasha Rekha* which in effect were just a possession certificate. In a sense what they get is not land but it is the possession, certain rights, and privileges to the individuals who are living in a particular land. They cannot sell the land, cannot cut trees in the land but can cultivate, dig well, built a house, and take revenue from the land. This has similarities with the old land tenure system under the caste-*Janmis*-ruling authority. Thus, it will be untrue to say that Adivasis are the real owners of the land with full rights.

For those who had land without full rights, all one could do was live on it cultivate on it, it had no monetary value to the land in which they live and cultivate. Even they were not eligible to get loans from banks on the guarantee of the land in their possession. However, on the other side majority of such lands are not feasible for agriculture due to low fertility, non-availability of irrigation facility and its proximity to forest make them vulnerable to attacks from wild animals. Some respondents also indicated that due to a lack of institutional support mechanisms to improve agriculture, to adjust to the situation, the farmers often avoid growing food crops, and plant perennial plants like coffee. In the case of Dalits, very few among them have additional land than a small piece of homestead land. As they do not have agricultural land most of them live in SC colonies with a small piece of homestead land, they do not get any return from land in their possession. Different from Adivasis most Dalits have a title deed for their homested land but still due to poor repaying capacity they do not get a loan from the bank. Besides, the labeling of the land as SC colony lead to low price for land at the sale. This shows that mere possession of land does not guarantee money value or profitable return from it, the socioeconomic, religious, and ethnic characteristics of the owners matter a lot.

Financial situation

As Wayanad is mainly a rural agrarian economy, the financial status of the district and the majority of its people are closely related to land, agriculture and forest resources. The changes in the land, agrarian relation and utilization of nature and forest resources in the district had a far-reaching impact on various social groups. Over the period in Wayanad, changes in agriculture lead to intensive commercial farming focused on cash crops and plantation, and changes in

market based forest conservation led to commodification of nature and forest resources for truism. At the time when it was tribal self-governing land, Adivasis enjoyed substantial independence in meeting their basic needs as they freely cultivated in the land and utilized the forest and other natural resources without many restrictions. Over the period when more commoditized market economy evolved Adivasis struggled to meet their basic needs which were earlier fulfilled by them. From a land and natural resource-based livelihood they were forced to follow a market-based livelihood. However, by the time when the area comes under the rule of Kottayam Raja the upper caste Hindus controlled the economy, and at the time of the Mysore's invasion, many Muslims were also able to take advantage.

During the colonial period and after the state formation, the socioeconomically powerful communities were able to maintain financial status but the lower castes and Adivasis failed to catch up. The data from SECC of 2011 reiterates this lower financial condition of Adivasis and lower castes in the district. During 2011, the percent of Adivasi households in the district who earn their main income from cultivation is 7.65 percent, and households earn their income from manual casual labour is 87.47 percent. In the case of Dalits and others, the share of cultivators is 6.7 percent and 27.05 percent, and the share of manual casual laborers is 81.76 percent and 52.78 percent respectively. This clearly shows how the Adivasis who freely cultivated the lands in the district have now mainly become manual casual labours. Further, the percent of Adivasi households with a monthly income of highest-earning member is less than five thousand is 94.58 percent compared to 88.89 percent among Dalits and 75.62 percent among others. In the case of households with the salaried job, when only 4.22 percent of households among Adivasis have a salaried job, among Dalits it is 9.55 percent and among others, it is 10.61 percent. In a market economy having financial stability especially through a permanent nature of salaried employment is crucial in maintaining the wellbeing of households. Here Adivasi community was forced to live in a market based economy with highest number of households having lowest monthly income and lowest share in salaried employment.

In Pozhuthana panchayat, one of the important indicators which shapes the class distinction among households across all social groups and within each social group is the size of land holding. Out of the 150 households interviewed except four comparatively poor households (one Dalit, two Adivasi, and one Muslim), all others have at least some land (see table A3 in

annexure). Even though almost all households have land, the majority, especially comparatively poor households only have a piece of homestead land. Except for Adivasi, only 3 comparatively poor households possess more than 0.5 acres of land (see table 4.3). This can be seen in table A3, that 52.1 percent of households from comparatively poor and 26.7 percent of better-off only have homestead land. In the case of better-off 73.3 percent of households have homestead land and other land.

As given in table 4.3, in the case of Adivasis, six households of poor and better-off have more than 0.5 acres of land. Even after 12 Adivasi households have more than 0.5 acres of land, only 5 have reported that own-farming gave a return more than the investment. Out of the total Adivasi households who do own farming majority reported their investment and return from land is breakeven. At the same time, 4 comparatively poor households among them reported a loss from own cultivation.

Table 4.3 Area of land owned by households and return from agriculture in Pozhuthana Panchayat

	Social groups:	Dalit				Adivasi				Thiyya				Upper caste Hindu				Muslim			
	Hamlets:	Better off		Comparatively Poor		Better off		Comparatively Poor		Better off		Comparatively Poor		Better off		Comparatively Poor		Better off		Comparatively Poor	
Area of land	<0.5 acre	12	(80)	15	100)	9	(60)	7	(54)	8	(53)	13	(87)	6	(40)	14	(93)	9	(60)	15	(100)
	0.5 to 1 acre	3	(20)	0	(.0)	3	(20)	1	(8)	5	(33)	0	(.0)	6	(40)	1	(6.7)	4	(27)	0	(.0)
	> 1 acre	0	(.0)	0	(.0)	3	(20)	5	(38)	2	(13)	2	(13)	3	(20)	0	(.0)	2	(13)	0	(.0)
Return from land	More than the investment	5	(50)	3	(43)	5	(38)	0	(.0)	3	(30)	2	(33)	9	(75)	3	(33)	6	(60)	2	(50)
	Breaks even	2	(20)	4	(57)	8	(62)	7	(64)	1	(10)	1	(17)	2	(17)	2	(22)	2	(20)	2	(50)
	incur loss	0	(.0)	0	(.0)	0	(.0)	4	(36)	1	(10)	2	(33)	0	(.0)	0	(.0)	0	(.0)	0	(.0)
	No investment	3	(30)	0	(.0)	0	(.0)	0	(.0)	5	(50)	1	(16)	1	(8.3)	4	(44)	2	(20)	0	(.0)

Even after having land for many Adivasi households the low earning from farming is attributed to many reasons. These are the land that the state government allotted to the Adivasi households at different points in time. These lands are less suitable to cultivate rice, vegetables, or any other cultivation which they traditionally practiced. The majority of the land which Adivasis got was land suitable for cultivating cash crops like tea, coffee, and pepper which they never cultivated earlier and to which they have the least resources to engage. Some of the households got such

lands in which already coffee is planted, but with the least resources in hand these households were unable to gain revenue out of it. In *Suganthagiri* and *Kurichyarmala* where the largest number of Adivasis got land are close to the forest and continuously face the attack of wild animal on crops. The attack of wild animals along with the lack of any irrigation facility restricts many in doing cultivation. Thus, as seen in table 4.3 even if they have found some resources to cultivate any vegetables or crops in such land, the return they received are less than their investment and less than enough to support their family.

We have already seen that number of households who have the primary occupation of own farming to meet their majority of needs is few. Further such households are mainly from the better-off class. Similar to that table 4.3 shows that out of the total cultivating households those who gain more than their investment are mainly from the better-off category. The table also shows that out of the total cultivating households who reported breakeven or loss is mainly from comparatively poor households. This should be understood in the context of homestead farming which has more popularity in the village. As we have already seen it is only the piece of homestead land that the majority of households own. A variety of crops including annual and perennial are grown in these smallholdings surrounding their houses. In many houses in the village, we can see such cultivation of coffee and pepper. In such crops, the least amount is spent throughout the year and it gives an income once a year. The major investment in such cultivation is mainly the labor of family members which is not accounted for. Thus, the return receives once a year is treated as more than the investment or as breakeven. In sum, those who were able to make good revenue from the land through cultivation in the village are mainly better-off communities. The mere availability of land to the Adivasi community does not empower them to substantially gain through own cultivation to meet their household needs. Further none among the Adivasis and Dalits reported no-investment in their land. It is mainly better-off households among other three communities who left their land uncultivated or without any investment on it.

One another important indicator used to understand class differences among social groups in the Pozhuthana is the financial condition of the household in relation to their livelihood. It gives a clear picture of the financial condition of different social groups and class groups within them. It is tried to understand by asking the question of whether their primary livelihood is capable of meeting the majority of their household needs. Besides, details about whether the household

borrowed cash during the last year to meet household needs are also gathered. Table 4.4 shows that to the question of whether the primary means of livelihood meets the majority of household needs, all households from the better-off class of Thiyya, upper-caste Hindu and Muslim reported that they were able to meet the majority of their household needs. In the case of better-off among Dalits and Adivasis, 80 percent of households also reported that they were able to meet their majority of household needs through primary livelihood. The case of comparatively poor among Thiyya, upper-caste Hindu and Muslims are not too different, the majority from them have reported they were able to manage most of their household needs with the primary livelihood. While majority of comparatively poor households among Dalits and Adivasis reported they were not able to manage most of their household needs with primary livelihood. In case of comparatively poor Dalits when more than half (53.3 percent) reported breakeven, majority (73.3) among Adivasis reported not able to meet majority of household needs.

Table 4.4 Financial condition of sample households among different social groups

		Dalits		Adivasi		Thiyya		Upper caste Hindu		Muslim	
		Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Primary livelihood meets majority of needs	Yes	12(80.0)	6 (40.0)	12(80.0)	3 (20.0)	15 (100)	11 (73.3)	15 (100)	12 (80.0)	15(100)	10 (66.7)
	No	0 (.0)	1 (6.7)	0 (.0)	11(73.3)	0 (.0)	2 (13.3)	0 (.0)	0 (.0)	0 (.0)	1 (6.7)
	Break even	3 (20.0)	8 (53.3)	3 (20.0)	1 (6.7)	0 (.0)	2 (13.3)	0 (.0)	3 (20.0)	0 (.0)	4 (26.7)
Borrow cash in the last year	Yes	6 (40.0)	8 (53.3)	7 (46.7)	6 (40.0)	7 (46.7)	9 (60.0)	6 (40.0)	7 (46.7)	7 (46.7)	9 (60.0)
	No	9 (60.0)	7 (46.7)	8 (53.3)	9 (60.0)	8 (53.3)	6 (40.0)	9 (60.0)	8 (53.3)	8 (53.3)	6 (40.0)
Whom did borrow	Employer	0 (.0)	1(12.5)	0 (.0)	2 (33.3)	0 (.0)	0 (.0)	0 (.0)	0 (.0)	0 (.0)	0 (.0)
	Private NBFI	0 (.0)	0 (.0)	3 (42.9)	0 (.0)	0 (.0)	0 (.0)	0 (.0)	0 (.0)	0 (.0)	0 (.0)
	Relatives	0 (.0)	0 (.0)	4 (57.1)	0 (.0)	0 (.0)	1 (11.1)	0 (.0)	0 (.0)	3 (42.9)	3 (33.3)
	Bank	1	0 (.0)	0 (.0)	1 (16.7)	5 (71.4)	1 (11.1)	6 (100)	4 (57.1)	2 (28.6)	4 (44.4)
	SHG	5 (83.3)	7 (87.5)	0	3 (50.0)	2 (28.6)	7 (77.8)	0 (.0)	3 (42.9)	2 (28.6)	2 (22.2)
Mortgaged assets	No mortgage	5 (83.3)	5 (62.5)	4 (57.1)	5 (83.3)	3 (42.9)	9 (100)	1 (16.7)	5 (71.4)	5 (71.4)	5 (55.6)
	Gold	1 (16.7)	0 (.0)	3 (42.9)	1 (16.7)	1 (14.3)	0 (.0)	2 (33.3)	0 (.0)	2 (28.6)	2 (22.2)
	Land	0 (.0)	3(37.5)	0 (.0)	0 (.0)	3(42.9)	0 (.0)	3(50.0)	2(28.6)	0 (.0)	2(22.2)

Table 4.4 also shows that a little more than half of the total households borrowed cash during the last year. It can also be understood from the table that there is not much difference among the percentage of better-off households among different social groups who borrowed cash during the last year. Among the comparatively poor households of Thiyya, Muslims, and Dalits, more than

half of them borrowed cash during the last year but among households of upper-caste Hindu and Adivasi, it is 46.7 percent and 40 percent respectively. The table further shows that only households of Adivasis and Dalits borrowed cash from an employer during the last year. Bank and SHG are the institutions from where the majority of households borrowed cash during last year. Further households of upper-caste Hindu and Muslims mainly depend on the bank for borrowing. In case of SHG, it is the households of Dalits and Thiyya who mainly depend on them for borrowing. Muslims, Thiyya, and Adivasi households are the groups who found borrowed cash from relatives during the last year.

Interaction with the respondents also helps to understand that households from Adivasi and Dalits communities borrowed cash mainly to meet shortage in their day to day expenses and to meet contingencies arrived out of health issues and occasions like marriage of family member. The amount borrowed by households from these two communities also found lower compared to other three communities. For the other three communities' educational needs of children, marriage of children, repair / construction of house, along with expenses to meet health issues were the major reason for borrowing money. Out of the households who have borrowed cash during the last year majority do not mortgage any assets to avail the loan. Among the households who mortgaged gold to borrow cash is mainly from better-off households. Also, comparatively poor households from Muslims, upper-caste Hindu, and Dalits mortgaged land to avail loan. Among the better-off, it is only Thiyya and upper-caste Hindu households who mortgaged land to avail loan during the last year.

Thus, for the comparatively poor, SHG is an important institution to borrow cash in case of any financial needs. SHGs generally lend comparatively small amounts of the loan without any mortgage and it requires the least paper works. Banks and private Non-Bank Financial Companys require mortgage generally gold or land deed to get a loan and it requires more paper works. Those better-off's who own gold can avail loan within few hours by mortgaging it. Those who own land can also take a loan by mortgaging it, but it takes some days' time to do the paper works. However, in the case of poor Adivasis and Dalits who owns lands the chances to get a loan is low due to their weaker repaying capacity. All these reasons make SHG more attractive to the poor and through the *Kudumbasree programme* these SHGs are supported by the state government. However, participation in SHG is only 24.1 percent among households of the

Adivasi community (see table A6 in annexure). Thus, the capacity to avail loans in case of any need is low among comparatively poor households (with no gold to mortgage or weak repaying capacity), especially from Dalit and Adivasi communities.

Education

The educational expansion in the district of Wayanad happened in close relation to the socioeconomic development happened in the region. In Wayanad, the indigenous communities were enslaved by the upper caste from the medieval period onwards, and even after the abolition of slavery, its spirit remained in different ways in the district until the early decades of the twentieth century. In such a socioeconomic condition, as in the case of many other developmental factors, indigenous communities face discrimination in education too. From very early onwards the traditional and indigenous system had been catering to the educational needs of children of upper-caste Hindu. It continued until the end of the nineteenth century until institutionalized education of the Western-type started to cater to students from other social groups (Nayar 1976). In the case of Muslims, during the time of the colonial period itself, there were well-known personalities among them who were educated and active in the politics of Wayanad. A remarkable improvement in education among Muslims in the district happened during the early decades of the twentieth century and after the state formation. Even though substantial progress has been attained by the community in educational status, comparatively poor and women among Muslims face multiple disadvantages (Hasan and Menon 2005; Menon 1981). While the first elected government in the state tried to bring reforms in the education sector by enacting the education bill of 1957, the Nair Service Society (NSS) and Christian community started liberation struggle against the government as the bill directed to control the private ownership and management of educational institutions. Though the government managed to pass the act in the assembly, the struggles lead to the dismissal of the state government. On the other hand, the disadvantages faced by indigenous communities and lower caste in the provisions implemented and amendments enacted in the education sector of the state do not get any serious attention from political parties or socio-religious institutions.

The lower castes like Thiyya and Pulaya in Wayanad district, who kept upper-caste Nayars as the reference group in their upward movement largely saw education in relation to status and

government employment. Thus, by the mid-20th century schools and schooling are generally well respected and prioritized by all except comparatively poor Adivasis in the district. However, the poor among Muslims and lower-caste Hindus were not affluent to educate their children up to a level sufficient to gain any white-collar employment or even any clerical employment. Even then they send their children to school with the hope of gaining employment and with the thought that without education life will be even more difficult in the future. However, it was only after the state formation, in the 1950s a sense of acceptance and minimum resources to access education pervades among large masses of poor lower castes in the district. However, Adivasis remained outside of these developments in education. Later by the 1980s and 1990s, the benefits from education become rewarding in the form of employment even for the lower castes and for few better-off Adivasis compared to the earlier benefits of bringing prestige to the family. Presently nearly every child in the district attends school at least up to high school. Even the poor Adivasi parents who have the least resources to educate their children send their children to school with the belief that schooling is good and will benefit better employment from it. However, there are many students from Adivasis in the district who discontinued their studies in high school and some of them even pointed out the plight of graduates from their community in getting a job after education. Even though many young Adivasi graduates remain jobless, the general trend among Adivasis is to send their children to school until the children themselves decide to discontinue. However, better-off among them with educated parents found sending their children for higher studies. For them, education is both gaining statuses to family and gaining better employment.

Even before the first school was started in Pozhuthana, the upper caste Hindus and few better-off among Muslims enjoyed the benefits of education in the form of respect and employment. During the time it was mainly the upper caste Hindus who were educated and who benefitted from education. When the first school was started in the village in 1926 as a Mappila school even the poor Muslims had a reason to send their children to school. The Mappila (Muslim) schools were not exclusive institutions for Muslims, but the curriculum and timing of the schools are aligned to suit the Islamic religious practices. Mappila schools in the Malabar region emerged as a result of the early British government initiative to educate the backward Muslim communities. The idea behind giving a brand (title later converted into a brand and then a label) was to promote the educational aspirations among the Muslims (Kumar 2010). Later in 1952, a single

teacher school was started in *Achoor* (one of the local markets in the panchayat). Later it became a Lower Primary School, then Upper Primary School, latter High School and now it becomes a Higher Secondary School in the panchayat. Still, this is the only school in the panchayat having classes from 8th standard onwards both in the public and private sector. Students from all social groups attend public schools in the village but dropouts or discontinuance from studies is a major problem among the ST community in the village. Dropout is high among them in high-school level at ninth standard and higher secondary level at final year.

Table 4.5 (also see table A4 in annexure) shows the educational status of household members from different social groups in the Pozhuthana panchayat. The table shows that illiterates are high among the Adivasi community compared to other social groups and it is highest among comparatively poor Adivasis. The Dalit community came second in the case of highest illiterates with 13.3 percent, but notably, the share of illiterates among them is less than the overall share of illiterates among all social groups together which is 14.1 percent. Illiterates are lowest among the upper-caste Hindu community, and among the other two social groups, Thiyya and Muslims share of illiterates are less than ten percent. Besides, among all social groups' illiterates are higher among comparatively poor than better-off and higher among women than men (see table A4 in annexure). Further, graduates are higher among Thiyya and upper-caste Hindu. The share of persons with the education of postgraduate and above is high among upper-caste Hindu, Muslims, and Thiyya. It is among upper-caste Hindu, a greater share of persons studied diploma or vocational training courses.

Table 4.5: Social group wise educational status of family members of households

	Illiterate	Lower/upper primary	High school	Higher secondary	Diploma	Graduate	Postgraduate and above	Total
Dalits	11 (13.3)	21 (25.3)	31 (37.3)	11 (13.3)	0 (.0)	6 (7.2)	3 (3.6)	83 (100)
Adivasis	35 (37.6)	23 (24.7)	16 (17.2)	8 (8.6)	1 (1.1)	5 (5.4)	5 (5.4)	93 (100)
Thiyya	8 (7.1)	19 (16.8)	49 (43.4)	12 (10.6)	3 (2.7)	15 (13.3)	7 (6.2)	113 (100)
Upper caste Hindu	7 (6.4)	23 (20.9)	39 (35.5)	12 (10.9)	6 (5.5)	15 (13.6)	8 (7.3)	110 (100)
Muslim	11 (9.8)	22 (19.6)	41 (36.6)	20 (17.9)	3 (2.7)	7 (6.2)	8 (7.1)	112 (100)
Total	72 (14.1)	108 (21.1)	176 (34.4)	63 (12.3)	13 (2.5)	48 (9.4)	31 (6.1)	511 (100)

Anganwadis and preschools are the other educational institutions found in the village. The government-run ICDS anganwadis are the popular among them which meets the educational needs of the preschool-aged children along with their health and nutritional needs. There are 34 anganwadis spread across the thirteen wards of the panchayat. When the majority of them function very well few anganwadis only have less than five children with regular attendance. The functioning of anganwadis in the tribal area is not that smooth due to the low enrolment of students especially from social groups other than Adivasis and the lack of teachers and helpers from the village itself. For example, in *Kurichyarmala* anganwadi only Adivasi children are enrolled, and the regular attendance is low. Even though households of other social groups live in *Kurichiarmala*, they were sending their children to faraway anganwadi's. They do this because in the nearby Anganwadi only Adivasi children are enrolled, and they express the fear that their child may acquire the behaviour of the Adivasi children if they send their child to this Anganwadi. Some of such households mentioned that they do not discriminate against Adivasis but the kind of education available in the nearby anganwadi is poor compared to other aganwadis. Interaction with the villagers and beneficiaries of different anganwadis revealed the poor functioning of some anganwadis especially in which Dalit or Adivasi children are largely enrolled. When this was the case in some, many other anganwadis in the panchayat found running with regular attendance of children in attractively maintained buildings with an emphasis on play and creative educational activities. In addition to such government-run anganwadis, there are also many other paid preschools run by the government and private educational institutions in the village. Better-off communities from all social groups send their children to such preschools with the perception of quality education. There are also preschools run by Muslim religious institutions in which children from both better-off and comparatively poor households of the Muslim community send their children.

Madrasa education system is the other important educational facility available in the village, through which children from the Muslim community receive basic Arabic education and religious instruction. Almost all Muslim students go to their schools after completing their two hours morning Madrasa from 7 am to 9 pm. Some of the students are also moving to evening Madrasas from 5 pm after completing their regular school. In the case of the Muslim community, in addition to the general education system, they have pre-schools run by religious institutions and a madrasa education system available in the village itself. Very early in itself, they have

attracted to the public schools through the establishment of a Mappila school in 1926. For the upper caste Hindus and better-off from Muslims, both public and private educational institutions all over the region were easily accessible. In the later years, all social groups and even some of the comparatively poor were also able to access quality education. The least considered throughout history are the students from Adivasi and Dalit communities.

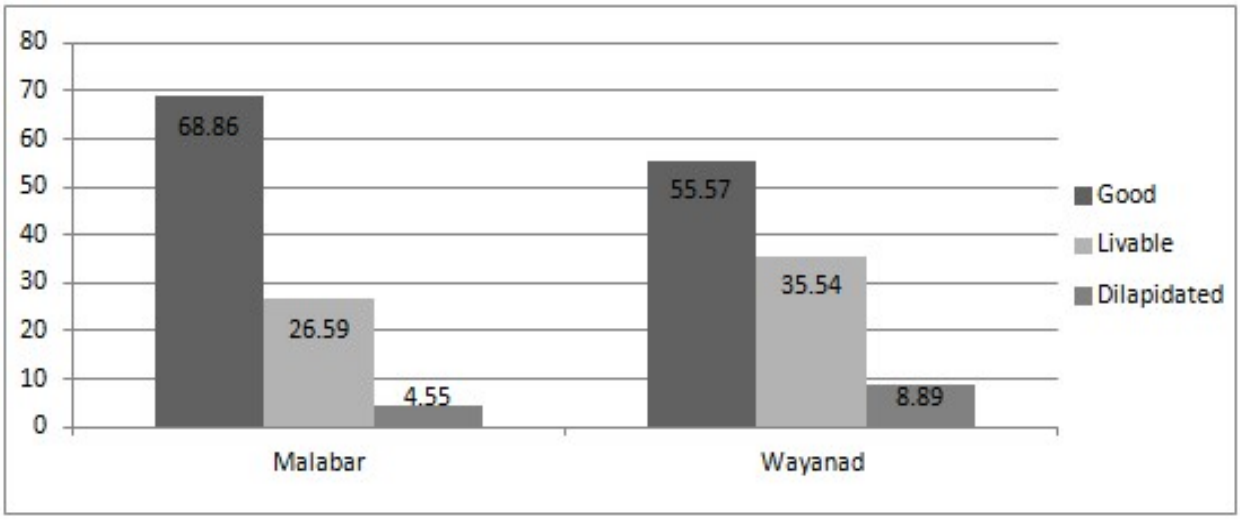
Housing and household amenities

Building own houses with all facilities in modern line is a trend among the villagers across all social groups in Wayanad and all over the state. In the district, just by mere sight itself, one can make a clear difference between the houses of the upper class and lower class in the village. The houses of better-off are generally built in two-storied structures with modern style and all household amenities within the premise. On the other hand, the houses of comparatively poor were found small in size and built with less expensive materials and without many household facilities within their premises. In the case of landless Adivasis and Dalits in the district, they are ghettoized in the crowded colonies of the district. There are many such colonies in the district with single or double-room houses. Each new generation adds similar new houses in the already crowded colonies. Census data helps to compare the condition of housing among various social groups, census judges the condition of houses based on the perception of the respondent and is classified as 'good', 'livable' and 'dilapidated'(Census of India 2011a). As shown in figure 4.2 both in the Wayanad district alone and in the whole Malabar more than half of the households have good houses. However, the share of livable and dilapidated houses is high in the Wayanad district compared to the Malabar region. When 4.5 percent of houses in Malabar are dilapidated, around its double 8.8 percent of houses in Wayanad are dilapidated. This trend is similar in rural and urban areas of both Wayanad and Malabar as a whole. As expected, the urban areas have more good and livable houses. However, a difference in this trend can be seen in urban areas of Wayanad where good houses are slightly lower than that of rural areas in the district. Similarly, livable houses are five percent higher in urban areas of Wayanad compared to its rural areas.

Concerning the material used in house structure, as shown in figure 4.3, in Malabar as a whole, around ninety percent of households have houses with a roof made of concrete and machine-made tiles. Around three percent have houses made of metal and asbestos sheets which are comparatively less costly than concrete and machine-made tiles. Using such roofing materials

gives us the idea that such houses will be having similarly good walls and overall strength which is needed to maintain the roof. While coming to the Wayanad district, around twenty-one percent of households have houses made of metal and asbestos sheets which is seven times higher than that of Malabar as a whole. In Wayanad, machine-made tiles, concrete and metal, and asbestos sheets altogether constitute around ninety-one percent. Both in the case of Malabar and Wayanad the category grass/thatch/bamboo/mud etc, which is the cheapest, constitute similar figures 2.74 and 2.17 respectively. However, in Wayanad plastic and polythene, which again one among the cheapest, constitute 2.38 percent compared to only 0.54 in Malabar.

Figure 4.2 Distribution of total households by condition of residence in Malabar and Wayanad

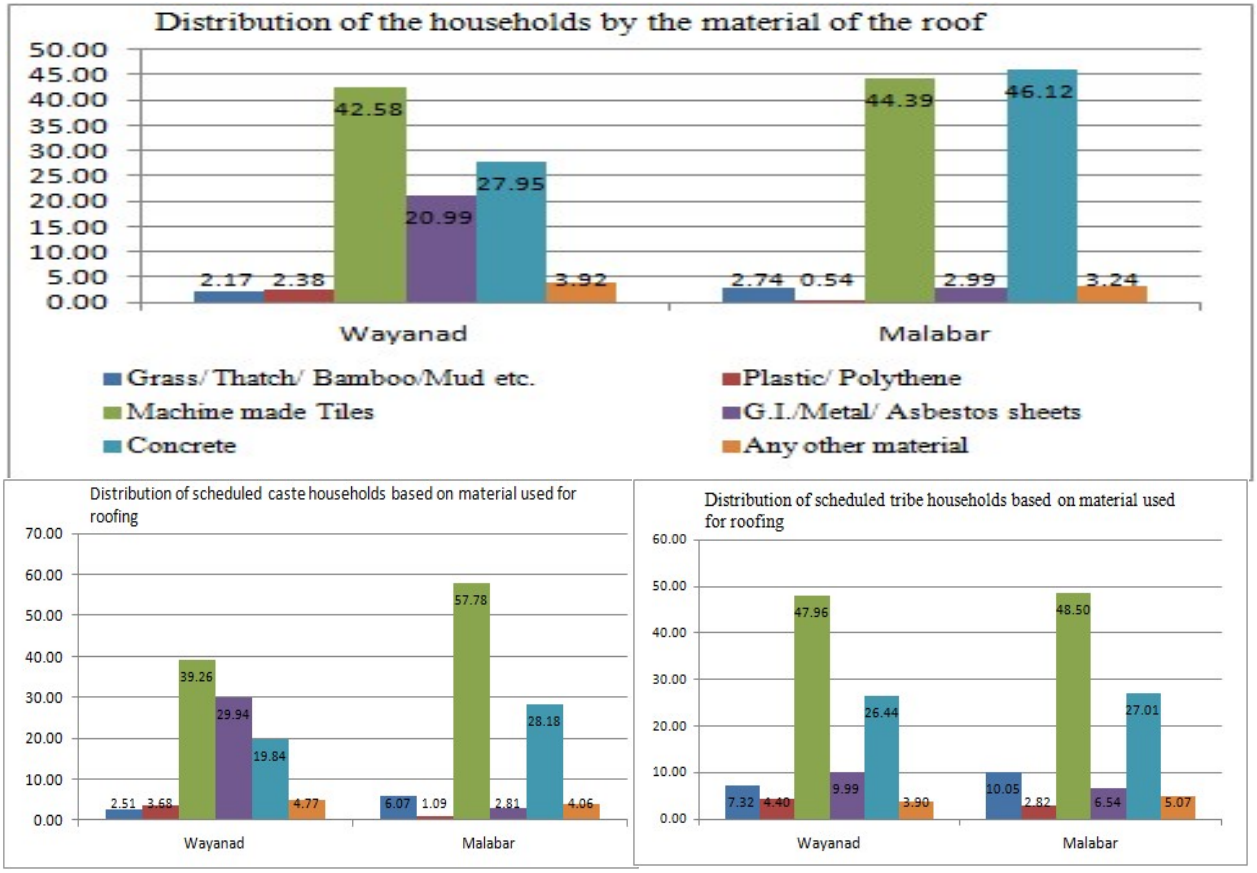


Source: Census of India 2011

Among Dalits in Wayanad and Malabar, machine-made tiles are the mainly used roof, but when it is 57.78 percent in Malabar it is only 39.26 percent in Wayanad. GI/metal and asbestos sheets are another important material used to build roofs by around 30 percent of households of Dalits in Wayanad, but in Malabar, as a whole use, it accounts for only 2.81 percent. Concrete is the other important material used for building houses by the Dalits, which is around 28 percent in Malabar and 20 percent in Wayanad. Among the Adivasis, both in Malabar and Wayanad a little less than half of the houses use machine-made tile and a little higher than one-fourth of houses use concrete. The comparatively good functioning of government-sponsored housing projects in the region is one of the main reasons for this. The use of grass/thatch/bamboo/mud etc along with plastic and polythene for constructing roofs is highest among Adivasis because of the lower

cost incurred. Houses built with such materials are highly prone to damage from rain, thus living in such houses is challenging during monsoon season. Around 7.32 percent of Adivasis households in Wayanad have their houses built with grass/thatch/bamboo/mud etc, and another 4.4 percent among them have houses built with plastic and polythene.

Figure 4.3 Distribution of the households by the material of the roof in Malabar and Wayanad



Households in Kerala by the source of lighting shows that Wayanad is the district with the lowest share of households having electricity and the highest share of households having kerosene as the primary source of energy. As shown in figure 4.4a, 4.4b and 4.4c the source of lighting in the households is an important factor that shows large differences among households of various social groups and subregions in Malabar. Data on electrification from the 2011 census shows that 92.70 percent of houses in Malabar and around 81 percent of houses in Wayanad use electricity as the primary source of energy for lighting. Kerosine is the other primary source of energy which 18.69 percent of houses in Wayanad and 6.99 percent of houses in Malabar uses. The

remaining 0.48 percent of houses in Wayanad and 0.31 percent of houses in Malabar use other energy sources like solar energy, oils other than kerosene, or do not have lighting.

Figure 4.4a Distribution of households by the source of lighting

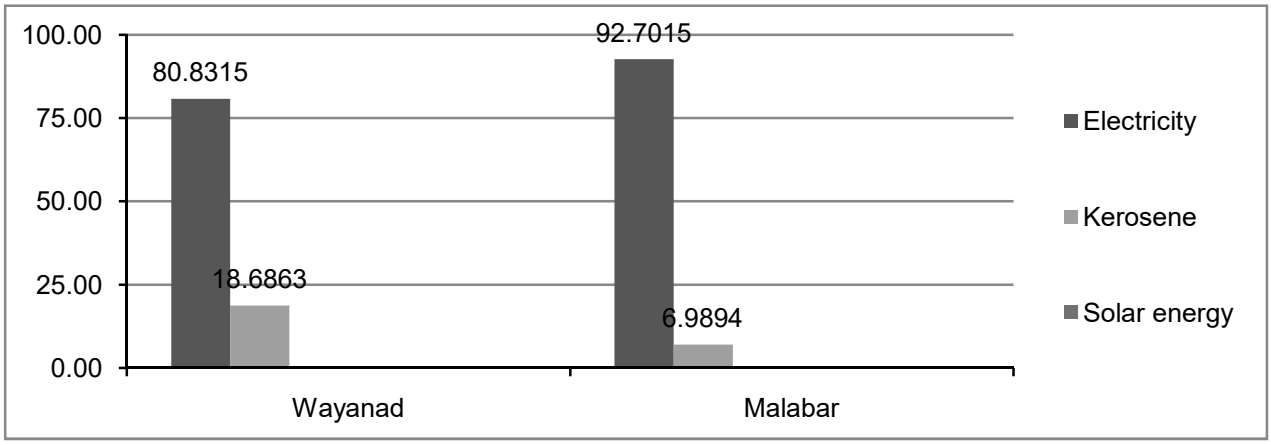


Figure 4.4b Distribution of SC households by the source of lighting

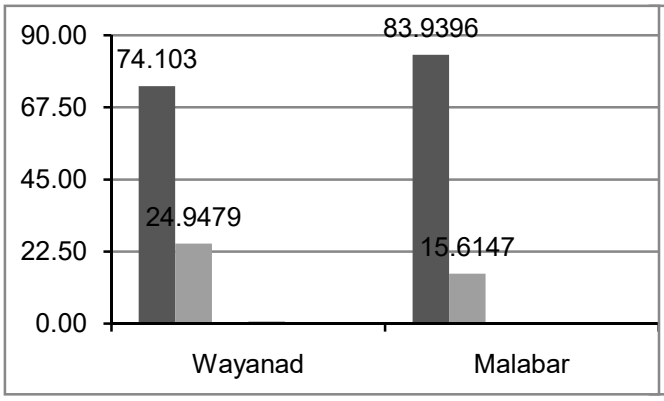
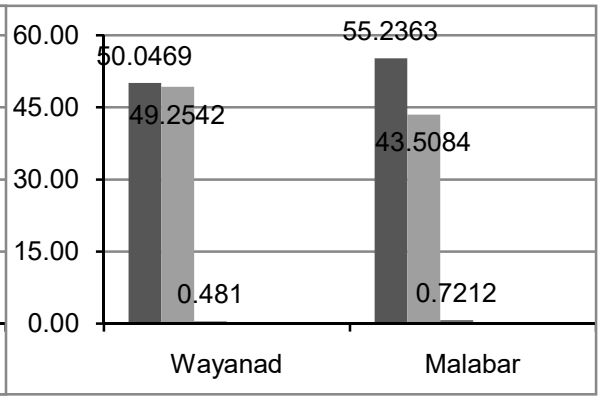


Figure 4.4c Distribution of ST households by the source of lighting



In the case of Pozhuthana panchayat, one of the important indicators to differentiate class distinction among households is identified as 'type of house and household amenities available'. Distinctive from an earlier period where existed socio-religious restrictions in building and naming houses according to one's wish, the general trend developed in the village is one with substantial resources building big houses with beautiful architecture. At the time of building a space in the social life of the village many other than upper-caste Hindus, for example, Muslims saw building big houses as a symbol of their improved socioeconomic status. Household level survey data presented in table 4.6 shows that (also see table A5 in annexure) majority of better-off households have pucca houses with three or more rooms built either with own resources or with government support. In the case of better-off among Thiyya, upper-caste Hindu, and

Muslims majority of them built their pukka houses with own resources. These three social groups only have less than one-third of their households having a semi pukka house and not a single one has a thatched house. In the case of Dalits, there are 73.3 percent poor and 6.7 percent better-off households with semi pukka houses. Whereas in the case of Adivasis there are 33.4 percent better-off and 13.3 percent poor households with semi pukka houses and 53.3 percent of poor households with thatched houses. Other than Adivasis only one poor Dalit household have a thatched house in the village. In the case of number of rooms also the majority of better-off households from Thiyya, upper-caste Hindu, and Muslims have three or more than three rooms in their house. It is also important to note that not a single household among these groups has a single-room house. In the case of Dalits and Adivasis majority have houses with less than three rooms. In case of better-off among them, 46.7 percent of Dalit households and 53.3 percent of Adivasi households have three or more than three rooms in their house. Further, in the case of comparatively poor among them, 66.7 percent of Adivasi and 33.3 percent of Dalit households live in a single-room house.

In the case of the primary source of drinking water, among the better-off from each social group when 66.7 percent of Muslims, 73.3 percent Thiyyas, and all upper-caste Hindu households have own well, only 33.3 percent Dalits and 46.7 percent Adivasis have own well. In the case of comparatively poor among upper-caste Hindu and Muslims, those who do not have own-well, hill-water through the pipeline is the major source of drinking water. It is also important to note that those who do not have a well among comparatively poor Thiyya, well of the neighboring house is the major source. Different from these three social groups comparatively poor among SC without own-well depends on public well, public pipeline and hill water. It is important to note that for the largest share of poor Dalits public well is the major source of drinking water and for better-off among them also it is an important source. In the case of poor Adivasi households, none of them have own well, and the majority of them depend on the hill-water through pipeline followed by public pipeline, well of neighbors, and the public well.

In the case of the primary source of energy for cooking, out of the total households, more than half of households use LPG as a primary source. Among better-off households when only 66.7 percent among Dalit households and 33.3 percent of Adivasi households use LPG as the primary source of energy for cooking, all households of better-off among other social groups use LPG as

a primary source. In the case of comparatively poor households among Thiyya, upper-caste Hindu, and Muslims more than half of the households use LPG as the primary source of energy. Whereas in the case of poor Adivasi households none of them use LPG as the primary source and only 33.3 percent of the poor among Dalits use it as a primary source.

Table 4.6: Distribution of sample households based on type of house and primary source for drinking water and energy for cooking in percent

		Dalits		Adivasi		Thiyya		Upper caste Hindu		Muslim	
		Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Type of house	Pucka with govt support	46.7	13.3	33.3	33.3	26.7	46.7	13.3	.0	.0	40.0
	Pucka with own resources	46.7	6.7	33.3	.0	73.3	20.0	86.7	86.7	93.3	33.3
	Semi pucka – own resources	.0	33.3	6.7	13.3	.0	33.3	.0	13.3	6.7	13.3
	Semi pucka - govt support	6.7	40.0	26.7	.0	.0	.0	.0	.0	.0	13.3
	Thatched	.0	6.7	.0	53.3	.0	.0	.0	.0	.0	.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
No. of rooms	One	.0	33.3	.0	66.7	.0	.0	.0	.0	.0	.0
	Two	53.3	60.0	46.7	20.0	13.3	33.3	.0	6.7	6.7	40.0
	Three	40.0	6.7	40.0	13.3	33.3	53.3	53.3	80.0	40.0	46.7
	Four or more	6.7	.0	13.3	.0	53.3	13.3	46.7	13.3	53.3	13.3
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Source of drinking water	Own well	33.3	26.7	46.7	.0	73.3	20.0	100.0	73.3	66.7	33.3
	Hill water through pipeline	26.7	26.7	13.3	46.7	20.0	26.7	.0	26.7	33.3	40.0
	Public pipeline	13.3	.0	6.7	20.0	.0	.0	.0	.0	.0	.0
	Well of neighboring house	.0	.0	33.3	20.0	6.7	53.3	.0	.0	.0	26.7
	Public well	26.7	46.7	.0	13.3	.0	.0	.0	.0	.0	.0
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100
Primary source energy for cooking	LPG	66.7	33.3	33.3	.0	100.0	53.3	100.0	60.0	100.0	66.7
	Firewood	33.3	66.7	66.7	100.0	.0	46.7	.0	40.0	.0	33.3
	Total	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100.0	100

There are open wells in a few Dalit and Adivasi colonies which are exclusively used by the respective community only. In such colonies, the problem is not the water quantity but the quality. In the Dalit and Adivasi colonies, no households have own well in their house. The Dalit and Adivasi households who have own well are from the better-off category and lives outside the

colony. For people who live in the hillside and from poor laboring class, having an individual well for households as in other parts of the state is geographically and economically not feasible for them. But in the plain lands, around one-third of the households in *the Achooranam* area and half of the households in *the Pozhuthana* area of Pozhuthana Panchayat have managed to get own sources of drinking water like open well. It is also important to note that most of those who live in the plain land are mainly Muslims, Thiyya, and upper-caste Hindus.

Another important source which many households depend is public tap and house connection of water supply provided through various schemes including the World Bank supported *Jalanidhi* project. A large number of households from the Adivasi community who lives in the plain lands of Pozhuthana do not have own well and mainly depend on such public water taps or household connection of water supply. During the formation of *Pozhuthana* panchayat, there were only a few public drinking water wells in the area. Thus by 1975 itself, the panchayat formulated a drinking water project named *Valiyapara* Drinking Water Distribution Programme. However, it started functioning only in 1995 by providing water connection to 10 wards in the panchayat. Besides, the household water tap connection is mainly provided through the *Jalanidhi* project. In the *Jalanidhi* project, the management of the water supply project including electricity bill payment is to be done by the beneficiaries themselves. Even though there are successfully functioning *Jalanidhi* projects in the village, two of such projects in the Adivasi settlements in the village were found abandoned due to a lack of resources in the hands of the beneficiaries to manage and run the project.

Food and nutrition

During the pre-colonial and colonial periods, Malabar repeatedly faced famines, malnourishment, and famine-related epidemics. However, until the arrival of the colonial government, the Wayanad taluk of the earlier Madras district was a major surplus producer of rice. In fact, the surplus produced in Wayanad mostly bridges the food shortage in other parts of the district. However, after the British occupation, Wayanad face difficulties in meeting its food requirements even during the years of better harvests as a result of converting large areas of land into plantation estates (Priya 2014). Besides, the migration of farmers from the southern part of the state to Wayanad had led to further disturbing the native farming communities. Following the

Second World War, there was a scarcity of food grains and a rapid rise in the prices of essential commodities in the region, and the worst affected by this was naturally the peasants and workers. There was a massive food shortage in the whole of Malabar during 1943, resulting in hunger, malnourishment, and epidemics like cholera (Kumar 2020). As Kerala was depending on Burma for a major part of the rice supply, the cut-off in this supply due to war had contributed to the crisis of food shortage.

The food shortage affected everyone and with the leadership of communists, demands were made for price control and the opening of rations shops. In June 1943, a protest of five thousand people confronted the district magistrate of Malabar to demand regular distribution of food (Jeffrey 2016). In Malabar communists formed food committees, like the All Malabar food committee of Calicut, started in 1943, to supervise the procurement and distribution of grains. Gradually a system of rice rationing started in Malabar by taking its initial steps during 1944. Over the period, the changes in agrarian relation in Wayanad resulted in the subjugation of Adivasi and Dalit communities from own cultivation. In the new market economy resulted from the increasing cash-crop cultivation, Adivasis, Dalits, and other daily wage labourers become increasingly dependent on the public distribution system for their food requirements. The Adivasi and rural families of the district still conserve a wide range of wild plants for their food needs, but under the new socioeconomic condition sustainable use of many 'wild' edible varieties and preserving of traditional knowledge systems, are under greater threat (Narayanan et al. 2004). As a result, tribal areas from the Malabar region and in Wayanad continued to report high undernutrition, hunger, infant and maternal death due to malnutrition (Edison and Devi 2019; Mohandas et al. 2019; Philip et al. 2015; Eqbal et al. 2013). On the other hand, the better-off were able to cultivate or purchase food grains from the market. The better-off especially the Gulf emigrants households have changed to a consumption pattern consonance with new socioeconomic status in which food became an important area of spending.

A detailed view of food consumption among various social groups can be seen from the data obtained through household survey in Pozhuthana. Table 4.7 shows a clear distinction between Adivasis and Dalits with other social groups in terms of any experience of a shortage of food in their household during the last six months prior to data collection. Except for the comparatively poor Adivasi household none other experience shortage of food throughout all months in the last

six months. The table also shows that in the case of comparatively poor, 73.3 percent of Adivasi and 33.3 percent of Dalit households experienced food shortages during some days in the last six months. Among the other social groups, only 13.3 percent of poor Muslim and 6.7 percent of poor Thiyya households experience any food shortage for some days during the last six months.

In case of changes in quality and quantity of food consumed during the last ten years, more than half of better-off households among Dalits, Adivasis, and Thiyya reported an improvement. However, in the case of comparatively poor when 40 percent of Dalit households reported a decline, only 20 percent among upper-caste Hindu, 6.7 percent among Muslims, and 13.3 percent each from Adivasis and Thiyya reported any decline. The main reason pointed out by respondents for a high decline among Dalits is the shortage of workdays available to them during the period and almost non-receipt of food grains in kind from the farming landlords as a result of the decline in rice cultivation. In the case of comparatively poor Adivasi households, 60 percent of them reported an improvement. This change is mainly because of the greater enrolment of Adivasi households into the public distribution system during the last several years. It is important to note here that some of the interviewed households who encroached land in this village received title deeds for their land only after 2003. Thus, these households were not having a ration card to avail of PDS services at that time. It is in the years after 2003 they got title deeds for their land and enrolled in the PDS services. In the case of Thiyya households, 47 percent of poor among them reported no major differences and another 40 percent reported an improvement. In the case of Muslims, both better-off and poor households among them reported that there were no major changes in the quality or quantity of food consumed during the last 10 years. Among the better-off households of upper-caste Hindus, more than half of them reported there is no change and 40 percent of households reported there is an improvement. In the case of comparatively poor among them more than half reported an improvement and around 27 percent reported no change.

In the case of purchase of food grains from PDS shop, table 4.7 shows that the majority of comparatively poor households from all social groups purchase food grains from PDS shop. One thing important to note here is, those who do not have a ration card among Dalits, Adivasis and Thiyya managed to purchase food grains from PDS shop by using the ration card of relatives or neighbors. In the case of Adivasis, it is found that some of the households who have shifted to

separate houses just near to their ancestral house after marriage do not have a separate ration card. In such cases, both the households use the same ration card to purchase food grains and they share the food grains. In the case of Dalit and Thiyya, it is found that they managed to get ration cards from their neighbors who do not use them regularly to purchase food grains from PDS shops. Further, the majority of better-off households from upper-caste Hindu and Muslims do not purchase food grains from PDS shops. The highest from better-off who purchased from PDS shops are from the Adivasi community followed by Dalits and Thiyya.

Table 4.7 Distribution of sample households based on experience of food shortage and details on food consumed by different social groups (in percent)

		SC		ST		Thiyya		Upper caste Hindu		Muslim	
		Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Experience of food shortage in past six months	Yes, every month	.0	.0	.0	6.7	.0	.0	.0	.0	.0	.0
	Some months	.0	33.3	13.3	73.3	.0	6.7	.0	.0	.0	13.3
	No, no months	100.	66.7	86.7	20	100	93.3	100	100	100	86.7
	Total	100.	100	100	100	100	100	100	100	100	100
Change in quality/quantity of food during last 10 year	Improved	53.3	46.7	80	60	73.3	40	40	53.3	33.3	13.3
	Declined	.0	40.0	.0	13.3	.0	13.3	6.7	20	.0	6.7
	Remained same	46.7	13.3	20	26.7	26.7	46.7	53.3	26.7	66.7	80
	Total	100.	100	100	100	100	100	100	100	100	100
Purchase from PDS shop	Yes	66.7	80	53.3	78.6	60	93.3	.0	86.7	20	100
	No	33.3	.0	6.7	.0	40	.0	80	.0	80	.0
	Yes, using relatives card	.0	20	20.	21.4	.0	6.7	.0	.0	.0	.0
	Yes, but not regularly	.0	.0	20.0	.0	.0	.0	20	13.3	.0	.0
	Total	100	100	100	100	100	100	100	100	100	100
Items purchased	Boiled Rice	60	60	57.1	84.6	44.4	80	.0	60	.0	86.7
	Non boiled rice	20	.0	21.4	.0	55.6	.0	100	20	75	.0
	Both	20	40	21.4	15.4	.0	20	.0	20	25	13.3
	Total	100	100	100	100	100	100	100	100	100	100

Among the better-off households of each social group, around 67 percent of Dalits, 60 percent of Thiyya, and 53 percent of Adivasis purchase subsidized food grains from PDS shops. At the same time, even though it is low some among better-off households of Muslims and upper caste

Hindu households purchase subsidized food grains from PDS shops. However, it is important to see that what kind of food grains different households mainly purchase from the PDS shop. The table shows that among the better-off households of Thiyya, upper-caste Hindu and Muslimswho bought food grains from PDS shops majority prefer to buy non-boiled rice, even though boiled rice is the major food grain used in their daily diet. This non-boiled rice is mainly used for preparing snacks for the breakfast and is rarely used for lunch and dinner. Those households who prefer non-boiled rice from PDS shops purchase costly boiled rice from the market to cook lunch and dinner. The availability of non-boiled rice at a cheap price from the PDS shop is the reason for the better-off household to prefer PDS shop for buying them. In the case of comparatively poor households majority of them purchase either boiled rice only or both boiled and non-boiled rice. Thus, for both better-off and comparatively poor among Adivasis, Dalits, and comparatively poor among other social groups PDS shops are the major source of household food.

Religious institutions

As Adivasis were the earliest native inhabitant in this area, they were ruled by the Rajas of the Veda tribe as a tribal self-governing kingdom. In their self-governance, tribal culture and values thrive in various aspects without any outside interruption. The worship places of Adivasis in the district *Valliyoorkavu* and *Thirunelli* are even well known for people from the rest of Malabar. Over the period, through the arrival of other communities new religious places of various castes and religious groups were emerged in the district. Through the arrival of a large number of churches, mosques, temples, and different ways of life centered around such religious institutions, the religious places and belief systems of indigenous communities and lower castes lost their popularity. The case of Pozhuthana helps to understand the growth and expansion of various religious institutions in the villages of Wayanad. The idols and the sacred groves in the forest area of Amba are helpful to understand that the area was one of the biggest worship places of Adivasis in Pozhuthana. Such evidence of well-established worship places of Adivasis is still present in the forest areas of the panchayat. However, over the period along with the subjugation of Adivasi life in the region the prestige and popularity of Adivasi worship in Amba got eroded. Even though idols and sacred groves are still present in amba, there is no regular worship is being performed. For that matter anywhere in the panchayat, there is not a single well-known worship place of Adivasis that exists today. During the later centuries of the medieval period

when the Malabar Kshatriya Rajas conquered this area, a new Brahminic belief spread and took dominance over the old Adivasi beliefs. The status and popularity enjoyed by the old religious places of Adivasis like Kavu / sacred groves in the village were lost and now it is being gained by the new temples built under the Brahminic belief system.

All the temples of goddess *Devi* and god S*hiva* in the village are built in the lands of Pozhuthanayidam landlord and they remained as the temples of Nayars. Such temples of the upper caste become the popular worship places in the village with beautiful and big buildings. The other lower castes like Thiyaa and Pulaya had their separate *Kavu* (worship place) based on the Dravidian belief. Such *Kavu* does not have temple-like buildings rather it is the traditional natural sacred groves. Different from temples there will not be daily rituals in the *Kavu,* on-demand from the devotees, rituals are performed sometimes by the devotee themselves or by someone from their caste. Significant changes came into the life of lower caste Hindus and Adivasis in the village was during the decades followed by independence. During this period, they got accelerated access to public spheres of life including temples, which were once denied to them. Over time when the temples of upper castes were open to all Hindus irrespective of their caste, gradually they become the major temples of Hindus in the village. The Kavu and devotional places of *Thiyyas* and other lower castes were never represented as a general temple of Hindus as a whole. Even though all Hindu castes have access in the K*avu*s and temples of lower caste, generally upper castes do not visit them. Through the traditional belief of the lower castes like Thiyya and *Paniyas*, every joint family will be having a *Kavu* and in practice as their, *Kavu* is still not public as they worship their gods and sprites of ancestors together. This has further led to erode the popularity of the worship places of lower castes as a village temple and lead to diminishing its popularity to their caste and further reduced even within to certain joint family.

In sum, in the present-day Pozhuthana, temples built and managed by the Nayar have become the only public worship places of Hindus as a Whole. Thus, an additional group of gods and temples which are different and new to the traditional belief of Adivasis and lower castes became the popular temples of Hindus in the village. The worship places of lower castes lost earlier pride, and along with many reasons due to financial constraints, most of them even dropped their yearly festivals for several years. As all the major temples in the village are once owned and managed

by the upper caste only, now some changes have happened in this. Now all the temples are managed by separate committees formed by villagers (known as temple committee) in which members from lower castes are also present, but no major changes in the rituals practiced in the temple which is wholly based on the upper caste Hindu beliefs. Similarly, no changes in the exclusive rights of the Brahmins to become the priests of these temples.

Under the rule of upper-caste Hindu Kings and later with Britishers, religious life-based in the Hindu caste system dominates the socio-cultural life in the village. When Muslims started to migrate to the village, they found some space for progress within that tradition, which was not available to the lower caste Hindus. As a result, a new Muslim religious culture with resources gained from trade, commerce, and employment in plantations spread across the village. At present, there are two main mosques in the village one in the *sixth-mile* town and the other almost in another end of the panchayat near the main road. Also, there are six more mosques and related institution like *Madrasas* in the interior of the village. For the Friday congregation, all Muslim men meet at two big mosques in the panchayat. As attending Friday prayers at Mosque is compulsory for Muslim men and young boys, the deserted view of the *sixth-mile* market during the time of Friday prayers is a usual sight.

Each mosque in the village consists of an Imam and *mosque committee* to look after the socio-cultural and religious life of members in their *Mohalla*. For smooth functioning, demographically Muslims are divided into Mohalla units, which is the group of families living around a Mosque. The *mosque committee* thus plays an important role in the life of Muslims, and the members of well-known families and persons with some holds among the villagers in the form of education and social status comes into constituting the committee. Similarly, in the case of Christians also Church and religious leaders have a great influence on every aspect of the life of believers. In the Pozhuthana it is unlikely among the majority of Christians to depart from the authority of the Church over their day-to-day life. In the case of Adivasis in Pozhuthana, most of them are strong followers of their indigenous rituals and beliefs. It is their traditional leaders of each *Ooru* who supervise the rituals, public functions, and ceremonies among them. However, some among the *Paniya* tribe in the village are not hesitant in having marriage alliances with another backward caste Hindus in search of a better quality of life. Except for Namboothiris, in the case of majority among all other castes, Nayar, Thiyya, and Pulaya there is no social pressure to be religious in

day-to-day activities. They have all freedom to live as they wish as no religious authority is present to supervise their daily life.

Political Dynamics

The four major political parties in the state have their presence in the panchayat, CPIM and IUML are the political parties with the largest supporters followed by INC. Almost all trade unions of these political parties were also functioning in the panchayat. A government under CPIM with nine out of thirteen elected members now in the government of the panchayat (2015-20). The LDF[22] and UDF[23] ruled the panchayat in turn at different points in time, and these two alliances of political parties become the only powerful forces to have a majority to win the elections.

Even at the time of Britishers itself Muslims played a strong role in the politics of the region, the representative to Malabar District Board from this area which includes the village is represented by a Muslim man. Thereafter Muslim community played an important role in the local politics of the village. Like other parts of the state majority of Muslims in the village are organized under the political party that emerged from the community itself. In the present local self-government, the Muslim league has two elected members out of the total thirteen. In the previous election of 2010-2015, they have elected in five seats and with the support of the Congress party, they won the president post. During 1995 and in 2010 also a member from IUML won the president post with the support of the Congress party. In all other elections, they won seats, and never they have gone below two seats in the panchayat. As Muslims are one of the major communities in the village, all political parties including Congress and communists also did everything to draw Muslims into their party. As a result, there are also supporters from Muslims in these political parties, some Muslims are even holding higher positions in these parties.

The upper-caste Hindu, Nayar community also organized their political party on caste line in the village as National Democratic Party (NDP). Then in the 1988 election NDP won the panchayat president post with the support of Congress. However, it fails to maintain its organization and

[22]Left Democratic Front
[23]United Democratic Front

stopped its functioning when it dissolved at the state level during 1996. However, the presence of Nayar's in the Communist Party and Congress party remained throughout the period, and they hold key positions in the party and government. Even though the Nayar community does not have its political party at present, they hold political power through their leadership in the communist and congress parties. In 1963, during the period when Pozhuthana was part of the Vythiri panchayat, three Nayar were elected along with a Muslim member as representatives to local self-government. Once Pozhuthana become an independent panchayat during 1972, a Nayar called *Nanu Nayar* becomes the president. Since then up to 2020 out of the eight elected presidents except two Muslim all other six time a Nayar either from Communist, Congress or National Democratic Party becomes the president.

The lower caste Thiyyas, Dalits and Adivasis in the village never attempted to organize their own political parties based on caste or ethnicity. In other words, the resources and atmosphere were never suitable for individuals from lower castes to become political leaders or to hold higher posts in local government either by forming their own political party or through engaging in already existing political parties in the village. They were part of the already established political parties, in other words most of the lower castes mainly rallied under these political parties in the village as their supporters. As Thiyyas are high in number, they were able to hold some strength in communist and congress party and in the governments they formed. However, Dalits and Adivasis were never well represented in any of the political parties especially in its higher-level committees. It was after the reservation of seats in local self-governance by the constitution ensured a reasonable participation of Adivasis and Dalits in the village governance. Adivasis and Dalits attempt to politically organize with communists and with the congress does not help them to become a political stronghold in the panchayat. A god evidence for this is, even today they only get chance to context in reserved seats and they were not considered under general seats for elections in local self-governance by the dominant political parties in the village.

The subjugation of lower castes and Adivasis in the politics and local self-government of the village is thus not just happened by chance but was a result of political development shaped advantageous to the upper caste Hindus and Muslim elites in the village. However, this is not just the case in political organizations, such a trend can be seen in the development of various social

and cultural organizations, arts and sports clubs, cooperative societies, self-help groups etc in the village. It will be difficult to find such a socio-cultural or other organization exclusively managed by Adivasis or lower castes in the village. Or any organization in which Adivasis or lower castes have stronghold in its management. Even though few organizations like arts and sports clubs of Adivasis and lower castes were formed in the panchayat at different time, they have not flourished as like that of other communities or in which other communities have stronghold. As the oldest collective organization of the people, it was in 1928 a cooperative society by including peoples of Pozhuthana panchayat started working in Vythiri with 121 members. It begins by collecting money from members to distribute loans to small farmers in the area. At the time of beginning, it was the educated Nayar's from the village and neighboring areas who were in the forefront in organizing it. Now the society has grown up as Vythiri Service Cooperative Bank with a branch in Pozhuthana. Now members from all social groups are part of the co-operative society, but still in its management and organization members from lower caste and Adivasis are least represented.

Social Dynamics

Even though Wayanad is predominantly a rural area, as like in rest of Kerala, there has always been historical rural-urban continuum with respect to demography, economy and development. That makes spatial and social group-wise interconnections active among the villagers. An important characteristic of the public life of the rural population of Wayanad is social cordiality and active participation in civic and political activities. In spite of strong electoral opposition and party politics at every public institution, incidence of civic conflicts and community-based conflicts have never been recorded in the district (Upendranadh 2008). An important demographic feature available in the district is the balance in terms of population among the three dominant communities Hindu, Muslim and Christian. This enables peaceful co-existence, and continued disagreements are observed only in party-politics. Majority of people from various social groups engage in political activities based on party ideologies, and different from some other sub-regions in Malabar there were no records of any communal unrest in Wayanad. However, there are issues between different social groups in certain aspects, like issues of land rights of Adivasis and encroachment of land by migrants from other social groups. Such issues are addressed through political and civil society actions and not been turned into communal

incidents. In fact, the political consciousness emerged in the district influenced by egalitarian values of renaissance and communist ideology was keen in intervening the issues of marginalized.

Migration of various social groups at different point of time played a significant role in shaping the cosmopolitan modernity in the district. The district experienced the assimilation of different social groups including Hindu, Muslim, Christian and Jews during different stages of its history. Today, almost all the major religious and ethnic groups share a bonded coexistence in the social, economic and cultural environment of the district. To an extend the cultural intermixing occurred among all the major communities irrespective of their position in the caste hierarchy. In fact, this cultural intermixing was greatly beneficial to the under-privileged of the society. The social mobility attained by backward caste Thiyyas, is an example for cultural intermixing and its related social dynamics among lower caste. In fact, the district witnessed social activism of local leaders from various social groups who shared the views of Sree Narayana Guru and other social reformers rooted in egalitarian liberal principles. Through social reforms and renaissance, the social landscape of Wayanad developed suitable for cultural interactions and assimilates with imported cultural elements. Even though this is the case, the cultural identity of native indigenous communities and Dalits got subjugated when different social groups were concentrated in establishing their own belief and culture. But, over the period, experience of modernity has minimized the hegemony of certain culture over the rest through cultural roles and functions.

The quality education spread all across the state under the leadership of various religious organizations also had widespread support to the coexistence of social life in Wayanad. The presence of a large number of Christian and Muslim populations in the district helped in building educational institutions all across Wayanad and educating students irrespective of caste, ethnicity and religion. In addition to schools and colleges, they also built hostels, vocational enterprises, medical institutions, and rest houses for patients and bystanders. When majority of the beneficiaries of these institutions are of same community, many such institutions cater the needs of comparatively poor from all social groups. When a large section has experienced modernity through education, migration and economic betterment, there are also traditionalists from all

social groups who criticize the cosmopolitanism as they consider it as a great threat to the basic structure of their culture and belief.

The aspects of rich multifariousness in the district are visible in the food culture and celebration of festivals. The improvement in household income along with exposure to various cultures through migration are helpful in this regard. Large-scale emigration of people from Malabar and Wayanad to Gulf countries not only brought an economic boom, but also an immense cultural assimilation. The vegetarian and non-vegetarian food are served in public functions and restaurants without hurting the religious sentiments of different social groups. The major festivals like Onam, Vishu, Christmas, and Eid al – Fitr are harmoniously celebrated without any strict sectarian differences. Irrespective of the minority, majority, ethnic and religious status, the festivals of all social groups celebrated with large people participation. The locally well-known festivals of indigenous communities like the *Valliyoorkkavu* festival have been attended and supported by people of different social groups even from neighboring districts.

In addition to the public functions of political parties and local self-government, the imported arena where different social groups of Pozhuthana come together is the collective actions for support to weaker sections and overall development of the village. It is through the collective efforts of people from various social groups in the village which lead to large-scale electrification in the village. In 1959 electricity connection came into the village through collective efforts of the villagers. It was villager's free labour that brought electric posts and related equipment to the panchayat. Similarly, it is the collective attempts of members from all social groups which led to the establishment of the first school and public water supply scheme in the panchayat. Another important is the palliative care association which functions in the village with the support of people from all groups. The palliative care association is active in the village which serves the needy irrespective of their socioeconomic status with the support of volunteers from all sections of society which include members of head-load workers, students, professionals, and petty shop owners. The treatment relief committees are another important forum that constitutes to help a particular patient who is financially weak. Other mechanisms for social interactions between villages are the existence of dairy and other agricultural and marketing cooperatives, sports, and arts clubs and libraries in the village. However, the social interaction among members of various social groups also depends upon their positions in the

village social network. When the Thiyya, Dalits, Muslim, and upper-caste Hindu communities are in the center of the village social network, Adivasis are in the periphery of the network. Informal social network in the village is the medium through important information regarding government initiatives, availability of opportunities, and services that can promote living standards are passed from one to another.

In addition to this, among women self-help groups and work under Mahatma Gandhi National Rural Employment Guarantee Act (MNREGA) are the important space where around 10 women frequently meet. Those who are in the same locality continued to work together under the SHG and MNREGA, and both act as a space for discussing general issues affecting them. Women self-help groups under the Kudumbasree programme exist in all the wards of the panchayat with around 15 members in each group. These self-help groups become very attractive to the poor women from the village as it helps them in building a culture of thrift. Many women especially from the households of Dalits and Thiyya mainly depend on the SHG for borrowing to meet their small financial needs. Besides, there are SHGs in the village which had got recognition at the national level for successfully running micro-enterprises. However, again it has been found that the least benefitted from the development of SHGs in the panchayat are the Adivasi women. However, the lower castes like Thiyya and Pulaya from the village were successful in running their SHGs and some of their SHGs even started micro-enterprises and collective farming. It is also found that women from better-off households of upper caste Hinds and Muslims are least interested in joining SHGs. It is the middle-aged married women from comparatively poor households who are largely active in SHGs. Even though Thiyya women and Dalit women have a larger participation in these SHGs, as shown in the household level data section participation of Adivasi women is the lowest.

Conclusion

There is no doubt in the fact that new and some of the old public resources which were once denied to some were now become available for all social groups to access. However, the above observation shows that the mere availability of these resources does not ensure equitable access to the neediest. The development process that happened in the village created obstructions in the pathways of accessing these resources by certain social groups. The improved access to various resources alone does not help individuals to use them in their capability enhancement, the social

environment in which the individual and the resource exists matters to a great extent. Even though some of the households from all social groups have enough agricultural land, land use practice of social groups found adjusted to the diversity of constraints and opportunities they face. The case of land-owning Adivasis shows that mere possession or even ownership of land is not enough to make revenue out of it, many other societal factors along with public policies, their financial stability are important.

As we have seen, Adivasis and lower-caste Hindus were always kept away from the political and social leadership in the panchayat, their share in the panchayat governance always remain very low. The high literacy, land ownership, and other benefits like access to the proper public distribution system, participation in MNREGA are termed as benefits earned by the Adivasis and lower castes in general in the village compared to Adivasis and lower castes in other parts of the state. However, none of these; education, land, or access to the public distribution system, MNREGA were enough to ensure freedom, equality, and dignity of marginalized in the village. They are not denied access to the public sphere but the pathways to reach and access public spheres of life are not enabling but distrustful for them. As we have seen they are nearly invisible in a higher level of socio-cultural and political organizations and the mainstream public life in the panchayat.

Chapter V

The shaping of health care among different social groups

How do existing health service facilities act on unequally positioned individuals and communities? It is important to understand whether the existing facilities ensure equitable provision of services to meet the differential health needs of people. Health services are one of the many parts of the health system and are being shaped under the overall development process. Those who are privileged in the process of development will be able to build their human and social capital. They will be able to have greater physical and economic access to health services and the resources necessary for having good health. Those who lose out from the benefits of socioeconomic development continue to suffer and able to enjoy only marginal gains from the public resources available. The differences in the socioeconomic status influence the orientation of different social groups towards their health, the kind of change in the nature of health problems, and how they seek to tackle these problems, and for what reasons. Hence it is vital to understand the health perception and health care utilization of various social groups in the context of the health resources available to each social group and overall health care facilities available, and their behavior towards the people, all of which is shaped by the social process of development.

Pozhuthana is around 10Km away from the district headquarters, and is well connected by road and public transport services. The villages near Pozhuthana town are also well connected by good roads but moving away from the plain terrain to hillside where Adivasis are the predominant settlers, roads remain potholed and damaged throughout the year. It is observed that majority of the Auto drivers are reluctant to drive over these roads, and walking around 2km is the only option left for the villagers to access facilities in the Pozhuthana town. The PHC, private clinic, dispensaries, and medical shops in the village are situated in the town area of Pozhuthana. There is one PHC functioning in Pozhuthana with out-patient services on three days in a week, from 8 am to 1 pm. There are five sub-centres under the PHC in this 71.3 sq km area, each caters around 3680 population on an average. In addition to the daily outpatient care, there are weekly specialist clinics like NCD clinic, eye clinic, and adolescent clinic functioning in the PHC. To

help the people for basic health needs at the village itself, there are 11 ASHA workers each serves around 1600 population. Further, there is one Homeopathic and an Ayurveda dispensary in the panchayat; both work six days a week from 9 am to 1 pm. In addition to this, in the private sector, there is one private clinic in the panchayat run by a qualified medical practitioner and an estate clinic situated in the coffee plantation to cater the needs of plantation workers.

In addition to the facilities inside the panchayat, specialist services are available at general hospital Kainatty, Taluk hospital Vythiri and district Ayurveda hospital Kalpetta, all situated around 7 km away from the panchayat. Along with these public facilities, in the town area of Kalpetta and Vythiri, there are many small clinics and specialty hospitals under the private sector. At seven kilometers away, the taluk hospital works with out-patient services at six days in a week and 24x7 inpatient and casualty services. However, it is also found that the Vythiri taluk hospital's casualty is set up with minimal facilities, and shortage of doctors is a major issue in this hospital. There were incidents of casualty and gynecology department of the hospital remaining closed for several days due to doctors' shortage.

For patients from Pozhuthana, Vythiri taluk hospital is the nearest public facility with inpatient care. However, from the village there are no direct public transport services like bus service or jeep service up to CHC. They get bus or jeep service up to the town Vythiri only; from there, they have to walk around 2 Km or hire an auto to reach the hospital. From a long time onwards, a pressing demand of people from the area and the district is for a tertiary care referral hospital, particularly a medical college in public sector. Many lives have been lost in the district due to non-availability of quality tertiary care facilities in public sector. The medical College in neighboring Kozhikode district which is around 75 km away is what they depend, but absence of adequate roads makes their attempts to reach hospital within a reasonable time impossible. During heavy monsoons, it is usual for even small landslides to lead to disruption in transportation through the ghats.

As this is the case of health care infrastructure in the village and neighboring areas, it is important to understand that whether the existing facilities ensure an equitable provision of services or create and reinforce existing socioeconomic disparities in health care utilization? To have a clear picture of this, it is important to understand the availability of resources among the villagers that facilitates equitable access to health care services. The socioeconomic data

collected at household level in the context of social histories shows differences in the resource base of social groups and class groups within them (see chapter IV). Data from household level survey shows that among the five major social groups in the village, the most deprived in socioeconomic status are the Adivasis. The primary occupation of the largest segment among Adivasis, is the low-paid and least regularly available agricultural labour and daily wage labour. Even though some of them have more than 0.5 acre of land very few among them were able to make a reasonable income from it. A large share among them still lives in single room thatched houses, when not a single household from other social groups lives in such houses. Out of the thirty households of Adivasis interviewed, only one-third of them have LPG connection as a primary energy source for cooking. Further, a large share among them experiences a shortage of food in at least some months. It was only from Adivasi community that some of the households reported facing shortage of food every month during the last six months. It is the subsidized food from PDS shops that keeps many among them from going hungry.

The case of Dalits is not too different from that of Adivasis, but in certain aspects they were able to derive an advantage to an extent. For example, even though they do not have much land and other resources like gold, in case of any need, many among them are capable of availing small loans from SHGs through their larger participation in *Kudumbasree*. Similarly, some among them were able to do own farming by taking land on lease through the help of SHGs. The improved education and community participation through SHG and Gramasabha, many among them were able to avail support from various government schemes. This helps a good share among them to have pucca and semi pucca houses with government support. However, they are still very poor in as much as they have little share in government/permanent salaried employment, inownership of land especially agricultural land, access to safe drinking water within residential premises, inadequate living space, or access to better energy for cooking, and financial capacity to meet other household needs.

In the case of Thiyya who belongs to OBC community, both better-off and comparatively poor are better positioned in terms of household resources than that of Dalits and Adivasis. In the case of comparatively poor among Thiyyas, even though there is a good share of them having their primary family occupation as daily wage labor, more than two-thirds were able to meet most of their household needs through primary occupation. The comparatively better availability of

workdays per month and the better wage through their engagement as main workers in different occupations are the main reason for this. However, some among them still experience shortage of food during some months in a year, while others face decline in quality and quantity of food consumed. Majority among them meet their food requirement through subsidized food grains from PDS shops. More than half among them depend on neighbor's house for drinking water, while a little less than fifty percent do not have LPG connection, and one third among them live in semi-pucca houses. Neverthless, comparatively good proportion of women among them participate in SHGs and are thereby capable of availing minor loans without any mortgage. A good share among them has the education of matriculation or above. In case of better-off among them, the majority are at par with their counterparts from upper caste Hindu and Muslims in terms of having household level resources.

Household level data shows that in the case of upper caste Hindus and Mulims in the village, they are better equipped to have household level resources compared to other social groups. When the largest share of better-off households among upper caste Hindus has salaried employment as primary livelihood, largest share among better-off Muslim households has Gulf remittance as their primary source of family income. More than two-fifths of Muslim and more than three-fifth of upper caste Hindu households among better-off have more than 0.5 acres of land. More than four-fifths from both communities have pucca houses, and more than two-fifths of both have at least four room houses. All better-off households from both communities have LPG connection and all from upper caste Hindus have their own well. Majority of households among both have more household utilities, and none from upper caste Hindu and only some from Muslim households depend on PDS shops for food grains. Further,the better-off among both communities have a good share of family members with education above matriculation with the proportion being greater among upper caste Hindus.

In the case of comparatively poor households among both upper caste Hindu and Muslims, when more than half of them have daily wage labor as their primary family occupation, among upper caste Hindu households around one-third among them have salaried employment as a primary family occupation. Among both communities, only one household from upper caste Hindu has more than 0.5 acres of land. When around four-fifth of households among both communities have pucca houses, two-fifths of houses among Muslims are built with government support.

Similarly, in the case of number of rooms and availability of own well, comparatively poor households from upper caste Hindus are better equipped than Muslims, and are even at par with better-off among Muslims. One fifth of upper caste Hindu households and a little less than two-fifth of Muslim households are unable to meet their household needs though primary livelihood alone. While none among upper caste Hindu households faced a shortage of food during any month, a few households among Muslims did face a shortage of food during some months. In the case of dependence on PDS shops for food grains, largest among both the community depends on it but it is less among upper caste Hindu compared to Muslims households. Even though, comparatively poor among both upper caste Hindu and Muslim households are better than comparatively poor among other social groups, some among them still faces difficulties in meeting their basic household needs through the available household level socioeconomic resources.

In sum, Adivasis followed by Dalit community have lowest level of socioeconomic resources available at household level compared to other social groups in the village. In fact, the condition of many better-off among these two social groups is not better than some of comparatively poor among other three social groups. As the household level resources influence shaping of health and health care utilization, the following section understand the health care utilization of various social groups in relation to the variations in household level resources available to them.

Health and health care utilization in the village: How do the people perceive and practice it.

The diverse social histories of various social groups presented in chapter 3 shows that people from the village have diverse views on health and illness. Social histories also shows that, the health care utilization or the health promoting way of life among villagers is deeply affected by the way people perceive causation of disease, manifestation of health or ill-health, and the resources they can afford. One of the important and generally accepted ideas of good health among villagers from various social groups is that of 'normality'. The 'normality' of physiological parameters is something patients from all social groups point out. People make sense of normal values of different measurements through their interaction with others including patients and health professionals. However it does not mean that all are well aware of the normal

physiological / biochemical values of different bodily measurements. For example, a man of 60 years old found following diet to control diabetics without getting diagnosed as diabetic. His understanding is that people in his age group is highly susceptible to high blood sugar, in fact some of his neighbors and friends of similar age have diagnosed to be diabetic. His close interaction with those who are suffering from diabetics shaped his understanding of controlling blood sugar to normal level, hence he started locally recognized diet to control blood sugar in the normal range.

Normality is also culturally defined among the villagers. Much strongly expressed by Adivasis and believed by all other social groups in varying degrees, following a normal life which in concurrence with rituals and beliefs, with the environment in which one lives are all part of normality in defining health by the villagers. One good window to understand how individual or community perception on disease causation influences health care utilization is the preventive care practices followed by the villagers. The interventions of prevention in averting any disease are not limited to preventive medical care but also include interventions in individuals' social and private lives. The practices being followed by villagers including seasonal changes in food consumption, the habit of drinking hot water, the collective attempts for vector control during monsoon season, and traditional wellness care during off-season are all part of the preventive measures based on the perception of individuals in the village.

It was found that there is great variation in the health care utilization among different social groups.The self-treatment followed is different, the utilization of system of medicine is different, and many are using more than one system of medicine to deal with particular disease. Along with the availability of facilities, many other socioeconomic and cultural aspects influence people's choice of action; one such important among the villagers is the perception of health, illness, and systems of medicine. For example, the common belief among the villagers is that in case of jaundice, after getting treatment from an Allopathic doctor having the traditional medicine prepared with a local plant *Keezharnelli* is a must to cure the disease completely. Those who use traditional medicine have the opinion that even if jaundice gets cured, its elements will not get completely removed from the body, and that’s why reports of blood tests repeatedly show irregular results even after the disease gets cured. They believe that having *Keezharnelli* will completely remove the disease-causing agents from the blood. What is important here is,

people's perception of normality, their perception on the causation of jaundice and their perception of the epistemological base of different systems of medicine.

In the village, people are not desperately roaming around different systems of medicine and facilities available to them. Rather the preference to self-treatment, certain system or multiple system of medicine for the treatment of a particular illness is from their recognition of the cause of illness and the epistemological bases of available medical systems through their experience of successful treatment. Further the different socioeconomic groups placed at different levels of the society have different preferences based on levels of their understanding conditioned by factors like education, quality of social capital, as also their economic status. This is explained in detail in comming sessions while discussing health care utilisation during acute illness, chronic illness and in th case of hospitalisation.

Even though there are variations across social groups, there is a general trend among the villagers in terms of medicine used for self-treatment for acute illness and chronic illness. During the household survey, it is found that, among those who did self-treatment in case of acute illness during the last 30 days, around 65 percent reported they commonly followed self-treatment in the village (see table A17 in annexure). Along with other factors, perception of health, illness and the system of medicines available is an important factor among the villagers in deciding when and what illnesses are appropriate for self or professional treatment. For example, the general perception of daily wage labours of various social groups in the village is related to functionality. Being able to do normal activities of day-to-day life with or without minor illness like body pain is what they see as normal health. Those who do heavy physical work are expected to face body pain is their explanation and they do self-treatment for that.

Another generally believed perception about ill health among some of the villagers is, ill health is due to issues in the right balance between supernatural beings or the environment. It is found that irrespective of religion and caste, some among the villagers offer prayers in temples and mosques in case of certain illness. In case of mental illness, stomach issues, cancer, and for many chronic illness villagers were found offering prayers even at temples outside the village to cure the illness. Another usual explanation of health by the villagers is health as the absence of illness. Through the experience of certain symptoms or feelings of illness they identify that they are not

healthy. Even though there are different views on health and illness among the villagers, these ideas are not exclusive of each other, rather, it is found that according to situations, different perceptions on health and illness are mixed to give a satisfactory explanation.

As there are differences in the health care utilization and practice among various social groups, there are also differences in their perception, which is an important factor that influence their health care practice. Thus, the evidence of differences in perceptions among various social groups is also presented in relation to their response in case of acute illness, chronic illness, and hospitalization in the following sections.

Health care utilization among different social groups in case of acute illness

Within the available health care institutions and providers in and around the village each social group have certain preference in availing care for acute illness, chronic illness and for hospitalization. To put this in perspective, an analysis of health seeking behavior is done here in this chapter in the context of the social histories mentioned in the previous chapter. Table 5.1 and 5.2 shows the first response of patients from all five social groups in case of any acute illness that occurred within thirty days prior to data collection. Table 5.1 shows that for all the five social groups self-treatment is the major way to deal with acute illness, with highest among ST and OBC. When it comes to utilization of healthcare providers, in case of SC and ST largest segment among them approach public health care institutions of PHC or CHC.

Within public health care institutions while largest segment among ST's visited the nearby PHC as the first resort, largest numbers among SC visited the Government Taluk hospital. In case of utilization of private providers, when as similar to other social groups around one quarter of patients from SC community visited a private clinic, only 8.9 percent of patients from ST visited them. In case of Thiyya, upper caste Hindu and Muslims largest share among them consulted private allopathic clinics or hospitals. However, it is also important to note that, when comparatively good share of patients from upper caste Hindu and Muslims visited both private clinic and hospital, only 6.7 percent of patients from Thiyya community visited a private allopathic hospital. In addition to this, except SCs, at least some among all other social groups utilized the service of a folk healer, and at least some among all other social groups except SC and ST utilized the service of Government AYUSH services during 30 days prior to data

collection. In addition to this 5.5 percent of patients from Muslim community visited an estate clinic which is situated in the coffee plantation to cater the needs of plantation workers.

Table 5.1: Social group wise first response in case of acute illness

Social groups	Self-treatment		Folk healer		Govt AYUSH		Estate clinic		Allopathic PHC		Allopathic CHC		Private Allopathic clinic		Private Allopathic hospital		Total	
SC	11	(26.8)	0	(.0)	0	(.0)	0	(.0)	7	(17.1)	9	(22.0)	10	(24.4)	4	(9.8)	41	(100)
ST	20	(44.4)	1	(2.2)	0	(.0)	0	(.0)	10	(22.2)	8	(17.8)	4	(8.9)	2	(4.4)	45	(100)
Thiyya	17	(37.8)	2	(4.4)	3	(6.7)	0	(.0)	5	(11.1)	4	(8.9)	11	(24.4)	3	(6.7)	45	(100)
Upper caste Hindu	13	(30.2)	1	(2.3)	2	(4.7)	0	(.0)	4	(9.3)	2	(4.7)	11	(25.6)	10	(23.3)	43	(100)
Muslim	13	(23.6)	2	(3.6)	1	(1.8)	3	(5.5)	5	(9.1)	5	(9.1)	14	(25.5)	12	(21.8)	55	(100)

Row percentage in brackets

Further, the class differences within each social group in terms of care utilization are depicted in table A8 in annexure. It shows among all social groups comparatively poor approach public health care facilities more than better-off. Table 5.2 shows that better-off among SC and ST have greater dependence on public health care institutions compared to better-off among other social groups. One thing important to note here is that different from better-off SC, largest from better of ST visited Taluk hospital instead of nearby PHC. The major reason for that is free public provision of specialists and laboratory services at Taluk hospital for all days except Sundays.

In case of private providers majority from comparatively poor of all social group preferred less expensive private allopathic clinics instead of private allopathic hospitals. Among those comparatively poor who availed care from private providers, it can be seen that it is the patients from upper caste Hindus approached then in greater number followed by Muslims. It is also important to note that there is one allopathic private clinic in the village and three more clinics in the nearby villages run by qualified doctors. Whereas an allopathic private hospital is available only in the nearby town which is nine kilometers away from the village. In case of public health care institutions one PHC is functioning in the village with out-patient services at three days in a week. And a Taluk hospital at seven kilometers away with out-patient services at six days in a week and 24*7 casualty services. In addition, there is one government homeopathic dispensary in the village and an ayurvedic dispensary from where patients from Thiyya, upper caste Hindu and Muslims availed care during the last thirty days.

Table 5.2: Social group and class wise first response in case of acute illness (in column percentage)

	SC		ST		Thiyya		Upper caste Hindu		Muslim	
	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Self-treatment	25.0	28.6	45.0	44.0	23.8	50.0	38.1	22.7	21.4	25.9
Govt AYUSH	.0	.0	.0	.0	4.8	8.3	.0	9.1	.0	3.7
Allopathic PHC	15.0	19.0	5.0	36.0	9.5	12.5	4.8	13.6	.0	18.5
Allopathic CHC	10.0	33.3	25.0	12.0	4.8	12.5	.0	9.1	3.6	14.8
Estate clinic	.0	.0	.0	.0	.0	.0	.0	.0	.0	11.1
Private Allopathic clinic	35.0	14.3	15.0	4.0	38.1	12.5	23.8	27.3	32.1	18.5
Private Allopathic hospital	15.0	4.8	10.0	.0	14.3	.0	28.6	18.2	35.7	7.4
Folk healer	.0	.0	.0	4.0	4.8	4.2	4.8	.0	7.1	.0
Total	100.0	100.0	100	100	100	100	100	100.0	100	100.0

While coming into the reason for consulting provider in case of any acute illness, table 5.3 shows that except ST and Thiyya community more than half of patients from all other social groups reported increased severity of symptoms as the reason for consulting a provider.In case of those who reported severity of illness blocked day to day activities as a reason for consulting a care provider ST community was foremost. In fact, it is the only community from which more than half of the patients reported the same. The other communities from which greater share of respondents reported severity blocked day to day activities are SC and Thiyya community. Importantly, comparatively poor among SC, Thiyya and both better-off and poor among ST are the groups from which greater share of respondents reported this (see table A9 in annexure).

The other important reason mentioned by respondents is self-treatment did not provide relief. Which is highest among Thiyya community followed by Muslims, ST and upper caste Hindu community. The table also shows that this difference in reason for consulting a care provider for any acute illness is significantly different among the social groups; however it is not statistically significant among class groups. Further, the differences in the reason for consulting a provider are more significant among comparatively poor households of different social groups. In the case of better off households from different social groups, the differences in their reason for consulting a provider is statistically not significant at 0.05 level. In other words, when there is a

clear distinction of social groups among comparatively poor households in their reason for consulting a provider, the differences among better-off households do not show a clear trend. This is clear in table A9 in annexure, in case of comparatively poor when severity blocks day to day activities and symptom increase severity are the important reason for SC, ST and Thiyya. For upper caste Hindu and Muslims, it is symptom increase severity and self-treatment did not cured are the major reasons.

Table 5.3 Reason for consulting a provider in case of acute illness

	Symptoms increase severity		Severity blocks day to day activities		Self-treatment did not cured		Total	
SC	17	(56.7)	10	(33.3)	3	(10.0)	30	(100)
ST	7	(28.0)	13	(52.0)	5	(20.0)	25	(100)
Thiyya	10	(35.7)	9	(32.1)	9	(32.1)	28	(100)
Upper caste Hindu	19	(63.3)	5	(16.7)	6	(20.0)	30	(100)
Muslim	27	(64.3)	6	(14.3)	9	(21.4)	42	(100)
Total	80	(51.6)	43	(27.7)	32	(20.6)	155	(100)

Pearson Chi-Square Test: Sig = 0.012

Table 5.4 shows the distribution of patients from different social groups based on reasons for preferring a particular provider for acute illness in the last thirty days. For the poorer sections of different socioeconomic groups in general, and the more oppressed sections in particular, accessing quality health care at an affordable cost / for free, was the guiding factor in determining choice of care provider. 'Free public provision' along with 'Quality care at public provision' together were the most important considerations for the SCs and STs communities. On the other hand, for upper caste Hindus and the Muslims the combination of 'Quality of care' and 'Convenience' together constituted the foremost reasons. The Thiyyas fell between the two sets of social groups.

The table shows that for the largest share of patients from ST community, free public provision is the reason for preferring the provider during acute illness. 'Quality care at public provision' and 'quality of care' are the other important reasons mentioned by at least one-fourth of the patients among them. A similar trend can also be observed among SC community, free public provision and quality care are the important reasons mentioned by them and at least one fourth of patients each mentioned these reasons. Nearby presence of a health care facility (19.4%) is the other important reason mentioned by SC followed by quality care at public provision (16.1) and

convenience (12.9). In the case of Thiyya, upper caste Hindu and Muslims largest share of patients from each group reported quality of care as a reason for choosing a particular provider. However, when convenience is the second largest reason mentioned by upper caste Hindu and Muslims, for Thiyya it is quality care at public provision. In addition, free public provision as a reason for preferring providers is lowest among upper caste Hindu and low among Thiyya and Muslims.

Table 5.4: Reason for preferring particular provider in case of acute illness

	Nearby	Free public provision	Quality care at public provision	Quality of care	Convenience	Preference to AYUSH and folk healer	Total
SC	6 (19.4)	8 (25.8)	5 (16.1)	8 (25.8)	4 (12.9)	0 (.0)	31 (100)
ST	2 (7.1)	9 (32.1)	7 (25.0)	7 (25.0)	1 (3.6)	2 (7.1)	28 (100)
Thiyya	1 (2.8)	3 (8.3)	11 (30.6)	12 (33.3)	5 (13.9)	4 (11.1)	36 (100)
Upper caste Hindu	3 (8.1)	0 (.0)	3 (8.1)	13 (35.1)	12 (32.4)	6 (16.2)	37 (100)
Muslim	5 (11.9)	3 (7.1)	7 (16.7)	13 (31.0)	11 (26.2)	3 (7.1)	42 (100)
Total	17 (9.8)	23 (13.2)	33 (19.0)	53 (30.5)	33 (19.0)	15 (8.6)	174 (100)

The class differences in the preference of provider shows that, largest share of better-off patients reports quality of care as the major reason for preference, for largest among comparatively poor it is quality care at public provision (see table A10 in annexure). Similarly, when quality of care and free public provision are the second largest reason for comparatively poor, for better-off convenience is the second largest reason.

Further, table A11 in annexure shows that quality of care is the major reason mentioned by the largest share of patients for consulting a private allopathic clinic or hospital for acute illness. It is only in case of private providers patients reported convenience as an important reason for preferring a particular provider. The major things include in the convenience mentioned by the respondents are facilities like booking an appointment through telephone and less queue. In the case of PHC, free public provision is the important reason mentioned followed by nearby availability and quality services at public provision. In the case of Taluk hospital, the largest mentioned reason is quality service at public provision. In quality service at Taluk hospital, it is

the availability of specialists and laboratory services mainly considered by majority of respondents. In case of reason for preferring AYUSH provider and folk healers, for largest, it is the preference over a particular system of medicine that leads them to prefer the provider.

Utilization of different system of medicines

Table 5.5 shows the utilization of different systems of medicine for the treatment of acute illness. This data also includes the self-treatment for which patients have used any medicine bought from the market. The table shows that irrespective of social groups majority of patients followed allopathic system for treatment of their acute illness. Patients from all social groups also availed treatment from the Ayurvedic system with comparatively greater utilization among Thiyya and ST community. In the case of homeopathic system, except for ST and Thiyyas, all others have availed treatment under the system during the last thirty days. It was only the Muslim community that followed treatment under Unani system for acute illness during the period. While understanding the utilization of different system of medicine it is also important to note that there is no public or private health care institutions under Unani is working in the panchayat except a traditional practitioner of Unani who caters patients at his residents on demand. Further, it is also found that patients from the village availing public and private AYUSH services from the nearby villages.

Table 5.5: Utilization of different systems of medicine for acute illness among social groups

Social Groups	Ayurveda	Homeopathy	Unani	Allopathy
SC	3 (8.8)	1 (2.9)	0 (.0)	30 (88.2)
ST	5(13.5)	0 (.0)	0 (.0)	32 (86.5)
Thiyya	11 (26.8)	0 (.0)	0 (.0)	30 (73.2)
Upper caste Hindu	2 (4.7)	3 (7.0)	0 (.0)	38 (88.4)
Muslim	5 (9.1)	1 (1.8)	2 (3.6)	47 (85.5)

Advise before consulting

In case of any advice taken or enquiry made before consulting a particular provider, table 5.6 shows that largest share of households from all social groups did not take any advice or made

any enquiry before their first consultation of a care provider for acute illness. In case of those who have taken advice or made any enquiry from friends and relatives before consulting a particular provider, Thiyya community recorded the highest, followed by SC and Muslims. A class-wise distribution of advice before consultation shows that better-off among Thiyya, SC and Muslims reports advice before consultation greater than comparatively poor among them (see table A12 in annexure). Comparatively poor among ST and upper caste Hindu reports greater than better-off among them in case of advice taken. The reason for such a trend can be identified from the cross tabulation of providers consulted in the first episode with advice taken (see table A13 in annexure). It shows that the highest share of patients who took advice are those patients who availed care from a private allopathic hospital and private allopathic clinic. In the case of public health care institutions, a greater share of patients who availed care from AYUSH institutions and PHC reported they took advice or enquiry before consulting a provider. One of the major reasons for this is lack of outpatient services all day in a week at the PHC. Outpatient services at PHC are available only three days in a week, and specific specialized clinics are functioning on particular days. In the case of CHC, except Sunday, regular outpatient services are available on all days and 24x7 casualty services are also available. People are more informed about the availability of OPD services at the CHC than that of PHC due to non availability of services at PHC on certain days in a week.

Table 5.6: Advise before consulting a provider in case of acute illness

	No	Friends and family	Total
SC	20 (64.5)	11 (35.5)	31 (100)
ST	21 (72.4)	8 (27.6)	29 (100)
Thiyya	23 (59.0)	16 (41.0)	39 (100)
Upper caste Hindu	25 (73.5)	9 (26.5)	34 (100)
Muslim	28 (68.3)	13 (31.7)	41 (100)
Total	117 (67.2)	57 (32.8)	174 (100)

Mode of transport

Given below table 5.7 shows the mode of transport used by patients from different social groups in case of availing care for acute illness. It shows that except upper caste Hindu and Muslims, at

least more than half of the patients from all other social groups used public transport to reach health care facilities. In case of, largest share of upper caste Hindu and Muslims private vehicle is the major mode of transportation. Further, it is highest among better-off households from these two communities. The private vehicle mentioned here includes both own vehicles and hired vehicles like autorickshaw. As we have already seen both upper caste Hindu and Muslims have a good share of households with own vehicle and resources to hire vehicle, use of private vehicle is high among them. The differences in mode of transportation to reach health care facility are more significantly different among economic classes. As shown in table A14 in annexure, when around 43 percent of patients from better-off households use the private vehicle to reach health care facility in case of comparatively poor households it is only 25 percent. On the other hand, in the case of public transport, 58 percent of patients from comparatively poor and around 45 percent of patients from better-off uses it.

Table 5.7: Mode of transport in case of consulting a provider for acute illness among social groups

	Private vehicle	Public transport	Walking distance only	Total
SC	6 (19.4	20 (64.5)	5 (16.1)	31 (100)
ST	8 (28.6)	15 (53.6)	5 (17.9)	28 (100)
Thiyya	8 (22.2)	25 (69.4)	3 (8.3)	36 (100)
Upper caste Hindu	18 (50.0)	14 (38.9)	4 (11.1)	36 (100)
Muslim	19 (45.2)	15 (35.7)	8 (19.0)	42 (100)
Total	59 (34.1)	89 (51.4)	25 (14.5)	173 (100)

Government homeopathic dispensary, ayurvedic dispensary, and PHC are the facilities available in the panchayat; thus the share of patients who reported ‘walking distance only’are high in the case of Government AYUSH and PHC (see table A14 in annexure). As a higher share of patients from SC and ST already reported that they visit PHC, similarly we can see a higher share in case of SC and ST in reporting ‘walking distance only’ to reach PHC. As in table A14 in annexure it is only in case of private allopathic hospitals more than half of patients use private vehicle to travel, and in case of private allopathic clinic it is around 44 percent. As we have already seen patients from better-off households have a preference towards private facility and a good share of

such households have own vehicle or are able to hire a vehicle, this trend in the utilization of private vehicle is expected. However, in the case of CHC around 43 percent of households report they either use own vehicle or hired vehicle. This is mainly because from the village, there are no direct public transport services like bus service or jeep service up to CHC. They get bus or jeep service up to the town Vythiri only, from there, they have to walk 2 KM or hire an auto to reach the CHC. If any patient has used a hired vehicle in any part of his/her journey towards health care facility, it is included in the category 'private vehicle'.

In sum, as we have seen, health care utilization in case of acute illness during the last thirty days shows differences and uniqueness among different social and class groups. Even though self-treatment is high among all social groups, it is highest among ST community. Similarly, public provider utilization is highest, and utilization of private provider is lowest among them. In addition, compared to better-off among other social groups better-off among ST community utilize public providers to a large extent. In the case of private providers, it is the less expensive private allopathic clinic they largely utilized, including better-off among them. Among the reason for consulting a provider it is from the ST community especially comparatively poor among them in greater share reported severity blocks day to day activities as a reason. Similarly, among the patients, it is from the ST community largest share of patients reported free public provision as a reason for choosing a particular provider for treatment. As similar to others social groups, the largest number of patients from the ST community also reported they utilized allopathic system, but in case of ST they are the second largest to utilize ayurvedic system of medicine. In the case of mode of transportation to reach health care provider ST community is one among highest who utilizes public transport services.

In the case of SC also they are the one among those utilized public provider highest. In fact, out of the total patients from better-off category, it is the better-off from SC who reported second largest in utilization of public providers. Similar to ST, better-off among SC has preference towards less expensive private providers than better-off among other social groups. However, different from ST community, for the highest share of patients from SC community, severity of symptom increased is the reason for consulting a provider. Further for choosing particular provider, highest among them reported two reasons free public provision and availability of quality services. However, in case of utilizing public transport service to reach health care

facilities, they also reported highest as similar to ST community. But different from ST, patients from SC are the one among the social groups from large share of patients reported they took advice or made enquiry from friends and family before consulting the provider.

Self-treatment among social groups

As we have already seen the high degree of self-treatment among all social groups it is important to see what exactly people do in self-treatment and the differences in its practice among different social groups. Table 5.8 shows that medicines prepared at home is the major contributor to self-treatment among all social groups in which SC and ST more significantly relying on it. These medicines prepared at home include *chukku kappi* (black coffee with elements of medicinal plants), preparation of juice of different plants, paste and extracting essence from medicinal plants. Such preparations are mainly used for illness like fever, cold and cough, stomach pain, mild burn, headache and jaundice. The other important ways of self-treatment are use of medicine bought from market in which upper caste Hindus followed by Muslims and Thiyya community relaying more compared to other social groups. However, there are no differences among the illnesses for which allopathic medicines are bought from the market and medicine prepared at house. The major difference, as what we can see from the table is the differences between social groups in using different methods.

In case of using medicine available at home the trend is not exactly like that of medicine bought from the market. In this case, Thiyya community comes first, followed by Muslims, Upper caste Hindu and then other communities. The close relation of Thiyya community from the region on traditional medical practices and the habit of Muslims in keeping basic medicines at home which are normally bought by Gulf emigrants will partially explain this trend. At least one medicine brought from Gulf countries is available in all emigrants' houses and almost in all houses of relatives and neighbors of emigrants. The commonly found medicines brought from Gulf are ointments, medicated oils, and sprays to treat illnesses like cold, headache, body ache, leg pain, teeth pain and mild injuries. In addition, the table 5.8 also shows that the relation of self-treatment with social groups is much significant than its relationship with different class groups. In other words, the differences among social groups in the method of self-treatment are significant in comparison with the differences among different class groups.

Table 5.8 Method of self-treatment followed by different social and class groups

	Herbal medicine prepared at home		Medicine bought from market		Medicine available at home		Total	
Social groups*								
SC	24	(92.3)	1	(3.8)	1	(3.8)	26	(100)
ST	29	(93.5)	1	(3.2)	1	(3.2)	31	(100)
Thiyya	15	(71.4)	3	(14.3)	3	(14.3)	21	(100)
Upper caste Hindu	15	(57.7)	9	(34.6)	2	(7.7)	26	(100)
Muslim	28	(73.7)	6	(15.8)	4	(10.5)	38	(100)
Class groups**								
Better-off	59	(83.1)	3	(4.2)	9	(12.7)	-	(100)
Comparatively Poor	52	(73.2)	8	(11.3)	11	(15.5)	-	(100)

*Pearson Chi-Square Tests: Sig=.018, ** Pearson Chi-Square Tests: Sig=.233

Table 5.9 shows the reasons for doing self-treatment by respondents from different social groups in case of acute illness. This data also includes those self-treatments that are done simultaneously with treatment from a provider. In almost all illness mentioned under acute illness, self-treatment is performed by majority of respondents from all social groups. The table shows that irrespective of social groups majority of patients followed self-treatment because they knew or were told of the effective remedy for the illness. ST, Thiyya and Upper caste Hindu community take the lead in this. Notably, they are the same community who least reported 'did not consider illness to be serious'as a reason for doing self-treatment compared to other communities. When majority have reported that they knew or told of the remedy, it is also important to note that these are mainly those illnesses for which their first response is self-treatment from a long time and those illnesses which in the past they were able to successfully cure with self-treatment. One of the other reasons pointed out by a few upper caste Hindu and SC community for doing self-treatment is to ensure easy/ speedy recovery from the illness.

When the majority have opined they knew or told of the effective remedy for the illness and a good share of patients reported they prepare the medicines for self-treatment at their house, it is important to look into the source of information for self-treatment among households (see table A15 in annexure). Parents and other old members in the family are the largest source of information for self-treatment for households of all social groups. However, educated young in the family is also an important source of information for self-treatment among all social groups. Except households of SC and ST, more than half of households from all other social groups

reported both old persons and young educated are the major source of self-treatment for them. To support this data, as we have already seen from table 5.8, medicine bought from the market and medicines available at home are an important method of self-treatment among these social groups.

Table 5.9 Reason for doing self-treatment in case of acute illness

	Knew /was told of effective remedy	Did not consider illness to be serious	For easy relief from illness	Total
SC	20 (66.7)	9 (30.0)	1 (3.3)	30 (100)
ST	34 (85.0)	6 (15.0)	0 (.0)	40 (100)
Thiyya	20 (83.3)	4 (16.7)	0 (.0)	24 (100)
Upper caste Hindu	18 (78.3)	2 (8.7)	3 (13.0)	23 (100)
Muslim	24 (64.9)	13 (35.1)	0 (.0)	37 (100)
Total	116 (75.3)	34 (22.1)	4 (2.6)	154 (100)

In sum, ST community is the one among the social groups in which practice of self-treatment is highest. In their practice of self-treatment, medicine prepared at their own house is major way of self-treatment, and medicine bought from market, medicine available at house is lowest compared to other social groups. The major reason for doing self-treatment as 'knew or told of effective remedy' is reported highest from them. In addition, they were one of the communities from which the highest share of individuals responded that parents and other older people in the family are the major source of information for self-treatment. Further, they are one among the lowest in reporting educated young as the source of information. In the case of SC community, the situation is similar, but one major difference is they are one among the two communities from which the highest number of patients reported 'did not consider illness as serious' as a reason for doing self-treatment. The other community from highest number of individuals reported self-treatment in case of acute illness is Thiyyas. In the case of Thiyya, even though the usage of herbal medicine prepared at home is the major way of self-treatment, more than one-quarter of patients either use medicine bought from the market or medicine available at home for self-treatment. Followed by ST community, it is from Thiyya community highest share of patients who responded knew or told of an effective remedy for the illness as a reason for doing self-treatment. At the same time, they are one among those communities from which the largest

share of households responded that both old persons and educated young persons as the source of information for self-treatment.

Among all the social groups, it is from the upper caste Hindu community largest share of patients have responded that medicine bought from market as a way of doing self-treatment. Similarly, they are the community from which the highest number of households responded that source of information as both old persons and educated young persons. In addition, they are the community from which more patients responded reason for doing self-treatment as 'for easy relief from illness'. All this shows that self-treatment among upper caste Hindus has more influence of allopathic medicines and information passed by educated young persons compared to other social groups. Compared to other social groups it is from the Muslim community lowest share of patients reported self-treatment as the first response in case of any acute illness. Also, they are the community from which the highest share of patients responded reason for doing self-treatment as they did not consider illness to be serious. At the same time, more than one-quarter of patients reported either medicine bought from the market or medicine available at house is used for self-treatment. When good share of patients from them does self-treatment to those illness which they consider not serious, at the same time use of medicine bought from market especially allopathic medicine is comparatively high among them. The greater share of Gulf emigrants from Muslims and the habit of bringing medicines and new information about self-treatment from the Gulf to home also influence shaping of self -treatment among Muslims.

Changes in utilization of providers over the period

Table 5.10 (also see table A16 in annexure) shows changes in treatment sought over ten years and whether respondents follow the same treatment which others do in the village in case of any acute illness. To the question whether they followed the same treatment ten years before for the same illness, more than half among all social groups responded that they followed the same treatment. However, when only 16.3 percent of upper caste Hindus responded, there are differences in treatment, 46.7 percent each from ST and Thiyya community responded there are differences in treatment which they followed ten years before while dealing with the same illness. In the case of SC and Muslims, around 32 percent from each group reported there are differences in their utilization of provider in case of acute illness.

In the case of patients who followed self-treatment as the first response for acute illness, more than half of them reported that they followed the same treatment ten years before (see table A17 in annexure). It is around 43 percent among them reported there are differences in treatment which they follow now compared to ten years before. In case of those who utilized care from folk healers and estate clinics for acute illness during last 30 days, none of them reported any change in utilization of providers over the period. From those patients who utilize care from a private allopathic clinic during the last 30 days, around 59 percent among them consulted a different provider ten years before for similar illness. In the case of other providers from where treatment is sought for acute illness during the last 30 days, more than half of respondents reported no major change in their utilization of provider. Patients who approached a PHC or CHC during the last 30 days are the one's who least reported any changes in approaching providers for similar illness ten years before.

Table 5.10: Distribution of patients from different social groups based on treatment sought 10 years before and commonly followed treatment in the village

	Treatment sought 10 years before			Commonly followed treatment in the village		
	Different treatment	Same treatment	Total	Same	Different	Total
SC	13 (31.7)	28 (68.3)	41 (100)	26 (63.4)	15 (36.6)	41 (100)
ST	21 (46.7)	24 (53.3)	45 (100)	18 (40.0)	27 (60.0)	45 (100)
Thiyya	21 (46.7)	24 (53.3)	45 (100)	25 (55.6)	20 (44.4)	45 (100)
Upper caste Hindu	7 (16.3)	36 (83.7)	43 (100)	19 (44.2)	24 (55.8)	43 (100)
Muslim	17 (31.5)	37 (68.5)	54 (100)	30 (55.6)	24 (44.4)	54 (100)
Total	79 (34.6)	149 (65.4)	228 (100)	118 (51.8)	110 (48.2)	228 (100)

In case of concurrence with the commonly followed treatment in the village for similar illnesses, except ST and upper caste Hindu community, more than half among all other communities followed the commonly followed treatment in the village. This exception of ST and upper caste Hindu matches what we have already seen in table 5.1 and 5.2, where the preference of ST and upper caste Hindu community in utilization of providers and self-treatment remains different from that of other communities. It is patients from SC community who least reported (around 37

percent) there are differences in their treatment of illness with commonly practiced treatment in the village. Among the patients who did self-treatment in dealing with acute illness during the last 30 days, around 65 percent reported they follow commonly followed treatment in the village, and the remaining 35 reported a difference (see table A17 in annexure). Out of this 35 percent who reported they follow treatment other than what commonly followed in the village; around 65 percent are from comparatively poor households (see table A18). As in table A16, in case of those who utilized care from a folk healer reported that majority of patients from the village consult a different provider.Among those patients who utilized care from a private allopathic hospital and private allopathic clinic, around 70 percent and around 76 percent respectively reported that villagers commonly approach different providers. Further, these patents who reported a difference are mainly from better-off households (see table A18 in annexure).

Treatment for chronic illness among different social groups

Table 5.11 and 5.12 shows the social group wise distribution of treatment sought in the first episode and treatment sought in the last episode of any chronic illness. As almost all those suffering from chronic illness reported they had done self-treatment at the time of the onset of the illness, details of provider consulted for first and last severe chronic illness are collected. In the case of provider consulted for first episode, except for upper caste Hindus and Muslims public institutions (Govt AYUSH, PHC and CHC altogether) are the most preferred provider than private institutions (Private AYUSH, private allopathic clinic and hospital altogether). Even though there are some differences, this trend is similar to what we have seen in the case of providers sought for acute illness (see table 5.1). Further, among upper caste Hindus and Muslims, care utilization is higher from the private allopathic hospital where specialist services are available compared to private allopathic clinics. The class differences show that the better-off from different social groups utilizes care from private providers in a higher rate. It is also important to note that when utilization of government or private AYUSH service is higher among upper caste Hindu and Thiyya, utilization of folk healer is higher among ST and SC in case of the first episode. In the case of provider sought for the last episode of severe chronic illness also, table 5.12 shows that only patients from upper caste Hindu and Muslim communities surpass the utilization of private providers over public providers. Table 5.12 also shows, in the

last episode, self-treatment is the most preferred way of dealing with chronic illness for all social groups with highest among SC and ST.

Table 5.11: Distribution of social groups based on provider consulted in case of first episode of chronic illness (in percent)

	Self-treatment	Govt YUSH	Private AYUSH	PHC	Allopathic CHC	Folk healer	Private Allopathic clinic	Private Allopathic hospital	Total
SC	12.9	.0	.0	25.8	12.9	12.9	25.8	9.7	100
ST	16.3	.0	.0	25.6	27.9	11.6	4.7	14.0	100
Thiyya	6.9	6.9	.0	34.5	31.0	.0	13.8	6.9	100
Upper caste Hindu	.0	6.9	10.3	13.8	10.3	.0	24.1	34.5	100
Muslim	7.7	.0	3.8	23.1	15.4	7.7	15.4	26.9	100
Total	9.5	2.5	2.5	24.7	20.3	7	15.8	17.7	100

Table 5.12: Social group wise distribution of response in the last episode of severe chronic illness (in percent)

Category	Self-treatment	Govt YUSH	Private AYUSH	PHC	Allopathic CHC	Folk healer	Private Allopathic clinic	Private Allopathic hospital,	Total
SC	29.0	.0	.0	19.4	19.4	9.7	6.5	16.1	100
ST	32.6	4.7	7.0	25.6	18.6	4.7	.0	7.0	100
Thiyya	24.1	10.3	.0	10.3	17.2	6.9	13.8	17.2	100
Upper caste Hindu	17.2	6.9	10.3	10.3	20.7	.0	10.3	24.1	100
Muslim	23.1	.0	15.4	15.4	11.5	3.8	7.7	23.1	100
Total	25.9	4.4	6.3	17.1	17.7	5.1	7.0	16.5	100
Better off	18.9	2.7	13.5	16.2	13.5	8.1	8.1	18.9	100
Comparatively Poor	32.1	6.0	.0	17.9	21.4	2.4	6.0	14.3	100

Compared to provider consulted in the first episode; in last episode, we can see an overall reduction in utilization of private providers. It is interesting to note that the reduction has mainly happened among the upper caste Hindu and Muslims. In addition, in the case of SC and Thiyya there is an increased preference towards private allopathic hospital in last episode. Even though comparatively poor among all social groups approach private allopathic hospitals it is higher among better-off households (see table A19 and A20 in annexure). The private allopathic hospital generally charges a consultation fee of Rs.100 to Rs.300 depends on the specialist but the private allopathic clinics charge only Rs.100 to Rs.150, and until recently they were even accepted less than Rs.100. The availability of specialist care, service of locally-well known

doctors like retired government doctors, appointment booking through telephone, comparatively shorter waiting time, availability of clinical facilities like laboratory and other facilities like comfortable waiting rooms, are the important reasons attract patients towards the private allopathic hospital. However, it is important to note that among the ST especially comparatively poor among them the higher utilization of private allopathic hospital is because of the availability of free care from charity hospital in the nearby town. Compared to first episode, we can see an overall increase in the practice of self-treatment and utilization of public and private AYUSH services in the last episode of chronic illness. Further, it can be seen that it is among SC the utilization of providers other than the allopathic system of medicine is low compared to other social groups. While comparing the utilization of providers other than the allopathic system for acute illness, we can see higher utilization among all social groups in case of chronic illness, especially in the last episode.

As chronic illness has a long history of treatment, sometimes of several years, provider sought in case of first episode and last episode is not enough to get a clear picture of different provider approached by the person suffering from it. From the first episode and last episode of the illness, we have already seen the utilization of public and private AYUSH services, approaching folk healers and doing self-treatment are important among those suffering from chronic health issues from different social groups. Further, an increase in the utilization of AYUSH services, folk healers, and self-treatment in the last episode of the illness is also notable. Among the chronic illness reported from different social groups, largest reported illnesses include body pain, bone attrition, leg pain, knee pain, blood pressure disorder, blood sugar disorder, cholesterol disorder, cardiac issues, cancer, and allergy. In treatment of such illness over the period, majority of the respondents reported they consulted multiple providers and multiple systems of medicine at different stages. It is from those who suffer from illnesses like bone attrition, body pain, back pain, and leg pain found using a different system of medicine in large. Those who suffers from disorder of blood pressure, blood sugar and cholesterol also found utilizing care from different providers of various system of medicine. Notably, it is among those who suffers from cardiac issues least reported they followed different system of medicine and consulted different providers. In fact, in the case of earlier two sets of illnesses, there are traditional medical practitioners of Ayurveda and Unani in the village who are recognized by the villagers as competent to manage the illness. In case of cardiac issues, even though one of the traditional

practitioners found mentioning he can treat such issues, none of the respondents found approaching a traditional practitioner for such illnesses except for cholesterol disorder. However, in case of cancer patients, two of them found consulting traditional medical practitioner while undergoing treatment under Allopathic system of medicine.

In the case of a 45-year-old ST men from comparatively poor household, now he is availing care from Government Ayurvedic hospital in the nearby town for his ten-year-old back pain. In the early days of the onset of the illness, he followed self-treatment with his mother's advice. His mother has knowledge in some of the traditional medicine, and she prepares a medicated oil for him to use. He mentioned the reason for doing self-treatment and not consulting a provider at the beginning as *"at the beginning, it was only a moderate pain, by applying oil before bath itself gave relief from that….there is no use in consulting a doctor, while doing heavy work back pain will be there…"*He managed the illness solely with self-treatment for two years, but when the severity of the back pain restricted him from performing his day to day activities he started availing care from District Ayurvedic Hospital in the nearby town Kalpetta. He continuously followed the treatment from the hospital for two months and got some relief from the pain. However, the back pain is not completely cured, and he occasionally visits the hospital when there is a severe pain. Otherwise, on a daily basis he uses the medicated oil prepared by his mother for self-treatment. He believes that the pain will not get completely cured as he is engaged in heavy physical daily wage labor. The medicines he gets from the Ayurvedic hospital are kashayam and a tablet to take orally, and two types of oils to apply over the body. He does not consult any other system of medicine or provider because he mentioned allopathic medicine will not suit to his body. However, on the doctor's advice from the Ayurveda hospital, he took an x-ray from the nearby private allopathic hospital in the town.

Now doing self-treatment is part of his daily life and in case of any severe pain, he avoids going to work and take rest. If the severe pain remains unchanged for two-three days, he consults the doctor at District Ayurvedic Hospital or dispensary in the nearby village *Pinagod*. In addition to the daily wage labour, he also does own farming in his land; thus whenever he skips daily wage labour due to backpain he works in his own farm without doing heavy physical work. At his own farming,, he has the freedom to work flexibly and engage in those works that do not increase the pain. He said,"*If going for work, it is not possible to do only those work which we like. As like*

*others, we also have to work. At own land [we] can do any work……[while skipping the work due to pain] for some time in the morning does works of arranging land for planting vegetables. Rest they will do [wife and daughter] ……. After that, takes rest at home or sometimes go to Pozhuthana town."*Further, during some of such days he even goes to Pozhuthana market where the PHC is situated but does not prefer to consult at the PHC for treatment. As already mentioned, he believes Ayurveda medicines are the most suitable for him and in case of chronic illness also does not want to try other system of medicine for treatment. On an average, he gets 15 days of wage labor in a month, and during the last month, he skips two days of work due to his poor health. Even though he uses the medicated oil prepared by his mother on a daily basis he do not know how to prepare it, and he has mentioned that it is only at the last days of his mother she will reveil details of it.

In the case of a 40-year-old Muslim housewife from a better-off household, for her 15-year-old chronic knee pain, she depends on self-treatment and treatment from a Unani practitioner near to her house. At the early stage of the pain, she did self-treatment and when the pain started disturbing her in performing her day-to-day activities, she consulted a Unani practitioner in the village. Even though it gives her relief from the pain, on her husband's advice who is a Gulf emigrant, she consulted a private allopathic clinic in the Kalpetta town. However, she believes that having allopathic medicine will give only temporary relief from the pain; thus she returns to the treatment from the Unani practitioner. She believes that having lot of allopathic medicines for such illnesses will adversely affect her health and will lead to fatigue. She also opinioned that having Unani medicine is less harmful and doing self-treatment is the best way to deal with her knee pain. She mentioned that *"husband told me to consult at Leo hospital….by having Unani medicine it will take time to get cured, in case of English medicine it will get cured in fast…….having a lot of English medicine is not good for health, knee pain won't go like that. It needs long time treatment. If it is Unani, it does not have much side effect on health."*It is also notable that in case of any acute illness like fever, cough, and cold she consults the same Unani practitioner. Even though the treatment from the Unani practitioner does not completely cured the illness, with the improved condition she manages to do the day to day activities. On the advice from the Unani practitioner she also bought medicine from the market and uses it whenever there is pain. Now she consults the practitioner only when there is severe pain, otherwise, the same medicine is used. Unlike the previous case, she does not do self-treatment on

a daily basis using the Unani medicine bought from the market but uses it only when there is pain.

In the case of a SC man of 42-year-old from a comparatively poor household, the way he manages a six-year-old back pain is different from what we have seen in the earlier two cases. At the onset of the illness, he also did self-treatment with an Ayurvedic oil, *Ashwagandha,* bought from the market. When the pain becomes more severe and lead to difficulties in going for daily wage labour, he rests at his house for few days and did self-treatment. However, the back pain remained unchanged along with fatigue and overall body pain. He then consulted a locally well-known Allopathic doctor at his private clinic. He got relief from fatigue and body pain by a week, however the back pain remains an issue while doing his daily wage work. Thus, he continued treatment from the provider along with self-treatment. He followed self-treatment to get easiness to the body, and believes that to cure the back pain it is necessary to avail professional care. During that time for two months he went to work only for few days due to back pain and followed treatment along with self-treatment using Ayurvedic oil. He explains it as

> *While plastering, it needs to climb on the ladder and work in a fast by keeping a pot of cement mix in hand. It is not possible to do that while having back pain. Thus, for few days I tried working as a helper, but it was also difficult to do…. Thus to cure the pain took rest for around three months….only for some days, I went to work during that time. To get money for consulting the doctor and to meet household expenses. Also borrowed some money from friends……self-treatment also done while taking treatment from the doctor. Does massage with Ashwagandha oil daily……. self-treatment was not enough; it only gave an easiness to the body. To recover from the illness had medicine from the doctor for around a month.*

Further, in case of latter incidents of severe pain, once he consulted at the CHC in the nearby town and later in the PHC. Now he uses the Ayurvedic oil bought from the market on a daily basis and an ointment prescribed by the doctor at CHC occasionally. He uses the ointment whenever there is severe pain and uses the Ayurvedic oil to massage the body every evening before bath. In addition, he occasionally applies the ointment after a bath and sometimes in the

night before he goes to bed. During the last month before data collection due to the illness, for a week he was unable to go for work and he availed care from PHC. For him, the back pain is now adjusted to his health, and he believes that it is not possible to completely cure. His case shows that what he does to manage the pain is consulting the allopathic doctor and taking rest by avoiding heavy physical works in case of severe pain and following self-treatment as a part of daily life.

The case of a 39-year-old Thiyya man from a comparatively poor household in managing his chronic back pain, and body pain is also similar to what we have seen in the previous case of SC wage labor. In this case also the initial response towards the pain was self-treatment using the Ayurvedic oil bought from the market. It is only after three years from the onset of the illness which developed into a severity that blocks him from performing his daily wage labour in the construction sector. It is at the point when the severity blocks him in performing the work when he consulted a provider first. He availed care from a private allopathic clinic from the nearby town Kalpetta. As similar in other cases, after a temporary recovery at several times, severe pain reemerges. By the time itself, taking a bath in hot water, using Ayurvedic pain relief oils before bath and use of specially prepared coconut oil in the hair become a part of his daily life. The next time when severe pain emerges, he consulted at the Taluk hospital in Vythiri, and he got admitted for four days. Further at home, he took rest for a week and continued the treatment from the Taluk hospital for a month. It resulted in a major relief in the body pain, but he continued using hot water for bathing and daily used the Ayurvedic oil to prevent any further occurrence of severe pain. He said it as *"continuous use of Murivenna is good for body and it makes the body more flexible to work. Further, the occurrence of severe pain will also reduce……taking bah in hot water is good for minimizing the pain; it becomes used to the body. Taking a bath in normal water will sometimes lead to fever."*

However, after two months, occasionally severe pain emerges while engaging in any heavy physical work. Thus, with the advice from his friends he availed care from district Ayurvedic hospital in the nearby town Kalpetta. But even treatment at the Ayurvedic hospital did not make any major changes in the condition. Further, he started to avail care from a well-known *Vydhyan* (traditional medical practitioner) in the nearby village who have successfully cured such illness through *Uzhichil* (a type of Ayurvedic oil massage). Even though he started the first stage of

Uzhichil he was unable to continue the care. It was during that time his son met with an accident at his worksite, and it led him to postpone his treatment for back pain from the *Vydhyan*. The catastrophic expenditure incurred due to his son's accident made their financial position further weak to an extent to disturb their normal family life. After that, he hasn't availed care from the *Vydhyan,* and in the next episode of the severe pain, he consulted at Taluk hospital, which is one among the nearest public facility. Now he follows self-treatment on a daily basis with the Ayurvedic oil bought from the market and consults at Taluk government hospital in case of severe pain. He believes that his severe backpain can be treated successfully if he does *uzhichil* at the *Vydhyan* and take enough rest. However, what restricts him from doing this is his financial condition and nature of employment. The *uzhichil* need to be done once in a month on a regular basis at least for four months and once in a year in the future. In addition to this, doing heavy physical work also need to avoid at least during the period of treatment. As he is the breadwinner of the family and only get an average 15 days of daily wage labor at the rate of Rs.800 per day, his family's financial position restricts him from doing desired treatment. He said that *"to do uzhichil it requires a good amount of money. To do once in a month, it requires around Rs.2000. and if started it has to be done continuously for three-four months……then while doing uzhichil it is not possible to go for work for some days. Need to take rest for few days after uzhichil."*
He has plans to do uzhichil after few months, when he will be able to save some money. He believes that doing the allopathic treatment will give only temporary relief, but as of now, it is the best suitable way to manage the pain until he has enough money to do *uzhichil*. Thus, the treatment which he now follows, doing self-treatment on a daily basis and consulting at the nearest public facility in case of severe pain to manage backpain, is shaped by his financial condition and nature of employment.

As similar to the previous case, Uzhichil is the preferred treatment for managing leg pain of a 50-year-old housewife from better-off household of an upper caste Hindu family. For her 11-year-old leg pain, self-treatment was the initial response. When the leg pain became severe, she consulted a doctor at private allopathic clinic in the Kalpetta town where she normally approaches in case of any acute illness. Later she approached an orthopedist at a private allopathic hospital in the same town and availed care for around a month. Even though there were some relief in the pain, severe pain remained while walking for some distance and climbing the stairs at her house remained.Since she is a housewife and has better household facilities and

has her daughter in law at her house to take care of household works, she is free from doing heavy physical work. However, the occurrence of pain, especially at night, made it difficult for her to get normal sleep. Then his son, who is a government employee, suggested her to consult an Ayurvedic doctor. Then she availed care from one of the locally well-known private Ayurvedic hospital in Sulthanbatheri town, where she has been admitted for ten days. It is the sixth year after the onset of the illness they consulted at this hospital, and while the time of discharge there was major relief from the pain. However, even after that, climbing stairs causes slight pain, and walking for long distances is not possible for her. From the hospital, she was given Murivenna to massage the legs from home in case of pain. Now, four years after availing care from the hospital she still uses the oil prescribed by the physician at the Ayurveda hospital. Now there is no frequent occurrence of severe pain and difficulties in sleeping as earlier. Even though it is not completely cured the leg pain is now less severe. She explains it as…*There is no severe pain now……. I used to walk in and around the house. But as earlier (before the illness become severe), now I cannot walk long distances, earlier I used to walk up to my brother's house (which is her ancestral house around half KM away)….. Earlier I go there at least once in a month, now only occasionally go in car with daughter in law and son.* Now she uses the Murivenna on a daily basis even if there is no pain. She believes continuous use of it will help to lower the occurrence of pain and have more flexible legs. Along with Murivenna occasionally, she also buys and uses Ashwaganthadhi thailam whenever there is a long-lasting pain. These are the same medicine which the provider gave her at the time of treatment at Ayurveda hospital and the effectiveness of the medicine made her to use it for self-treatment. By using both the medicine, she massages both the legs by herself and some time with the help of her daughter in law. This is how for the last four years, she was managing her leg pain.

Treatment for illness required hospitalization among different social groups

Table 5.13 (also see table A21 in annexure) shows the social group and class wise distribution of hospitalization cases during one year prior to the data collection, including hospitalization cases for childbirth. Out of the total 67 hospitalization cases, private allopathic hospitals are the major provider sought by patients from all social groups together. However, in the case of total 33 comparatively poor who have sought hospitalization care, 19 is from public health care institutions, and the remaining 14 is from a private provider. In case of 34 better-off, 10

approached a public health care institution, and the remaining 24 approached a private hospital. When we go further in detail, it is visible that it is the better-off among upper caste Hindu, Thiyya and Muslims along with poor among Muslims which used private provider in large. In case of public health care institutions, it is the comparatively poor among SC and ST who approached them in large for hospitalization care. Further, one patient from comparatively poor household availed hospitalization care from District Ayurvedic hospital, and one patient from the better-off household of upper caste Hindu utilized hospitalization care from a private Ayurveda hospital during the last one year.

Table 5.13: Distribution of social groups by provider sought for hospitalization during the last one year

		Govt Allopathic hospital	Private Allopathic hospital	CMC Calicut	District Ayurveda Hospital	Private Ayurveda Hospital	Total
SC	Better off	33.3	50.0	16.7	.0	.0	100
	Comparatively Poor	42.9	42.9	14.3	.0	.0	100
ST	Better off	33.3	50.0	16.7	.0	.0	100
	Comparatively Poor	66.7	16.7	16.7	.0	.0	100
Thiyya	Better off	40.0	60.0	.0	.0	.0	100
	Comparatively Poor	50.0	33.3	.0	16.7	.0	100
Upper caste Hindu	Better off	14.3	71.4	.0	.0	14.3	100
	Comparatively Poor	37.5	50.0	12.5	.0	.0	100
Muslim	Better off	.0	90.0	10.0	.0	.0	100
	Comparatively Poor	33.3	66.7	.0	.0	.0	100
Total	Better off	20.6	67.6	8.8	.0	2.9	100
	Comparatively Poor	45.5	42.4	9.1	3.0	.0	100

In addition, the table also shows that SC and ST, irrespective of their class differences, approached the government Medical College (CMC) in Kozhikode for hospitalization. The others who visited CMC Calicut during the period is one patient from a comparatively poor household of upper caste Hindu and another patient from a better-off household of Muslim community. The lack of facilities at the taluk hospital in Vythiri is the major reason mentioned by patients for going to CMC Kozhikode for treatment. It is also found that the casualty of the Vythiri taluk hospital is set up with minimal facilities, and shortage of doctors is a major issue in this hospital. There were incidents when the hospital's casualty and gynecology department were closed for several days due to shortage of doctors.

As given in table 5.14, for large share of patients, availability of the better quality of service is the reason for consulting the particular provider for hospitalization, and it is highest among Muslims and upper caste Hindus. Further table A22 in annexure shows that, out of the total patients who reported quality of care as a reason, around 85 percent of them consulted at the private allopathic hospitals. However, it is important to mention here that quality of care alone is not the reason for all patients who mentioned it. Out of the total 27 patients who reported quality of care as a reason, around 29 percent (8) among them financed their treatment through public health insurance. Thus, for a good share of those who availed care from the private allopathic hospital and those reported availability of quality care asa reason for consulting, acceptability of public health insurance card by the provider is also an important reason. The second most mentioned reason is nearest free public facility, which is highest among the patients from comparatively poor households and among SC and ST community. As Vythiri taluk hospital and Kainatty Government General Hospital are the public institutions with hospitalization facilities in the nearby area, all the patients who reported free public provision as a reason availed care from these hospitals.

The other reasons mentioned are the convenience of patient and family (highest among Muslims and upper caste Hindus) followed by reference (highest among ST) and availability of specialists (highest among Thiyyas). Among the patients who reported convenience as a reason highest is from the households of upper caste Hindus followed by Muslims and SC. Further, it is higher among better-off households of these three social groups compared to poor among them. All those patients who reported convenience of the patient and bystanders as the reason for consulting the particular provider, except one all others availed care from the private allopathic hospital. The remaining one availed care from private Ayurveda hospital in *Muttil* town. By convenience of the patient and bystanders, what majority of respondents valued is the friendly atmosphere in the hospital like private rooms, friendly staff, clean and hygienic surroundings, etc. One of the Muslim men from the better-off household who have availed inpatient care from a private allopathic hospital mentioned that *if my wife has to do namaz (prayer), there is no space in the government hospital to do that. In private, they can do it comfortably; we just need to think about the money nothing else.* Table A22 in annexure also shows reference as the major reason for patients to visit CMC Kozhikode, which is the nearest public medical college to the villagers. In addition to this, the table also shows that the availability of specialists as one of the

important reasons for patients consulting government allopathic taluk hospital and private allopathic hospital.

Further out of the total patients from comparatively poor who availed inpatient care, the largest share mentioned the quality of care as a reason for consulting the provider (14 patients / 42.4 percent). As already mentioned, for 8 patients among this, the acceptability of public health insurance card is also a reason for availing care from a private provider. For another one-third of patients from the comparatively poor nearest public facility is the reason for choosing the provider. In the case of better-off, around 38 percent mentioned the quality of care, about 29 percent mentioned convenience, around 11 percent mentioned nearest free public facility and around 9 percent mentioned the availability of specialists as the reason for availing inpatient care.

Table 5.14: Reason for consulting the particular provider among different social groups (in percent)

		Nearest free public facility	Availability of specialist	Quality care	Convenience	Reference	Total
SC	Better off	33.3	16.7	.0	33.3	16.7	100
	Comparatively Poor	42.9	.0	42.9	.0	14.3	100
ST	Better off	16.7	.0	50.0	.0	33.3	100
	Comparatively Poor	66.7	.0	16.7	.0	16.7	100
Thiyya	Better off	20.0	20.0	40.0	20.0	.0	100
	Comparatively Poor	.0	50.0	16.7	.0	33.3	100
Upper caste Hindu	Better off	.0	14.3	42.9	42.9	.0	100
	Comparatively Poor	25.0	.0	62.5	12.5	.0	100
Muslim	Better off	.0	.0	50.0	40.0	10.0	100
	Comparatively Poor	33.3	.0	66.7	.0	.0	100
Total	Better off	11.8	8.8	38.2	29.4	11.8	100
	Comparatively Poor	33.3	9.1	42.4	3.0	12.1	100

In the case of managing hospitalization expenses, the table 5.15 shows that the use of public insurance schemes is high among the ST, Thiyya, and SC community, and self-management of expenses is high among upper-caste Hindus and Muslims. Further, borrowing is high among SC and ST, and even while using public health insurance, some of them borrow cash to meet hospitalization expenses. However, except for ST, only patients from comparatively poor borrowed cash while using public health insurance (see table A23 in annexure). In addition, the table also shows private health insurance, either managed by self or private insurance from employer, is one of the important ways of dealing with health expenses among the better-off class of upper-caste Hindu, Muslims, and Thiyya community. Table A23 in annexure shows that

majority of households from the better-off class managed to meet hospitalization expenses from their income, and in case of comparatively poor largest share among them met their expenses through public health insurances, own income and borrowing. Further table A24 in annexure shows that borrowing is higher among patients who availed care from CMC Kozhikode, followed by private allopathic hospitals and government allopathic hospitals. In case of patients who availed care from the private allopathic hospital around 43 percent of them met the expenses from own income, about 21 percent met expenses with own income and borrowing, and around 8 percent with public insurance and borrowing. Further, around 13.5 percent met hospitalization expenses at the private allopathic hospitals through public insurance, and another 13.5 percent met expenses through private insurance schemes.

Table 5.15: Distribution of households based on how hospitalization treatment financed

	Self-paid	Govt. insurance	Private insurance	Self-paid and borrowing	Public insurance and borrowing	Total
SC	2 (15.4)	5 (38.5)	0 (.0)	3 (23.1)	3 (23.1)	13 (100)
ST	3 (25.0)	4 (33.3)	0 (.0)	2 (16.7)	3 (25.0)	12 (100)
Thiyya	2 (18.2)	5 (45.5)	1 (9.1)	1 (9.1)	2 (18.2)	11 (100)
Upper caste Hindu	9 (60.0)	2 (13.3)	2 (13.3)	2 (13.3)	0 (.0)	15 (100)
Muslim	8 (50.0)	3 (18.8)	2 (12.5)	3 (18.8)	0 (.0)	16 (100)
Total	24 (35.8)	19 (28.4)	5 (7.5)	11 (16.4)	8 (11.9)	67 (100)

Figuers in parenthesis are row percent

As we have already seen, health insurance, especially public health insurance, is an important way of dealing with expenses due to hospitalization for all social groups of both the comparatively poor and better-off households. Table A25 in annexure shows that, majority of households of all social groups have at least a private or public health insurance. And majority of comparatively poor households and more than half of better-off households have public health insurance. It is also notable from the table that around 40 percent of comparatively poor from ST community does not have any health insurance. Such a similar trend can also be seen in the case of their possession of ration card, around 27 percent of comparatively poor households do not have a ration card (see table A6 in annexure). Further, the table also shows that except upper caste Hinuds only better-off households have any private health insurance or both . In the case of upper-caste Hindus, around 41 percent of better-off households and around 16 percent of comparatively poor households have at least one member with both public and private health

insurance. However, one thing important to mention here is that out of the 19 households with private health insurance or both public and private, 12 are either households of government employee or gulf emigrants.

Health information and action for health

In addition to the individual acts, collective actions in preventing and curing ill health are also important in the village. The collective efforts of prevention include vector control, waste management, and protection of drinking water sources. With the help of villagers, the local health workers and local self-government does the vector control activities at the beginning of every monsoon season. The previous occurrence of Leptospira and dengue outbreak created an awareness among the villagers for the need of vector control and they are actively participated in the yearly cleanliness drive. In addition, there are arrangements for non-biodegradable waste collection from houses by the SHG members. The collective effort of the villagers helps to prevent dumping of waste in public places and water bodies. In fact, one of the unauthorized dumping yards in the village was converted to a public park by villagers as a result of increasing threat to health. The other important attempt by the villagers is the maintenance and protection of natural drinking water sources in the hill side. As there are no efforts from the local self-government to protect these water bodies, the villagers protect it from contamination and depends on such water bodies for drinking water needs.

Treatment relief committees are the important informal collective of villagers to help the comparatively poor households who are unable to meet the financial burden imposed by unexpected health issues. Such treatment relief committees are formed for individual patients or households on demand from households or through the collective decision of villagers in case of any health emergencies like accidents in the comparatively poor households. Such committees collect financial contributions from villagers and help the concerned patient in meeting their treatment expenses. In addition to financial support, such committees also act as a support system to the patient and their household in availing quality health care. Even though people from all social groups participate in such committees, they are active in *Settukkunnu* settlement and among Muslims in the village compared to other social groups. Such treatment relief committees are not found among Adivasis and no such committees were there to help the needy poor Adivasis.

Mosque committees are the other important collective that support patients from very poor households of Muslims community. Mosque committee supports poor households under their *Mohalla* in the form of supplying food grains and financial support to avail quality health care. For example, a poor Muslim household in *Settukunnu* with elderly parents and young widowed women were supported by the local mosque committee. The health care expense of unwell parents and the food requirement of the whole family are all supported by the mosque committee, and the daughter is taking care of her parents with the help of palliative care volunteers. Such social support available to the poor Muslims in the village from religious authority is not available to any other group.

The pain and palliative care association is the other important collective which provides health care support to the villagers. Irrespective of social groups all are part of the palliative care unit in the village, and the needy from all social groups get their support. They frequently visit the patients at their house, especially bedridden patients, to support them in their treatment without any fee. Even though they work everywhere in the village and among all social groups, the better social network of Muslims, upper-caste Hindus, and Thiyyas makes the functioning of palliative care more regular and better among them. The collectives like treatment relief committees, mosque committees, and pain and palliative also act as source of general information relating to health and treatment for the villagers.

Regarding health information, table 5.16 shows whether any member from the household of the respondent read any health magazines or watched any health-related programmes telecasted in television or in any other media during the last three months. It shows that more than half of households from Muslims and upper caste Hindus have at least one person who read about health or watched any programmes related to health during the last three months prior to data collection. Around 47 percent of households each from SC and Thiyya community also reported at least one member from their household gone through any health-related materials or programmes during the last three months. One of the reasons which many of the respondents mentioned for watching health-related programmes or reading health-related materials is the fear developed out of the outbreak of Nipah virus in the region during the period. Other things which villagers generally look into are the health-related programmes telecasted in television channels and videos and short write-ups of doctors and traditional medical practitioners shared through

social media. It is also important to note that there are only few households among the interviewed who does not have a TV or smart phone in their house. And almost all television channels in the state telecast health-related programmes on a weekly basis. An important reason mentioned for watching health-related TV programmes is that it will help to know what all things one can follow and what need to be avoided to deal with or to prevent any particular illness like cardiac issues and cancer.

In addition, the use of social media to communicate health-related issues and activities is important in the village. For example, the members of treatment relief committee formed by people of Settukkunnu to help cancer patients found actively using social media to share health-related information to villagers. Similarly, the members of pain and palliative clinic working in the village also reported the use of social media in sharing of health-related information is important in the village. The district administration also used social media during the time when outbreak of Nipah virus in May 2018 and the outbreak of leptospirosis concern the district after the flood in September 2018 and August 2019. During the 2018 flood, when there was some reluctance from the villagers in consuming tablets to prevent leptospirosis due to confusion regarding the effect of medicine, the efforts made by the medical officer of Pozhuthana PHC through social media got good positive response and got well acclaimed.

Table 5.16: Habit of reading health related materials or watching health related programmes on TV or social media

	Yes (%)	No (%)	Total
SC	46.7	53.3	100
ST	20.0	80.0	100
Thiyya	46.7	53.3	100
Upper caste Hindu	53.3	46.7	100
Muslim	60.0	40.0	100
Total	45.3	54.7	100

Table 5.17 shows the distribution of households based on any activities performed by any member of the household to improve health other than curative measures, which include activities like consumption of specially prepared food, nutrition health drinks or foods, use of food supplements for children, and physical exercise. Careful analysis of the responses among economic categories of each social group can help us understand the dynamics of social and economic categorization in determining the perception of health, of health status, as also the

health seeking behavior across social categories. All similar economic categories across different social groups are not behaving similarly; the trend towards similarity is tempered by social identity. For example except better-off among ST's, majority of better-off households from all other social groups regularly perform certain activities to improve their health. Similarly, except SC and ST communities, at least one third of comparatively poor households from all other social groups regularly perform some activities to improve their health.

Except ST community, irrespective of their social group and class differences more than half of the household performs some activities to improve health. However, discussions with the respondents help to understand that there are differences in the activities performed by different social and class groups. As food supplement for children is an important activity found among almost all social groups, among ST and SC also, it is a major one. All those households with a child attending Aganwadi will get cereal-based powder mix as supplementary nutrition in the form of take-home ration. At least half of children below 3 years old from ST and SC attend Anganwadi and consume this nutrition mix. Among Thiyya, upper-caste Hindu and Kurichya tribe, the major thing observed is the preparation of *Uluvakanji* (fenugreek porridge) during the monsoon, and many believe it assists in bringing down ailments during monsoon. Among Muslims, Thiyya, upper-caste Hindu and Kurichyar tribes, post-delivery medicines called *pettumarunnu* (a herbal paste formulation) and *pettumarunnupodi* (a herbal powder formulation) are common. Availing *Uzhichil* (different types of oil massages) is the other important activity found among men of these social groups during the monsoon season.

Table 5.17: Distribution of households based on activities performed to improve health

		Yes	No	Total
SC	Better off	73.3	26.7	100
	Comparatively Poor	53.3	46.7	100
ST	Better off	66.7	33.3	100
	Comparatively Poor	40.0	60.0	100
Thiyya	Better off	73.3	26.7	100
	Comparatively Poor	73.3	26.7	100
Upper caste	Better off	85.7	14.3	100
	Comparatively Poor	80.0	20.0	100
Muslim	Better off	86.7	13.3	100
	Comparatively Poor	66.7	33.3	100

Similarly, another thing which is generally practiced by old age men from Thiyya and upper caste Hindu community but less practiced now is the regular visit to Ayurveda medical shop in the *Pozhuthana* town or *Kalpetta*. A 65-year-old Thiyya from a better-off household reported earlier at least once a week he used to visit the Ayurvedic medical shop in *Pozhuthana* where medicines are prepared and sold. It is usual for him and many like him to consume an ounce of *Dasamoolarishtam* or *Balarishttam* as a health tonic. Generally, in the evening old men mainly from these two communities gather at Ayurvedic medical shop to meet and talk, and also to have an ounce of *kashayam*. The medicine is consumed at the same place where it is made and the price for each ounce is paid immediately. In case the person has any health issue, based on the suggestion of the vydhyans particular medicine or a mix of Kashayam are consumed. The frequency of visit is generally once in a week, however, some of them even visit more frequently. However, at present there is no such shop in *Pozhuthana* town. But some of the old age men from Thiyya and upper-caste Hindu still visits such shops in the Kalpetta town.

Conclusion

The health care utilization among different social groups shows a strong existence of multiple views on illness and its management in the village. Instead of looking for a single coherent, linear, and progressive approach to illness and its management, people from all social groups are experienced to multiple ways of dealing with illness. The utilization pattern shows increasing evidence for valuing expert ideas from the institutionalized formal health services along with lay perception and ideas on health and its management. Further high self-treatment among all social groups and the existence of several folk healers and its users in the village is an example for multiple ways of dealing with illness. The preference of illness management among different social groups reflects their socioeconomic, cultural characteristics and their perception of health, illness and medical systems available.

Chapter VI

The shaping of health perceptions and health care utilization

This chapter brings all ideas together to illustrate the shaping of health perception and health care utilization by weaving in all the various dimensions examined in the thesis. This is done with the evidence of the intersection of area-level social inequality and social group level inequality leading to health status disparity among various social groups. The study of all major social groups in the region allowed for a rich understanding of the social dynamics which shapes health in an interactional mode. The discussion of shaping health perception starts with the definitions of health expressed by people from various social groups in lay language and concludes by discussing the process and wider social factors which influence in forming the health perception. The development of health resources among different social groups in the context of diverse social histories is examined to showcase how health perception and health care utilization among various social groups reflects the social gradient.

Further, the chapter examines the characteristics of health care utilization among different social groups in the context of their resource base. The graded differences reflected in health care utilization among social groups are discussed in relation to the socioeconomic status of each social group. In the last section, the bases which ultimately shape health perception and health care utilization among different social groupsare discussed. The basis for shaping health perception and health care utilization is discussed through the dynamics and differences across different 'structural locations', and the 'agency' each social group is able to garner.This ultimately helps to understand the experiences, perceptions, and worldviews of various social groups,how they make sense of their context and attempt to improve their health and well-being.

The shaping of the health perceptions among social groups in the backdrop of health care resource development

What does health mean to a comparatively poor Adivasi living in the rural village of Kerala? '*Being able to save oneself from being bedridden or death……*'was the response of a 55-year-old Adivasi man who works as daily wage labour in the village. Are such perceptions valid, or do they have endorsement from others is open to question, but at any rate such an understanding

appears to be an inevitable result of their condition of living. In the definition, the focus is on the existence of an individual human being with functional activity and continual adaptation until death. In this definition, health could be with or without any disease but so long as one retains the necessary ability to perform the functions one wishes and needs to perform. So, what saves one from bad health or being bedridden or death? For him, it is through minimizing the risk of accidents and ensuring enough food to eat. What is central to his view is the work-food-health relation and that is an important articulation among Adivasis in the village especially those who are comparatively poor.

As they have the belief that the medicinal value of herbs varies depending on the climate, they do have the idea that food has nutritive values and it changes according to the climate. However, if we look into their dietary pattern, we will be able to identify that their articulation of nutritious food brings better health also means heavy meals like boiled rice improve the strength of the body for the short term which is also closely related to functionality. In other words, for them nutritious food is not necessarily a balanced diet having different types of food, but essentially enough quantity of their staple food such as boiled rice in order to have the energy to perform heavy physical labour. Except few better-off, one of the common beliefs among Adivasis in the village is that one has to eat enough food to perform hard physical work. In other words, the food intake is closely related to the strength of the body, which in turn is necessary for physical work one must do.

The dietary pattern of Adivasis in the village also hints this, they do not follow the common breakfast, lunch, and dinner schedule followed by others. Rather two-time food in a day, in which a heavy meal in the night is the common pattern especially among comparatively poor households. Their preference towards boiled rice instead of non-boiled white rice is due to their belief that the hard-boiled rice will give more strength to the body than the non-boiled rice which will just satisfy one's hunger and taste. Boiled rice is digested slowly compared to non-boiled rice; hence one does not feel hungry for a longer period of time compared to one who consumed non-boiled rice. Their dishes mainly include *kanji, rice*, and *puzhukk* which are considered a heavy diet; supplementary dishes or snacks are not part of their regular diet with the meaning that food is to give strength to the body not just to satisfy the hunger. Further, it also observed that the one who is the primary breadwinner, who has to do heavy physical work, will get

preference while sharing the food among other family members. Some of the young men main workers in the family also found regularly having their favourite food from restaurants in the town, which they believe will help to maintain the strength of their body while engaging in heavy physical work.

Now, what disturbs them in making their health comparatively good while following their conceptualization of health, illness, and health care utilization is important to know. As a multiplicity of views on health and illness co-exist among individuals within Adivasis, among allwe can see common factors which are adjusted to the concerns of the Adivasis as a whole in the village. They are identified as work, food, traditional knowledge, natural resources freely available in their vicinity, and harmonious relationship with the environment. In fact, it is the changes in these factors and processes shaping the factors, which influence the activities of Adivasis to establish a condition in which they can protect and promote their health

As we have already seen the importance of land and agriculture to the work, health, and life of Adivasis, even today, many Adivasi families do not have their own agricultural land in the village. As seen in the social history and household-level data, the lack of agricultural land doesnot just keptthem out of work and pushed them into hunger but also disturbed their organization of life and health. As found in Attappadi, alienation of land involved not only Adivasi's physical alienation of land but induced a deeper alienation from their traditional culture and ways of life (Edison and Devi 2019). As similar to what happened in the village, elsewhere in the state also instead of ensuring lands to the Adivasis, the position of continued governments in the state helped to protect the non-Adivasi migrant settlers who had grabbed the lands of Adivasis (Bijoy 1999). Such attempts even took place at the highest level of law-making that is in the legislative assembly of the state. The attack of landlords and vested interests on the Kerala Agrarian Relation Bill, the Kerala Tribal (Restriction on Transfer of Lands and Restoration of Alienated Lands) Act 1975, and the consequent dilution of pro-poor provisions in these Acts are examples of this (Sreekumar & Parayil 2010).

There is a close relationship between poverty and land ownership in South Asian agrarian societies. As similar to the land-owning households in the village, the land is both a key productive asset and can help to protect households against economic shocks (Agarwal 1994).Land reforms undertaken in Kerala helped to restructure the rural classes by ensuring at

least a small amount of land to many rural labourer households, but still, disparities persist (Jeffrey 2016). As found in the village, even though some among them own land, disparities in type of ownership, area of land and type of land, etc largely exist, especially among tribes. Further, as the data from the village shows mere ownership of land is not sufficient for Adivasis to do own agriculture and to enrich their valued dispositions, skills, and knowledge; the burden of low socioeconomic positions matters a lot.

Even today, Adivasis depend on both forest and own agriculture for their food needs. Thus, in addition to their agricultural produces, they also consumed non-vegetarian food which they get from hunting. The freely available jackfruit, papaya, herbs, mushrooms, and other plants grown in the edges of the forest and public lands are also widely used. However, at present fish, meat, milk, and dairyproducts are not part of their regular diet. Many reasons contributed to such a change in their diet, which include their lower financial status to purchase fromthe market, ban on hunting, low availability of fish in the river, high cost and lack of facilities to grow livestock's and changes in land ownership reduced availability of seasonal fruits and vegetables which were earlier freely available in the public lands.

Over a period of time, due to a variety of social, economic, and political reasons, the earlier condition of reliable dependence on easily accessible natural resources that were in abundance around them, for meeting their food requirement has changed. With the change in occupation under the impact of the socioeconomic processes, land ownership, and other factors, there is a greater shift towards increasing dependence on PDS shops for food requirements. This shows how the changes in the developmental process eroded the capabilities of Adivasis to be self-reliant in their food requirement and made them dependent on ration shops. Further, the umpteen problems in the implementation of such public distribution systems, the nature of rations provided, and possible lack of assured supplies, make the conceptualization of food-work-health triad of the tribal people all the more precarious. An account of impact of land alienation suffered by Adivasis in Attappady, another sub-region in the Malabar shows:

> *Earlier, their own crops were sufficient for their needs and they produced a surplus. They enriched their diet with roots, nuts, honey, and fruits, gathered from the forest. The meat was a substantial component of their diet. Most families were armed to shoot animals such as wild boars, rabbits, and deer. This satiated their hunger and made them strong for the*

heavy work in the fields. We were told there was never a situation where they had to rely on food sources from outside their hamlet. Food security was assured within the community (Edison and Devi 2019).

In fact, similarto other places, in Wayanad also the development schemes initiated for the tribal communities itself become a cultural displacement for the tribes, which were exemplified in the loss of their traditional cultural ties with forests (Damodaran 2006). Thus the changes havecome at the cost of restriction in access to the forest, alienation of land, changes in the pattern of agriculture, changes in their lives which were intertwined with the natural environment, and altogether a decline in the tribal way of life and health which they practiced earlier.

As we have seen in the previous chapters, Adivasis continue to face suppression in the village as dominant groups invariably succeed in influencing the local self-government to implement projects and policies in their favour. The provision of household-level support like provision of safe drinking water, financial support to build houses, support to agriculture & animal husbandry, provision of materials through the public distribution system, financial support to old age people, differently-abled, widows,etc. shows bottlenecks in its smooth functioning for the Adivasis. Besides, public facilities in their area like rural roads, bridges, streetlights, drinking water projects,etc. get little maintenance to remain damaged throughout the year. Further, the nature and behaviour of local government officials and local health workers, who are usually indifferent to the sufferings of Adivasis, shows how vulnerable they are in terms of attaining a good life with better health.

If we look into their conceptualization of health, illness, medicine, and consequent health care utilization over the period we can see all is closely related to the social environment in which they live with little choice left. This was not something that happened in the village only, but the village witnessed the reflection of what happened all over in the Malabar and outside. For example, the district-wise deprivation index calculated based on the quality of housing, availability of drinking water, sanitation, and electricity for 2001, shows the highest deprivation index for Adivasis and Dalits in all districts of Kerala. Among the districts, it is highest in Wayanad, Palakkad, and Kasargod which comes in the Malabar region (UNDP 2013). Such an observation call for reflection on why is it that the policy paradigm continues to be reticent to the needs of the most oppressed sections despite being fully aware of the picture as it stands. In

media and even in academic literature, Kerala has much of a reputation for having progressive political culture, but, accounts shows that it is not much qualitatively different from other states in terms of how the state structure deals with the class interests of different sections (Mukunthan 2012; Pramod 2020; Sreekumar and Parayil 2006).

Another important dimension of his definition of health is minimizing the risk of accidents and hazards. Such risks and hazards exist everywhere, and they believe some are man-made and others arise from the environment. Their main ways of stabilizing the risk include establishing harmony with the environment through rituals and ceremonies, adapting their way of living to the surrounding conditions in which they live all their lives. As hinted at in the idea of health, survival is the primary aim while working or living in a harsh environment. The changes in the livelihood of Adivasis over the period are the greatest example of how they have adjusted/forced to adjust their life to the changing social environment from which ultimately they have to meet their health needs. The changes in livelihood and lifestyle of some sections of Adivasis happened differently, and some were able to become better-off while others remained comparatively poor. When a large number of Adivasis lost the land in which they had freely cultivated, they became daily wage labourers and were forced to be part of a new cash-based economy. Where they have to increasingly depend on the market economy run by others, but with limited access shaped by the low wage.

The earlier way of life has changed to a new order where they get only a few days wage compared to the earlier freedom to work in own land based on their knowledge and tradition. The nature of work, working hours, freedom at work, and the life linked to work all changed. Over the period they become increasingly out of work for several days in a month, leading to hunger and complete dependence on PDS for food. Such changes have disturbed the close association of tribes with nature and now they face further constraints in stabilizing the risks which affect their health. As opposed to viewing nature and humans as binaries, with the latter dominating the former, tribes perceived their evolution and existence as rooted within nature and its processes (Doye 2015). Thus, any sense of alienation from one's living environment destructs the proud claims of being conscious managers of one's life-world (Edison and Devi 2019). That limits the choice of Adivasis in protecting their health.

When constraints in availing old resources have been removed and new resources become available at least to some among them, their conceptualization of health also changed as it was linked to the material constraints and limited choice produced by it. The changes in lifestyle, less preference towards heavy physical work, a new dietary pattern which de-link the work–food relation, new forms of health promotion activities like yoga, more concern on nutritional power of food than the strength it provided, changes in self-treatment with more influence of biomedicine etc., among the better-off Adivasis, is an example for this.

The changes in the lifestyle and new socioeconomic resources available to *Kurichayar* tribes in the village depict this change. As the social structure have a great influence in shaping the perception of health, it similarly shapes the perception of medicine and health care. When the constraints in availing resources on which their conceptualization of health was based, their traditional way of health management got disturbed. Especially among Paniyas in the village, their poor socioeconomic background made them flip around different ideologies and modes of practices available in the village. Different from *Kurichyar* tribes, who have earned new resources in the village and through it influenced larger dimensions of health and wellbeing, the struggles of Paniyas and *Kattunayekkar* are rendered invisible. In fact, the social causes of illness are reconfigured into medical terms for management in the clinical setting in practice among Paniyas under the influence of the dominant system. However, specific practices within the *manthravady* ritual (black magic) draw on deeply embedded cultural idioms that caution against the coercive influences of dominant groups and help the Paniya make sense of their placein the contemporary world (Badami 2010). Such changes had impacts among Adivasis, leading to significant health inequalities within tribal populations. The Paniya have higher levels of underweight (54.8 vs. 40.7%) and anemia (17.2 vs. 5.7%) than other Scheduled Tribes. The predicted prevalence of underweight becomes 31 and 13 percentage points higher for Paniya and other scheduled tribe members, respectively, compared to forward caste members (Haddad et al. 2012). In sum, the social gradient in health becomes evident not only between tribes and non-tribes but even within tribes themselves.

Even though Dalits in the village and elsewhere in the state have improved their resource bases and opportunities compared to yesteryears and compared to Adivasis. As elaborated in the social histories and household level data analysis, they still positioned in the lower ladder of social

hierarchy in the village and elsewhere in the state. Caste tends to overlap with socioeconomic position; upper castes have access to more and better resources and opportunities (Roy, Kulkarni, and Vaidehi 2004). A study among women of different social groups in the state shows that, among SC/ST and OBC women, the influence of socioeconomic variables on health tends to have a magnifying effect, whereas, among forward caste women, there is a buffering effect (Mohindra, Haddad, and Narayana 2006).

As Dalits in the village are mainly agricultural labourer's lives in their settlements near to agricultural land and plantation. From time immemorial hard physical work is part of their daily life, thus they closely connect the idea of health with functionality. Health is seen as being able to do normal activities in the day to day life. They tend to consult a care provider when anything related to their health incapacitates them in performing their day-to-day activities. However, it does not mean that illness which did not prevent in performing their work does not get attention, they do self-treatment for that or may find alternative ways for dealing with it. One of the agricultural labours from the village told that, whether an illness is incapacitating? is not a decision made purely based on health status but made under various pressure. Earlier they do not have the freedom to skip the work on any ground. But they present themselves as sick to skip from the labour at the time of any disease, thoughthe final decision was up to the *Janmmi*. At many such times, they were forced to work in the field under pressure and with the disease. Thus, even within their idea of health concerning functionality, they do not have the free choice to make.

However, today it is important to show oneself healthy to get daily wage labour as there is a general view in the village that Dalits are less able-bodied to do heavy physical work. The health-damaging behaviour of Dalits, especially of comparatively poor is termed as the reason for their weak body strength by people from all social groups except Adivasis. However, it is found that one of the reasons to get labeled as less able-bodied is they are traditionally agricultural labours and do not have much expertise in other fields of daily wage labour. Further, lack of own land and lesser employment days kept them unemployed for several days in a month, this, leads to label them as lazy workers. Even some of the local health care professionals and local self-government officials have the opinion that they are reluctant in changing health-damaging behaviour like alcohol and tobacco consumption, living in filthy and unhygienic

condition, and least interested in health promotive aspects especially of children and aged parents. In fact, as similar to some other parts of Malabar, the health and health behaviour of Dalits in the village have been labeled by others as poor.

So, it is important to understand the idea of Dalits on health and to know whether they are really concerned about their health or not. Evidence from the field shows that, irrespective of comparatively poor or better-off, Dalits considered health as something that they are expected to act to enhance its quality or ready to risk health issues or death if they do not. Valuing of such an idea by Dalits is clear from their response, that whether an illness is incapacitating is a decision made under various pressures and not just purely made based on the health issue. Further, they also know how certain works themselves become a cause of poor health, but still, continue to do. A Dalit man who works in the tea plantation said, *after the work of spraying pesticide, Iwill not be able to do anything. Usually, I go and laydown in the verandah for some time to get relief from fatigue. Not just the present health issues* ***from*** *it, these are heavy pesticides and will have serious health consequences in the future.* Even though he knows the health consequences of his present work, without this job his life and family will be in more difficulties. Thus, as like any other social group in the village, Dalits also considered health as an achievement instead of something granted for a long time.

Both functionality and absence of disease are closely interconnected among Dalits in the village. The absence of disease is the way of expressing their availability for daily wage labour and being able to work without any difficulties is their way of expressing fitness for the work. At a time when they get less than ten days of work in a month, losing a day's work on the ground of disease is not affordable tothem. The remarks from some of the villagers from higher castes, local health care professionals, and local self-government officials show that they have failed to understand the Dalit's attitude towards health and life. To say whether they act or not act upon any disease, it is important to understand people's ability to survive in the village, and their social and cultural way of living. As labeled by those with substantial resources, caste, and religious status, the reason for the comparatively poor health of Dalits in the village is not their attitude, behaviour, or human agency. But it is due to their low position in having social resources like land, labour, education, good housing, drinking water, lower presence in political parties, local self-governance, cultural organizations, lower caste status, and of course poor

implementation of welfare projects among them. In fact, this is the situation in other parts of the state too. Inter caste disparity continues to underlie overall disparity in the state, expenditure on food, clothing expenditure, land-holding, and education levels of heads of household indicate substantial inter-caste disparity between the SC/ST population compared to the other population (Deshpande 2000). A study of three districts in the state revealed that, generally, higher levels of morbidity have been observed among females, scheduled castes, and scheduled tribes as compared to their counterparts. Among the important socioeconomic determinants, education and economic status showed a negative relationship with morbidity. Poor are at greater risk of morbidity than the rich. (Navaneethan & Kabir 2009; Krishnan 2009).

As we have seen in the process of development among *Thiyyas* in the village, *Thiyyas* from the rest of Malabar were also engaged in articulating a status of equality with the *Nayars* (Panikkar 1983). They did not have to facediscrimination on caste lines as much asthose of other lower castes like Pulayas in the village. The comparatively better position of Thiyyas in deprivation even after belonging to a backward polluting community can be traced in the changes in ecology, cropping pattern and tenurial system that existed in the region.As we found the emergence of Thiyyas as a powerful social group in the village, elsewhere in the Malabar also there existed an atmosphere in which the claims of a backward Thiyya group could be articulated and substantiated (Mundon 2003). The development of a widely followed and historical local health tradition and indigenous medical practice among Thiyyas is an important example of theexistence of an enabling atmosphere. The *vaidyars* (indigenous medical practitioners) among the Thiyyas were respected by all communities in the region.

As among Adivasis, in the case of Thiyyas also the relation of food and work is significantly related to their idea of heath. However, still, we can see a clear difference in the perception of Thiyyas and Adivasis on work-food relation to health, a move from ‘strength’to ‘life’. As we have seen Adivasis articulation of heavy food brings better health primarily means improved strength of body to perform physical work. In Thiyyas articulation of food- health- work relation, in addition to strength to do physical work, it also means /explicitly expressed that food brings nutrition to improve life in the long run. Their preference for a diversified diet with a three-time meal in a day instead of earlier *kanji* (rice gruel) based diet is an important example for this. It has been found that over the last decade majority of Thiyyas households including comparatively

poor improved the quality and quantity of food they consumed. Among the important reasons mentioned for this, besides, the increase in wage and improved availability of milk, dairyproducts, fruits, fish, and meat; concern over the health of family members especially of children and young women areimportant reasons. The lifestyle of Thiyyas shows that in addition to their daily diet, dependingonthe season, age, health status they have provisions for special medicinal food, special wellness care, Ayurvedic medication to improve health. This includes preparation of medicinal food for all family members during the rainy season, wellness care like *uzhichil* for labouring adults during the off-season, medicinal food for mothers of all ages at the month of Karkkidakam. If we look into some of their local sayings, we will be able to understand the importance they have given to uninterrupted regular food, the timing of food, and its importance in the nourishment of health. Some of their local sayings related to health read as *if you missed the dinner for a day you will lose flush from the body which is equal to that of a pigeon, mere sight of the excreta of a child is enough to say whether child nourishes or not, lunch before noon and child before the age of thirty.*

If we look into their lifestyle, we will be able to find the close relation of functionality and food in almost all aspects of Thiyya's life. Even their use of words for strength is closely related to life or health. It has been found that they are interchangeably using the words strength of body and life in their local slang especially while talking about physical work. For example, one of the daily wage labour while digging a well, said to his fellow worker *if you dig it out the soil from below it is easy to takeout the stone,* ***no need to give life*** instead of saying no need to give more force. As shown in social histories, we can see many such aspects of Thiyya life in which they take food- work- health relation to wider dimensions. When asked a Thiyya woman who works as daily wage labour, why did she go for daily wage labour even she had chronic leg pain? Her reasonwas not financial constraints she had four sons and her husband working as daily wage labourers to look after their family. She said that '*if I won't go* ***to*** *work now, later some other big diseases may come*'. As her symptom is not too disabling and unmanageable, for her it is not enough to categorize as an illness in which complete rest is required. Similarly, many Thiyya men and women of the working class opined that people who do heavy work may consider backache normal and people who work long hours may expect to be tired. Thus, their definition of health goes beyond the dichotomous definitions of with/without disease/illness. In the previous example, she embodies the leg pain with her life experience and expressed the strive

for good health in the future through engaging in work at present. So in a sense, for her doing work become a therapeutic and a symbol to express as healthy. She believes that to maintain good health / to prevent other big diseases it is important to keep the body functioning in the form of engaging in daily wage labour, even at the cost of suffering slight pain. Thus, here what is important is not whether you have a disease or not, or whether you have the strength or not but what is important is whether you are able/ unable both in the short and long run. Institutionalized martial culture and maintaining a strong body by the Thiyyas through their *chekavan* tradition is an example of their view of health as a continuum of fitness. Thiyyas through their significant engagement in *Kalari*, helps in creating a network of martial culture in Malabar from the medieval times itself (Barbosa 2009).

Thiyyas become a fairly advanced group in socioeconomic status when compared with Adivasis and Dalits in the village. As a result, they do not face any such caste discrimination similar to what Dalits faced in their attempt to create an environment in which they can protect their health and wellbeing. Thiyya improved their social status by accumulating economic and cultural capital through employment, migration, education, politics, and marriage (Osella& Osella 2000). The strong reform movement and political participation among the Thiyyas, who are the second-largest community in the state,help them to develop as a powerful social group and in fact, their support becomes a necessity for major social, economic, and political organizations to nourish.When Thiyyas are spread across the state with around 21.6 percent of the total population during 2011, all other lower caste social groups altogether constitute only around 10 percent of the state population (Zachariah 2016). The double deficit in health due to the intersection of the burden of low socioeconomic position with lowness of caste got a buffering effect among Thiyyas compared to Dalits. Studies from the region found that caste interacts with socioeconomic variables on health by magnifying or buffering the effect among different social groups (Mohindra et al. 2006).

The other major community which emerged as a powerful social group with a substantial social, economic, political, and cultural resource base in the village and throughout Malabar is Muslims. What is the right response in the onset of a disease? to seek treatment immediately from a doctor is viewed as the correct action by many Muslims who wereinterviewed. However, it does not mean that other aspects like food, self-treatment, hygiene, and environment are less important.

But it reflects how the changes in these aspects increased the importance of medical care among Muslims in the village. The high level of health anxiety especially due to changes in food patterns and surrounding environment, made consulting a doctor an important way they care for their health. Food patterns have changed with the increase in income, the quantity of rice, meat, fish, fried food, snacks and vegetables, and fruits bought from the market have generally increased. During an informal discussion at a tea shop in the *Settukkunnu*, a sixty-year-old Muslim man from a comparatively poor household mentioned by pointing out the changes in the dietary pattern that- *if we eat good food it will do the effect of medicine otherwise it will lead to various diseases. Most of us now have digestive issues and it is one of the major reasons for almost all diseases.* The tea shop owner, another Muslim man of 52 years old added that- *over the period use of homegrown vegetables and fruits substantially declined and* ***the*** *use of market products increased. Use of sugar, oil, maida**,etc.,** increased, and previously consumed rice soup, tapioca**,** and various wild roots were replaced.* The formerly mentioned is generally seen as health-damaging food and believe that its regular use for several years could disadvantageously affect the body. They believe such food brings or at least induced major health issues like cardiovascular diseases, cancer, etc. However, it is also observed that,those food they have mentioned as health-damaging has been important items in their daily diet, especially among the better-off households. This increases anxieties about obesity, heart attacks, and blood sugar-related problems. As they know they consume health-damaging food daily, treatment from a doctor of modern medicine is the only way left to maintain good health. Hints of such an idea come in the discussion, the earlier men said- *compared to earlier, people now frequently consult a doctor, especially for digestive issues and stomach pain. The food we eat at present is no more capable enough to protect us from diseases.*

About the dependency on health care among Muslims in Malabar, a previous study points out anxieties about heart attacks have increased as more men from the Muslim community in particular suddenly suffer or die from heart attacks. Further, poorly controlled diabetes is also become one of the important health problems, leading to complex health problems and high levels of dependency on doctors by Muslims (Wilson 2010). Further, the shaping of seeking medical care as an important aspect of health maintenance is also due to the improved economic position and a strong belief in allopathic medicine and modern values of health and education. Osella & Osella (2009) observes elites from the Muslim community, as a result of the affluence

of emigration and consequent expansion of private facilities in health and education, widely embraced the modern values of health and education. A large section of Muslims can study in private institutions as a result of the affluence of remittance from the Gulf and the emergence of several minority medical educational institutions (Nafeesathul 2014, Nazeer 2011).

The importance of good food in maintaining a healthy body is a general idea existing among Muslims even before prioritizing health care as a way of maintaining health. Food has been an important area of spending among them not only due to its health aspects but also to nourish good social relationships with the family and neighbors (Osella and Osella 2009). Both better-off and comparatively poor among them largely followed the local health tradition of consuming medicinal food and special food for weight gaining during its season as part of their yearly routine. During the household survey, the majority of households from both better-off and comparatively poor opined that along with an increase in the quantity of food, they did consider improving its quality. Generally, among Muslims and especially among households of Muslim emigrants spending on food especially on fish and meat become an important area. Banerjee et al. (2002) in their comparative study of emigrants and non-emigrants, found the improved socioeconomic background of the emigrants bear a direct impact on the health of their children. They point out the high rate of child mortality among Muslim children compared to other religious groups, but a comparatively lower child mortality rate among the emigrant Muslim households. Similarly, they point out the high prevalence of malnutrition among children of non-migrant Muslims compared to children of migrant Muslims.

Another important aspect in their idea of health is the relation with the environment where one lives and work. The husband of a plantation worker said- *now there are many cancer patients in the village* (he counted four women in the locality). *It is mainly seen among women and those who worked on the plantation for long years.* Few more households opined similar idea, and some went on saying- *no need to work in the plantation, the fertilizers used by them which pollute the land, air, and water is enough to damage health.* A Muslim woman of 40 years of age from *Settukkunnu* believes that the existing fresh air and water protect them from various diseases, especially communicable diseases. She pointed out the previous jaundice outbreak in the Pozhuthana town area and the seasonal occurrence of chikungunya and dengue fever in the town area. She mentioned *it is the contaminated water and unhygienic surroundings in the town*

which cause such diseases. Here we do not face such issues and the water and air in this area are good due to less contamination. Similarly, when asked about the purity of open-ditch water from the hillside which many families in the village uses for drinking, all believe that it is the purest water. They mentioned it is purer than the water from a well or a pipe connection as it is originating from the forest land and flows without any human intrusion. Environment, especially the work environment is also seen as an important factor that induces bad health. In addition to plantation workers, other daily wage labours and their relatives also talked about the health hazards of doing heavy physical work for several years. Even the relatives of Gulf emigrants and Gulf returnees talked about the difficulties in managing good health at work in a foreign country. In addition to the physical health issues, they talked about the mental strain of staying away from family for several years. The majority of Gulf emigrants get only two- or three-monthvacation for their two years of work. To express this, they usually point out the examples of their relatives or friends who just lived only a few years with their family throughout their thirty to forty years of Emigration.

Residents with a history of migration reported a higher prevalence of cardiac diseases, hypertension, and diabetes in the state. The prevalence of risk factors is more than double among those with a history of migration (Hameed et al. 2013). The case of the reason for return emigration from Gulf countries also reflects the relationship between poor health and harsh working conditionamong Muslims. They had been accustomed to different working conditions back home compared to a difficult living condition in Gulf countries. Ill health, injury, accidents, and conditions back home required the migrants'presence reported as important reason for the return of emigrants to the state (Zachariah, Nayar, and Rajan 2001).

Religion and health are closely related among Muslims, as almost all aspects of their daily life are closely related to religious belief irrespective of better-off or comparatively poor or educated or uneducated. The belief in the evil spirit as a reason for illness, especially psychiatric disorders exists among both better-off and comparatively poor Muslims. Giving adored betel leaf for pregnant women to eat just before childbirth, even at ICU beds to ensure safe delivery and good health of the child exists among educated and illiterate. Such work of healing through religious saying and practice is done by the local religious head, called *thangals*. Even in their choice of care provider also such a relation can be identified. Even though people from the Muslim

community consult hospitals and doctors run by other communities but institutions run by members of the Muslim community are preferred. By understanding this, doctors from the Muslim community have started their clinics where a substantial Muslim population resides, and this significantly helped in extending services to the local community. For example, in Pozhuthana panchayat the only regular private practitioner is from the Muslim community and he runs his clinic at the 6th-mile town which is surrounded by the settlement of Muslims. Members of the local Muslim community believe that it is a religious duty for all including doctors and owners of hospitals to behave with benevolence in charity and social service. Thus, when a hospital or clinic is owned by someone from the Muslim community, it raises expectations of benevolence rather than profit. It meets the expectation of good medical care which is in concurrence with religious beliefs or at least a care that is not against the religious beliefs. Even though ritual healing practices are generally devalued in the way to modernity, still an increasing utilization of ritual healing practices is observed in the state (Osella and Osella 2000). *Thangals* who possess the highest religious status among Muslims in Kerala are attributed a sacred status and spiritual power in healing (Sathar 1999). Muslims especially among the Sunni sect has a strong belief in their power in healing and maintaining good health and wellbeing. Further such ritual healers in Kerala even started to engage with the modern discourse of psychology in their practices (Lang 2014; Tarabout 1999).

Even though religion is closely related to health and its management among Muslims, there is only one practitioner of the Unani system of medicine in the village, in the past also there were not many of its practitioners who exclusively practiced the Unani system. Unani does not spread or advocate in the village as like Ayurveda, Homeopathy or as traditional medical practice of Adivasis or Thiyyas. There are traditional folk healers in the village from the Muslim community who practice folk medicine which is similar to that of other folk healers in the village who were based in non-textual local plant-based medication with no evidence of a strong and exclusive connection with the Unani system. Besides, there is no public or private Unani medical institution in the village. Despite the substantial Muslim population and established religious power, particularly in a setting where people strongly believe that Unani is a distinctively Islamic medicine, Unani does not experience any flourishing time in the village. The sole practitioner of the Unani system of medicine in the village said that Unani exists in the village even before the introduction of English medicine. Unfortunately, not many knew its practice, and it does not

spread among villagers as an effective way of health maintenance. When money came into the hands of people, they become followers of allopathic medicine which they approached only for an emergency health issue in the past.

As we have seen among other social groups, in the case of upper-caste Hindus also,issues about the perception of health are closely related to the social, economic, political, and cultural resources available to them. As they were the chieftain of local administrative units before independence and they keep hold of the local self-governance after state formation, throughout the period they enjoyed much freedom in their lives. Even the comparatively poor among them were free to make decisions and choices regarding oneself and their life. As in the village, Nayars were formerly the 'dominant caste'of Kerala in economic, social, and political power (Jeffrey 1994). From very early itself the share of enrolment of the upper castes in educational institutions was higher than their share in the total population (Aiyar 1918). The case of upper caste in representation in government employment is also not different (KSSP 2006). Their employment situation is in complete contrast to that of the lower castes and their participation in manual labour is almost nil (Scaria 2014). Compared to the engagement in manual work by women from a lower caste, upper-caste women in the village are mainly engaged in government and formal employment. It is proved that such employment can lead to positive effects on women's health by enhancing their autonomy and bargaining power, providing access to financial and social resources, producing greater emotional satisfaction, improving their social status, and increasing the perceived value of women by household members and society (Chen 1995).Previously medical profession was generally opened to the affluent communities like upper caste Nayar and Christians only until the other communities attained middle-class status (Wilson 2010). Similarly, the forward caste Hindus treated Ayurveda medical knowledge and practice as their monopoly before lower castes as a community started to practice it.

As a result of the different developmental experiences of the upper caste Hindus, they were able to shape and maintain the perception of health often match with their valued dispositions, skills, and knowledge. Different from another social group, the idea of health among upper-caste Hindu especially from better-off households found to give greater importance to self-control and the responsibility to be good health. When talked about the health of oneself or the health of people from different social groups in the village, these are the common factors importantly point out by

upper-caste Hindus. Even the role of food and environment in health maintenanceis placed under the idea of responsibility to ensure good food and a safe environment. Responsibility to maintain good health is seen as both individual responsibility and collective responsibility of people. To the question, whether any changes in quantity or quality of food consumption over the last decade;the answer of a 52 years old upper-caste Hindu man from a comparatively poor household is 'decline in quantity'. When asked for reasons, one important reason he mentioned is about a controlled diet. He said- *it is important to control the food we eat to the minimum which is required to maintain our body. Most of the diseases which cause in old age are due to the food we eat over the period. We should control it by eating less and if possible eat homegrown food that is the best.* By saying this he shows the individual responsibility to self-control and the responsibility to eat healthy food. In the household survey, among the better-off, it is the upper caste Hindu (6.7%) who reported the highest decline in the quantity of food consumed over the last decade. In case of comparatively poor among them also such a trend of decline in the quantity of food consumed is observed.

In the case of a retired man from the better-off household, who does own farming of rice, vegetable, fruits and also hastwo cows, is concerned about the contamination and presence of pesticides in vegetables and other food products bought from the market. He believes such contaminated food is one of the major reasons for diseases and long-term health issues. He believes- *without having pure food and water, it does not matter whatever medicine we take. It won't give any permanent solution to* ***a*** *health problem.* When discussed the lack of resources among comparatively poor to do own cultivation and buy good quality food from the market, he hinted out the individual and collective responsibility as- *the governments* must *ensure safe and pure food products in the market and it is the duty of each one to protect their health by consuming homegrown pure vegetables and fruits*. This means, as similar to other social groups they do believe in the importance of food in good health, but the way through which food ensures good health is decided by the individual responsibility in addition to the government's responsibility to ensure good food.

This importance of individual and collective responsibility in maintaining health is also reflected in their view on the environment and health. While discussing the drinking water availability, all the upper caste Hindu households who live near the river opined that the biggest water

body, *Pozhuthana River* in the panchayat itself is highly polluted. They point out the contamination of the river water through the pesticide use in the plantation and dumping of market waste into it. None of these households uses river water except for agricultural uses, and some of them criticized the use of contaminated river water for household uses by people from other social groups. Without any doubt, all of them believe it is the responsibility of the local self-government to ensure safe drinking water in the village for all. But it is the responsibility of the individual to ensure its safety at the site of consumption by different ways like boiling the drinking water and bleaching the water if required. Similarly, when talked about the poor health status of comparatively poor households from SC and ST communities to some of the educated and politically active Nayar men, they linked the bad health with individual responsibility. The respondents include Nayars men from one of the powerful local political parties, one from the local self-government, another retired government employee, and another man from the local health workers. All of them opined that one of the major reasons for bad health ishealth-damaging behaviour like alcohol addiction and an unhygienic environment. In addition, the health worker even mentioned that they are reluctant in any change and the local health workers are engaged in sensitizing them. In other words, the lack of self-control and least interest in taking responsibility forone's own and their family's health is labeled as their reluctance to change.

The most common strategy followed by caste groups for acquiring a presence in the emergent political field in early twentieth-century Kerala was to build modern community organizations that would then negotiate with the state(s) for resources. This strategy was followed by all kinds of caste groups, when lack of economic resources was a major hurdle in the path of the lower-caste groups, higher castes easily succeed in modern community formation (Zacharias and Devika 2006). It is reported that the accumulated privileges enjoyed by upper castes serve as a buffer, to lower the effect of low socioeconomic position on health, whereas the accumulated deprivations and continued discrimination of lower castes or tribes serve to amplify health disparities (Mohindra et al. 2006). As discussed in the social history the way people engage in public places in the village is also influenced by caste, religious and ethnic characteristics. Public life in Kerala is shaped by spatially distributed gendered caste practices, forms of progressive civility in seemingly caste-free associational publics should be understood not as the elimination of caste practices but their reconstitution (Thiranagama 2019).

The shaping of health care utilization among social groups in the backdrop of health care resource development

To an extent, the attempts of colonial governments to create a network of allopathic institutions in the state lead to imbibing and following the Allopathic/western ideology firstly in the southern part and later all over the state (Kabir & Krishnan 1992). By the time of independence, western medicine started to develop in its full swing in the Malabar region, the spread of education and modernity in the region further helped this developmental process (Kutty 2000). As the development of public health care institutions in Malabar happened in a short period, the development of private institutions happened much later, in a much shorter period, and even surpassed the growth of the public sector (Palafox 2011). Wilson (2010) observes that cities in the region have become a local medical market, where institutions compete to introduce modern technologies and equipments, compete to arrange international facilities, and supreme comfort to attract patients from all over the state as well from foreign countries. On the other hand, the region became a medical marketplace where people developed a high dependency on doctors, hospitals and technologies; people prioritize spending on health care and shop for treatment in the marketplace, and many look upon the medical profession as a respectable job to do (Wilson 2010). In sum in the development of health care services, the dominant western medicine under the support of government impose its definition of health and illness on the people and healing practices of indigenous systems of medicines. However, indigenous medical knowledge never faces a complete subjugation due to the over dominance of western medicine, instead what happened was a reframing of the contemporary healing techniques and practices of indigenous medicines (Cleetus 2007). Even with fewer institutions, indigenous systems of medicine in the public sector attracted a large number of users for outpatient care, about 47% i.e. about half the OPD attendance during 2013 (GoK 2013). Besides, there is a significant private sector and a large number of traditional practitioners who provide indigenous medical care to the wider population. Under this context of organizing health care services in the region, the next section looks into the health care utilization among different social groups.

Even with the establishment of widespread health care services, self-treatment is the important way of dealing with illnesses among all social groups especially in cases of acute and chronic illness. The present study found for all the five social groups self-treatment is the major way to

deal with acute illness, with the highest among Adivasis and Thiyya. It is found that it is only among the Muslim community, self-treatment is the second-largest way of dealing with acute illness compared to any single provider category. In fact, for the majority of acute illnesses self-treatment is found as the first response even if it gets treated in the later stage. Such a high prevalence of self-medication is reported by previous studies from different parts of the country (Ahmad et al. 2014; Balamurugan and Ganesh 2011; Phalke, Phalke, and Durgawale 2006).

The present study shows that medicines prepared at home are the major contributor to self-treatment among all social groups, in which SC and ST more significantly relying on it. The other important ways of self-treatment are the use of allopathic medicine bought from a market in which upper caste Hindus followed by Muslims and Thiyya community relaying more compared to other social groups. One of the studies done in an urban setting in the southern part of the state found 69.3 percent of households had at least one person using a pharmaceutical product for self-treatment during the two-week recall period (Saradamma, Higginbotham, and Nichter 2000). They also found that 16 percent of self-medication was done with commercial Ayurvedic products. The present study does not find any major differences among the illness for which allopathic medicines are bought from the market and medicine prepared at the house. The major difference is between social groups in using different methods. Similarly, differences among social groups in the method of self-treatment are found statistically significant in comparison with the differences among different class groups. In the case of using medicine available at the house, Thiyya community comes first followed by Muslims, Upper caste Hindu and then other communities. The close relation of Thiyya community from the region on traditional medical practices and the habit of Muslims in keeping basic medicines at home which are normally bought by Gulf emigrants will partially explain this trend. Even though data on social group-wise differences in self-medication is not found, a previous study in the state found more antibiotic self-medication among university graduates (3.8%) and skilled workers (8.5%) (Rajendran et al. 2019). This shows the greater preference for medicines bought from the market for self-treatment among those social groups which have a higher share of educated skilled workers.

The present study also shows that irrespective of social groups majority of patients followed self-treatment because they knew or weretold of an effective remedy for the illness. ST, Thiyya, and

the Upper caste Hindu community take a lead in this. Notably, they are the same community who least reported ‘did not consider illness to be serious’ as a reason for doing self-treatment compared to other communities. In the case of patients who followed self-treatment as the first response for acute illness, more than half of them reported that they followed the same treatment ten years before. Among the patients who did self-treatment in case of dealing with acute illness during the last 30 days, around 65 percent reported they follow commonly followed treatment in the village, and the remaining 35 reported a difference. A study was done in the state on the prevalence of self-medication also reported a similar trend of previous knowledge, that about 10% of pharmaceuticals consumed are antibiotics and roughly 20% are acquired without a prescription (Saradamma et al. 2000). Another study finds that more than one-third of respondents used a doctor's previous prescription to get antibiotics. And the same study reported, convenience was the reason for the majority of respondents to do self-treatment (Rajendran et al. 2019).

Regarding the source of information for self-treatment, parents and other old members in the family arethe majorsource of information for self-treatment for households of all social groups. However, educated young in the family is also an important source of information. Except for households of SC and ST, more than half of households from all other social groups reported both old persons and young educated are the major sources of information for self-treatment among them. To support this data, as we have already seen, allopathic medicine bought from the market and medicines available at home are an important method of self-treatment among these social groups. Previous studies also indicated the increasing importance of education as a source in doing self-treatment with allopathic medicine (Balamurugan and Ganesh 2011; Rajendran et al. 2019).

Self-treatment, which is the first and major way of dealing with acute and chronic illness among Adivasis, especially of comparatively poor reflects their perception of treatment. Self-treatment is something that is exclusively happening within their belief system and social boundaries with the medicine prepared at their home. The plants and herbs collected from the environment in which they have free access, the knowledge which has been imparted by the elder generation and uses for those health issues which they have successfully treated before. However significant changes can be identified in the self-treatment of Adivasi from the better-off category with the

use of biomedicine, inputs from educated young, and preference towards certain diseases only. This reflects that all the self-treatments followed by poor Adivasis are not voluntarily chosen but some are induced by certain pressures. Or shaped by the limited resources like knowledge, money, and access. Such a significantly high self-treatment among Adivasis is substantiated by results from other studies which show that comparatively poor households have lower recourse to access medical care (Gupta and Dutta 2003; Pillai et al. 2003) and higher rates of self-medication persist among them (Saradamma et al. 2000). As found among the Adivasis and Dalits in the village, Dilip (2000) suggested that increasing costs of care even push the poor not to consider themselves sick. Besides, physical accessibility to health care provisions was also found as an important reason for not seeking care (Kerala State Planning Board 2009). Further, economic reason for higher self-treatment is reported by previous studies from south India and other parts of the country (Balamurugan and Ganesh 2011; Phalke et al. 2006).

The present study further looked into the reason for availing care and found that the difference in reason for availing care for any acute illness is significantly different among the social groups, however, it is not statistically significant among class groups. In the case of both the economic classes, symptom increase severity is the major reason followed by severity blocks day to day activities and lastly, self-treatment did not cure. However, when class and caste intersect, comparatively poor among Dalits, Thiyya and both better-off and poor among Adivasis are the groups from which a greater share of respondents reported severity blocks day to day activities as a reason for availing care. Among the different social groups, Adivasis reported 'severity blocked day to day activities'as the main reason. In fact, it is the only community from which more than half of the patients reported the same. The other communities from which a greater share of respondents reported severity blocked day-to-day activities are Dalits and Thiyya communities. In the case of upper-caste Hindus and the Muslim community, the foremost reason reported (more than three-fifth) is symptom increase severity. And they are the ones who least reported severity blocks day-to-day activities. This clearly shows that there is a relation with the socioeconomic status of households from various social groups in their reason for availing care for acute illness. The Adivasis, comparatively poor from Thiyya and Dalits waiting to consult a provider until it affects their day to day activities is because of their low socioeconomic status.

The present study found an overall high utilization of private providers than public facilities in case of acute illness in the village during the last thirty days of fieldwork. Similar to the present study, higher utilization of private providers than public institutions in case of acute illness (only around 28.3 percent utilization in government institutions) is reported in the rest of the state too (Kunhikannan and Aravindan 2000; NSSO 2004). The present study found that in the case of SC and ST largest among them approach public health care institutions of PHC or CHC. Within public health care institutions when the largest among ST visited the nearby PHC largest among SC visited the Government Taluk hospital. Even, better-offs among SC and ST have a greater dependence on public health care institutions compared to better-off among other social groups. Other studies conducted in the region also found higher utilization of public facilities compared to private facilities by Adivasis and other poor (Sarkar et al. 2014, Levesque et al. 2007). And further reported greater availability of free medical services in the public sectoris important among the poor (Levesque et al. 2007).

In the case of OBC, upper-caste Hindu and Muslims largest share among them consulted private allopathic clinics or hospitals. However, it is also important to note that, when a comparatively good share of patients from upper-caste Hindu and Muslims visited both private clinic and hospital, only 6.7 percent of patients from Thiyya community visited a private allopathic hospital. In the village, in the case of private providers majority from comparatively poor of all social groups and even better-off from Adivasis preferred less expensive private allopathic clinics instead of private allopathic hospitals. Such a trend of higher utilization of organized private sector by the better-off and un-organized private sector by the comparatively poor was already reported from the region (Nandu 2015; Wilson 2010). The private sector is very heterogeneous, it includes a wide range of facilities, from sophisticated hospitals serving the high-income classes to small clinics largely utilized by the poor (Yesudian 1994).

With regard to the treatment for acute illness, the present study found that for SC and ST communities, free public provision is the major reason for preferring the provider during acute illness followed by quality of care and nearby availability. In the case of Thiyya, a strive towards middle-class characteristic of quality care at an affordable cost with convenient access is found. Quality care (33.3%) and quality care at public provision (30.6%) are the important reasons reported by them followed by convenience in access (13.9%). However, in the case of upper-

caste Hindu and Muslims largest share (33.3%) of patients from each group reported quality of care as a reason for choosing a particular provider, followed by convenience as the second-largest reason 32.4% and 26.2% respectively. To support this, previous studies from the state found that inadequate facilities, inconvenient timing, and long-distance are the reason for not using public health facilities (Navaneetham and Kabir 2006); better facilities available in the private healthcare institutions are the reason for larger utilization of private facilities in the state (Wilson 2010, KSSP 2006).

However, as found in the present study even within the public facility, in the case of Adivasis and to a lesser extent Dalits, from their usage of infrastructure to interact with health care professionals reiterate their outsider image. This means a restricted choice of source of care among those who have less resource when we consider the fact that public health care officials and institutions are less attractive for comparatively poor especially from Adivasis due to their previous bad experience. Mohindra etal.(2010)in their study among tribal people also found that tribal communities predominantly used free public health services. And their perception that the quality of the public healthcare system is poor, leads them to seek suboptimal care or deters them from using services (Mohindra, Narayana, and Haddad 2010).Such a situation got strongly shaped over the last few decades when health care costs, especially private services have increased significantly in the country (Bhat 1999; Dilip 2000; Purohit 2001).

When new resources become available to all, some among Adivasis and Dalits were indeed able to make benefit out of it, but in general Adivasis and poor Dalits were alienated beneficiaries with the impression of availing charity. The process of development in public resources, more than a mere assurance of access does not recognize the needs and aspiration of Adivasis. They were never able to engage with these resources to substantially improve their capabilities, instead, in practice, they become mere users alienated from the social environment in which these resources develop. This estrangement (impression of no longer being part of the society) of Adivasis is visible in various spheresof public life in the village like in their engagement in the market as an outsider, or interaction in PDS, segmentation within educational institutions like schools and anganwadis, lack of role in general worship places, etc. When all these public resources mold the engagement of Adivasis as an outsider, the approach of health care institutions or providers alone cannot be assumed as different. Previous studies also found that

better behaviour from doctors and staffs in private hospitals and availability of adequate care from the private hospital are important reasons for people in opting for private hospitals (Kunhikannan and Aravindan 2000). A study on utilization and source of outpatient care in Kerala found, among the reasons for utilization of private facilities instead of public facilities, around 22% referred to problems of availability of public care and 32% reported insufficient services in the public facility on previous occasions. (Levesque 2006). Dalit women from the state even reported that the doctors at the local hospital spend more time examining and treating upper-caste women (Shah et al. 2006).

Further, it is found that preference for AYUSH and folk healers is also an important reason for choosing a particular provider. This is highest among upper-caste Hindus and Thiyyas followed by Adivasis and Muslims in case of acute illness. Similar to this Sankar (2001) also notes that the chance of using traditional medicine increase with improved access and short distance for travel. Education has a positive correlation for the usage of homeopathy and Ayurveda in respective order (Sankar 2001). One important feature noted in its usage is that the choice is not made hierarchically but at the same level and traditional medicine is used not merely seen as an alternative (Payyappallimana 2010).

Data from the present study shows that patients from all social groups also availed treatment from the Ayurvedic system with comparatively greater utilization among Thiyya (26.8%) and ST (13.5%) community. In the case of the Homeopathic system except for ST and Thiyyas, all others have availed treatment under it during the last thirty days. It was only the Muslim community (3.6%) that followed treatment under the Unani system for acute illness during the period. According to a study among all social groups found 21 percent of the population seek healthcare through alternative forms of medicines (Kunhikannan and Aravindan 2000). However,an allopathic system of treatment remains the first preference for the majority of patients from all social groups. Even in the case of Adivasis who have wide expertise in the traditional system of medicine in the state, Kerala State Planning Board (2009) reported that the majority among the community preferred an allopathic system of treatment in case of any illness.

Further, concerning the advice before the consultation, the present study found that those who have taken advice or made any inquiry from friends and relatives before consulting a particular provider are high among Thiyya community followed by SC and Muslims. A class-wise

distribution of advice before consultation shows that better-off among Thiyya, SC, and Muslims reportgetting advice before consultation greater than comparatively poor among them. Compared to better-off, comparatively poor among ST and upper-caste Hindu reported greater in the case of advice taken. The higher practice of taking advice among Thiyyas, SC, and Muslims could be due to the greater social interaction found among them in their day-to-day social life. It is also found that the highest share of patients who took advice are those patients who availed care from a private allopathic hospital (43.3%) and private allopathic clinic (38%), which are the highest among Muslims and Thiyyas respectively. Further, Caroline also noted that men from the Muslim community are interested in discussing the biographies of different doctors, including their qualifications and where they have studied (Wilson 2010), and interpreting their personal experiences in the health care institution. Knowing about modern medical knowledge, its doctors, and facilities become an important part of shaping modern selfhood (Abel 2008; Dumit 2004; Van Hollen 2003). The perception about health, health services, and its utilization show such a trend is dominant among upper-caste Hindus, Muslims and emerging among Thiyyas and Dalits in the village.

Further physical accessibility and resources to have smooth transportation are important in accessing health care facilities irrespective of their public/private characteristic. It shows that except for upper-caste Hindu and Muslims, at least more than half of the patients from all other social groups used public transport to reach health care facilities. In the case of, the largest share of upper-caste Hindu and Muslims private/hired vehicle is the major mode of transportation. Further, it is highest among better-off households from these two communities. The differences in mode of transportation to reach health care facility are more significantly different when it comes to class difference. While around 43 percent of patients from better-off households use private/hired vehicles to reach health care facilities, in the case of comparatively poor households it is only 25 percent. A previous study in the region also finds a similar lack of ability of poor and Adivasis to pay the significant costs unrelated to service use or purchase like travel cost (Mohindra et al. 2010). On the one hand, it shows how lack of low-cost public transport lead to high spending among the poor (for example in the case of lack of direct public transport to PHC and CHC from many parts of the village), on the other hand, it shows how having own vehicle or resources to hire a private vehicle make availing health care more convenient for certain groups.

To the question of whether they followed the same treatment ten years before for similar illness, more than half among all social groups responded that they followed the same treatment. However, only 16.3 percent of upper-caste Hindus responded there are differences in treatment, whereas 46.7 percent each from ST and Thiyya community responded there aredifferences in treatment which they followed ten years agoto deal with a similar illness. In the case of SC and Muslims, around 32 percent from each group reported there are differences in their utilization of providers in case of acute illness. When around half of the ST and around one-third of SC report a change in their care utilization at present compared to ten years before, it is important to remember whom they are consulting at present in large numbers. It is the public health care institutions of PHC and CHC they predominantly approach now, and the major change that happened was a movement from self-treatment and approaching folk healers. Further, forthose patients who utilize care from a private allopathic clinic during the last 30 days, around 59 percent among them consulted a different provider 10 years before for a similar illness. This shows a movement towards higher utilization of private providers for acute illness even after having nearby free public facilities. This reiterates the argument that a larger share of people is looking for paid private health institutions even with the availability of free public hospitals is due to the more convenient type of service people expect and the importance they show in health matters (Rajan and James 1993). Further, except ST and upper-caste Hindu community more than half among all other communities believe they follow the commonly followed treatment in the village. This exception of ST and upper-caste Hindu is in the match with what we have already seen in the preference of upper-caste Hindu and ST community in the utilization of private providers and self-treatment respectively.

Health care utilization in case of chronic illness

In case of provider consulted for the first episode of chronic illness, except for upper-caste Hindu and Muslims, public institutions (Govt AYUSH, PHC, and CHC altogether) are the most preferred provider compared to private institutions (Private AYUSH, private allopathic clinic, and hospital altogether). Further, among these two social groups utilization of care is higher from the private allopathic hospital where specialist services are available compared to private allopathic clinics. Concerning the class differences, it is the better-off from different social groups that utilize care from private providers at a higher rate. This trend is similar to what we

have found in case of acute illness, a preference of private providers especially among better-off among upper-caste Hindus and Muslims. And also a preference towards public institutions from comparatively poorof Adivasis, Dalits, and Thiyya. In the case of providers sought for the last episode of severe chronic illness also, the present study found that only patients from upper caste Hindu and Muslim community surpasses utilization of private providers over public providers. Compared to the provider consulted in the first episode, in the last episode, we can see an overall reduction in utilization of private providers. The reduction mainly happens among the upper caste Hindu and Muslims who were high in utilizing private providers. Besides, in the case of SC and Thiyya there is an increased preference towards the private allopathic hospital in the last episode. The preference of public health care institutions in the first episode and an increasing move towards private providers among the marginalized, along with their financial constraints and perception about public health care institutions, reflects on the differences in the type of care they expect and receive. A previous study among them from the region finds a large unmet need for chronic health care in scheduled caste and tribe households (Mukherjee, Haddad, and Narayana 2011).

It is also important to note that while utilization of government or private AYUSH service is higher among upper-caste Hindu and Thiyya, utilization of folk healer is higher among ST and SC in case of provider consulted for the first episode. Compared to the first episode an overall increase in the practice of self-treatment and utilization of public and private AYUSH services reported in the last episode of chronic illness. Further, it is among SC the utilization of providers other than an allopathic system of medicine is low compared to other social groups. Whilecomparing the utilization of the AYUSH system in case of acute illness and chronic illness, the present study found a higher utilization of them among all social groups in case of chronic illness especially in lastepisode. Similar to this an earlier study found utilization of traditional systems of medicine for chronic ailments is significantly higher compared to acute treatment, where the preference is for an allopathic system. It is also noted that patients with pains and aches largely prefered traditional systems (Sankar 2001).

Hospitalization cases among different social groups

Out of the total 67 hospitalization cases reported among the household interviews, private allopathic hospitals are the major provider sought by patients from all social groups together.

However, in the case of a total of 33 comparatively poor who have sought hospitalization care, 19 is from public health care institutions and the remaining 14 is from a private provider. In the case of 34 better-off, 10 approached a public health care institution and the remaining 24 approached a private hospital. The present study further went into details and find that it is the better-off among upper-caste Hindu, Thiyya, and Muslims along with poor Muslims who used private providers in large. In the case of public health care institutions, it is comparatively poor among SC and ST who approached them in large for hospitalization care. These results match with the previous studies which find a higher dependence on private health care institutions for inpatient care as compared to public institutions among people from all economic classes. But among the lowest Monthly Per Capita Consumer Expenditure (MPCE) quintile it was 54.8 percent and in the highest quintile, it was 82.5 percent (Dilip 2010).

Concerning the reason for consulting a particular provider, the present study found that for a large share of patients availability of the better quality of service is the reason for consulting the particular provider for hospitalization, and it is highest among Muslims and upper-caste Hindus. Out of the total patients who reported quality of care as a reason, around 85 percent of them consulted at the private allopathic hospital. However, one thing is important to mention here that quality of care alone is not the reason for all patients who mentioned it. Out of the total 27 patients who reported quality of care as a reason, around 29 percent (8) of them financed their treatment through public health insurance. The second most mentioned reason by the respondents is the nearest free public facility, which is highest among the patients from comparatively poor households and SC and ST communities. The other reasons mentioned are the convenience of patient and family (highest among Muslims and upper-caste Hindus) followed by the reference (highest among ST) and availability of specialists (highest among Thiyyas). Further, convenience as a reason is higher among better-off households compared to poor. All those patients who reported convenience of the patient and bystanders as the reason for consulting the particular provider, except one all others availed care from the private allopathic hospital.

In the case of managing hospitalization expenses, the present study finds that the use of public insurance schemes is high among the ST, Thiyya, and SC community, and self-management of expenses is high among upper-caste Hindu and Muslims. Further borrowing is high among SC

(26.3 percent) and ST (16.7 percent), and even while using public health insurance some of them borrow cash to meet hospitalization expenses. A previous study also found the proportion of households spends more than 100 percent of their annual per capita consumer expenditure for health care was 18 percent in the poorest quintile compared to only four percent in the richest quintile (Dilip 2010). Another study conducted by Kerala Sasthra Sahithya Parishad (KSSP 2006) found a threefold higher burden of health expenditure among the poor compared to the upper-middle class. Another study from the region found that hospitalization expenditure had more impoverishing effects on households of scheduled caste, scheduled tribe, and backward community households (Mukherjee et al. 2011). Further, the changes in the livelihood of Adivasis in the village to wage labourers without diverse sources of income and resources lead them to borrow even after utilizing care from a government hospital or even after availing public health insurance. As another study points out they become forced to borrow from employers of higher caste to meet their hospitalization expenses (Mohindra et al. 2010).

Health information and activities to improve health

The present study found that more than half of households from Muslims and upper-caste Hindus have at least one person who read about health or watched any programmes related to health during the last three months before data collection. Around 47 percent of households each from SC and Thiyya community also reported at least one member from their household gone through any health-related materials or programmes during the last three months. One of the reasons which many of the respondents mentioned for watching health-related programmes or reading health-related materials is the fear developed out of the outbreak of the Nipah virus in the region during the period. Even in such a rural village, the continued interest in health-related information among all social groups can be because of the availability of TV or a Smartphone among all households except very few comparatively poor. Previous studies already reported that the local television, radio channels, weekly magazines, and newspapers through frequent health stories along with advertising health care, made information and communication technologies central to health care management in the state (Nayar 2009; Wilson 2010). However, as already mentioned data from the present study shows that access to and use of such information is influenced by the socioeconomic and class position of the households.

Such class and social group differences are also visible in the use of social media to communicate health-related issues and activities in the village. When members of the treatment relief committee, members of pain and palliative, local health care professionals, and officials of district administration use social media to share health-related information to the villagers. Its reach is restricted to certain groups only, for example, the treatment relief committees found functioning well among the comparatively poor Muslims, the functioning of palliative care is well among both better-off and comparatively poor among Muslims, upper-caste Hindus and Thiyya. In the case of access to information from local health professionals and officials of district administration, it is also least accessed by Adivasis, Dalits and especially comparatively poor among them. In addition to the availability of material resources, the greater degree of social relation and interaction of Thiyyas and Muslims in their day-to-day life as explained in the social histories helps them to maintain various networks of information.

When health information has more to do with non-material resources, activities to improve health has much to do with material resources. Data shows that irrespective of a social group and class differences at least one member from the majority of the household regularly performs some activities to improve health. However, discussions with the respondents help to understand that there are differences in the activities performed by different social and class groups. Evidence shows that people from all social groups in the village to varying degrees are aware of general health issues and all have the idea that they are required to take actions to promote their health. Food supplementation for children, seasonal preparation of healthy food, postnatalmedication are important among Adivasis, especially comparatively poor among them. Short leisure visit to the maternal house at the time of any health issues, weakness or pregnancy, regular and seasonal preparation of traditional health foods, postnatal medication, seasonal Ayurvedic massages from the Folk healers are important among comparatively poor Thiyya, upper caste Hindus and Muslims. Even though such practices of leisure visits to maternal houses for health promotion are practiced by better-off among these social groups, their improved socioeconomic status made them capable of avoiding such regular visits.

Basis for shaping health and health care utilization

What is defined as health and illness has been differed from time to time and continues to differ from culture to culture. The changes in the conceptualization of health and illness of course are

in part a matter of development in medical science, but not only that, but its conceptualization is also bound up by social relationships and wider social structure. Thus, as discussed in the literature (chapter one) it is important to understand the relationship between social variables and health beyond the usual conceptualization, that social variables as the distant or secondary influencer on health and illness, not as direct causes. Cockerham (2008) observes social variables have a much more direct and fundamental influence in inducing adversity or enrichment in health outcomes. That is, the social context of an individual shapes the risk of exposure, the susceptibility of the host, and the disease's course and outcome, even if the disease is infectious, genetic, malignant, or degenerative. We have already seen in literature that socioeconomic factors can even reverse the biological risk, for example by explaining how income translates into better education, living situation, jobs, quality medical care, and a good diet, and other healthy lifestyle practices (Conley et al. 2003). The present study through social histories and household level analysis reiterates the socioeconomic and cultural characteristics of different social groups in shaping their conceptualization of health, illness, and its management.

Drawing from our concept of the health system as explained in methodology, it can be understood that improvement in the health of people is more influenced by the improvement in the social and economic condition of people than the only direct effect of health services (McKeown, Brown, & Record 1972, Panikar 1975). Further, the socioeconomic conditions at the individual level are not the only factor other than health services that determine the ill health of people, a much wider spectrum of the community-level factors also influence the health of a community (Banerji 1978). Thus, our conceptualization of health resources shall include all household and community level resources that impact a person's health and facilitate access to and utilization of health services. Such health resources shall include, but not be limited to economic, social, cultural, and political resources; and it operates at individuals and community level. As the findings of the present study shows, in the case of marginalized communities (SC and ST) their conceptualization and management of health, illness, and utilization of care shaped by their adjustment to the social environment which is characterized by the availability of low socioeconomic resources and cultural marginalization is significantly different from that of other social groups in the village which have a different resource base.

Thus, it is important to understand the bases of conceptualization of health, illness, and its management by various social groups in relation to their development in the village in socioeconomic, cultural, and political aspects. The social process happened throughout the history with greater influence during the nineteenth and twentieth century shaped the present-day Malabar and its villages. Similarly, in the study village also major changes in the social relations involving attempts to gain political and administrative power from different social groups occurred through the establishment of a democratic governance system during the post-independence period. In the nineteenth century, even a Thiyya man (OBC) was not allowed to freely walk through the public roads in the village due to the distance pollution maintained by the upper castes, but by 2019 an Adivasi woman from the village can pass the prestigious civil service exam of Union Public Service Commission. At the same time, majority of the native inhabitants and other marginalized in the village largely become vulnerable and the earlier powerful social groups gained a new form of power. From the early decades of the twentieth century, signs become evident of disturbances in the earlier social and political order that prevailed in the village as a result of the availability of new resources to almost all social groups. This further helps different social groups to compete in social, economic, and political aspects. As a result, the ritual status exclusively enjoyed by upper castes as it existed earlier started to decline. At least for some from all social groups, the wealth and educational qualification of an individual started to define his social roles in the village in contrast to the earlier caste, religion, and ethnicity-based defining of individual's roles. Similarly, from the development of a new administrative governing system, the formerly neglected public services and resources of all kinds started to reach throughout the village. Which include the building of roads, drinking water supply, opening of educational institutions, distribution of food grains, electricity, support to agriculture and employment, the establishment of rural health centres and recruitment of health care professionals. However, these public resources, the force of new socioeconomic changes have not reached everywhere and in the use of everyone. Such a development of resources in the village has made a greater impact on health among different social groups based on the resource base of each social group.

Here it will be good to recollect the pathways through which social resources shapes the health of an individual as discussed in chapter one based on literature and in subsequent chapters based on data from the field. Firstly, the material interpretation, which explains health inequalities are

the result of the differential accumulation of exposure and experiences that have their sources in the material world. Then behavioural explanation, which describes that there are health-damaging and health-promoting behaviour, and its differences among social groups influence health inequality. Next is psycho-social interpretation, which proposes that psychosocial factors like social support and autonomy at work are important in understanding the effects of inequality in health. Finally, the life-course approach, which reflects that the pattern of social, psycho-social, and biological disadvantage experienced by individuals over time leads to disadvantage in health. In this complexity of issues in defining and interpreting the pathways through which marginalization influences health, it is hard to find a single comprehensive approach that incorporates different views. By considering the diverging views, the bases behind the shaping of different pathways to influence health among various social groups will enable us to point out the differences among various social groups.

Irrespective of social and class groups all respondents have reported that health is something on which they have to act to maintain. The degree of their involvement may vary depending on various characteristics, but they consider it is important to involve. The high prevalence of self-treatment, multiple care utilization, preference towards a certain system of medicine and providers all reflect this. Besides, studies also reported situations where the patients resisting the attempts which minimize their control in diagnosis and treatment (Stimson & Webb 2001). For example, as found in the present study, utilization of care by patients from each social group is significantly influenced by their perception of health. This reflects the importance of individual freedom and choices in health management based on their valued behaviour and dispositions. Human agency is important here, which is the capacity of the individual to freely select his or her behaviour. It is the process by which individuals influenced by their past but also oriented toward the future (as a capacity to imagine alternative possibilities) and the present, critically evaluate and choose their course of action (Emirbayer and Mische 1998). As it is finally choosing the course of action, the choice is important in an agency-oriented approach. In other words, always there is a scope for individual actors to choose their behaviour regardless of structural influence. Besides, individuals could have acted otherwise in a particular situation of health management if he or she has chosen to do so (Cockerham 2008). We have seen the importance of choice among villagers in varying degrees, in following previous successful experience of oneself, in deciding whether an illness is incapacitating or not, in deciding the system of medicine to be approached,

and in deciding how to finance the treatment in managing their health problems. Similar to this symbolic interaction, a leading agency-oriented theoretical paradigm provides a social-psychological model of explanation to behaviour. According to Blumer (1986), Symbolic interaction theory maintains that individual acts are based on their meaning-making to things around them through social interaction with other members in the society. It assumes that objects in the social environment do not possess meaning by their very nature, but it is the people who give meaning to them. Similarly, an individual's self is formed out of social interaction with other people, where other individuals in the interaction defining a person to himself.

However, the degree of social interaction among individuals of different social groups and class groups within them varies widely in the village. In the case of social support especially in the case of Thiyya and Muslims, during the annual renewal of thatch in the past, during any family occasions like marriage, death ceremony, housewarming the support from fellow villagers is multifaceted and adapted to the need like emotional, material, informational and even appraisal. However, we have seen the differences in these supports among different social groups. When Thiyya and Muslims in the village enjoy this to a greater degree, upper-caste Hindus are luxurious enough to not depend on such support, and SC especially ST are not even capable of rendering and not even fortunate to receive many forms of such social supports. We have also seen the functioning of a treatment relief committee among Muslims, engagement of religious authority among Muslims in the health and wellbeing of needy people. The greater engagements of women from Thiyya, Muslims, and SC in SHGs, greater participation in political parties, trade unions, and local self-governance by upper-caste Hindu, Muslims, and Thiyyas. Such collectives of course intensify the interconnectedness and frequent interaction of individual and consequent sharing of material and non-material resources, information among its participants. We also see the differences in the interaction of individuals from different social groups while they were at their family, while they were at the village market, while they were at any public institutions like panchayat office. This reflects on the boundaries of choice, individual acts, and behaviour by pointing out the structural organization of the village.

Besides, the over-emphasis on individual behaviour and human agency to understand the idea of health among individuals will end up with victim-blaming. One of the important social issues reported among the ST community in the study village is the addiction to alcohol and tobacco

products, especially among young men and women. The reason pointed out by leaders of political parties, elected representatives and health workers in the village is that ST men and women have been using such products for a long time, and they do not want to leave it as it is their liked way of life. Such an observation of course is an easy explanation and crude denial of structural factors predisposing alcoholic addiction among them. Further, their behaviour and lack of ability to plan and control their lives are seen as reasons for many burning issues of the community from low financial security, non-availability of regular jobs, and dropout of children from schools to unhealthy behaviour. When individual behaviour and human agency are seen in a narrow sense and argue human behaviour as a reason for promoting unhealthy habits for bad health, it ends up with victim-blaming.An understanding of forming perceptions through the interplay of experience, socialization, and class circumstances can argue that structural factors predispose the individual towards a particular behaviour. Thus, behavioural choices are typical in keeping with the norms of a group or social class, and the wider structural factors impose boundaries on the probable form of action (Blaxter 2004).

Thus social structural perspective maintains that society is not held together by shared norms and values as discussed in agency-oriented approaches, rather they are imposed through the social process where people act on the external world by means or labour and through the production of material objects (Blaxter 2004). Thus, those with the least means remain disadvantaged in the society to have a quality life, as seen in the case of Adivasi and Dalits in the village with the coexistence of material deprivation and poor health. The substantial improvement in the wellbeing and health management among Thiyyas and better-off among SC and ST along with the accumulation of new resources also reflects the effect of material influence. However, the crude denial of the role of agency and simply posing importance on social structure alone or vice versa is not well accepted. Cockerham (2010) cites a theoretical background for these discussions in the writings of Weber through his two concepts: life conduct and life chances. Conduct represents agency or choice, the voluntary direction in behaviour. Chances represent the class position, the boundaries within which people act according to their social situation. When lifestyle choices are explained by assigning complete freedom in individuals it fails to notice the boundaries placed on those choices by the social structure. This shows the necessity of an interplay of both life conduct and life choice in shaping lifestyle outcomes.

French sociologist Bourdieu explains that the everyday practices of individuals are influenced by the structure of their social world and their everyday practices, in turn, create that structure. Individual practices are connected to culture and structure, and ultimately to power, through the conception of habits. He explains this using the concept 'habitus', which is 'the way society becomes deposited in persons in the form of lasting dispositions, or trained capacities and structured propensities to think, feel and act in determinant ways, which then guide them'(Wacquant 2005: 316, cited in Navarro 2006:16). In other words, actions in the everyday life are habituated and, as they are embodied in a person they are then taken for granted. Thus, individual activities cannot be understood solely in terms of socio-structural factors, or solely in terms of behavioural factors. A good understanding requires an integrated causal system in which direct influence of socio-structural factors and their operation through a psychological mechanism to produce behavioural effects are also included.

Conclusion

This thesis has illustrated how diverse social histories of various social groups havedifferently shaped their health perception and health care outcomes. The public health learning it offersis, the changes ina wider set of social forces and systems shaping the condition of daily life and the condition in which people are born, grow, work, live and age can change the epidemiological history of diseases, and through collective attempts, people can shape a social environment in which everyone has the capability to thrive their health. It has been observed that there is a strong dependence on formal institutionalized health care and its knowledge bases, along with a strong dependence on a broader informal and community-based alternative and its knowledge bases among the villagers. Both exist with varying degrees of acceptance among different social groups depending upon their health care resource bases. This analysis helped to point out the evidence for an alternative to the biomedicine oriented health care provision approach to public health. It shows the importance to see the individual as a whole person, a member of a larger social group whose health is ultimately connected with the conditions of life; the importance of lay perception on health, illness, and health care; the role of local health tradition and community involvement in health promotion especially in such situations where the dominant institutionalized system fails; the importance of extending all kinds of public services to rural areas which are now not available to them; and the importance of making local self-governance

and its institutions still more democratic to understand the sufferings of people from marginalized social groups and those who live in remote areas.

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Appendix 1: Annexure Table

Table A1 Occupation of family members from different social group

	SC		ST		Thiyya		Upper caste		Muslim		Total	
	Count	Column N %	Count	Column N %	Count	Column N %	Count	Column N %	Count	Column N %	Count	Column N %
Govt Employee	0	.0%	3	3.8%	1	1.6%	8	15.4%	1	1.8%	13	4.3%
Salaried employment	3	5.7%	0	.0%	4	6.6%	8	15.4%	0	.0%	15	5.0%
Gulf emigrant	1	1.9%	0	.0%	3	4.9%	0	.0%	10	18.2%	14	4.7%
Retired Govt employee	0	.0%	1	1.3%	0	.0%	3	5.8%	0	.0%	4	1.3%
Plantation worker	2	3.8%	0	.0%	2	3.3%	0	.0%	3	5.5%	7	2.3%
Self-employment	4	7.5%	4	5.1%	8	13.1%	12	23.1%	6	10.9%	34	11.4%
Own farming	10	18.9%	11	14.1%	5	8.2%	9	17.3%	4	7.3%	39	13.0%
Agricultural labor	12	22.6%	10	12.8%	9	14.8%	0	.0%	7	12.7%	38	12.7%
Agricultural labor and farming	0	.0%	19	24.4%	5	8.2%	0	.0%	2	3.6%	26	8.7%
Daily wage labor	16	30.2%	15	19.2%	19	31.1%	8	15.4%	11	20.0%	69	23.1%
Daily wage labor and farming	3	5.7%	7	9.0%	0	.0%	4	7.7%	8	14.5%	22	7.4%
MNREGA	2	3.8%	8	10.3%	5	8.2%	0	.0%	3	5.5%	18	6.0%
Total	53	100.0%	78	100.0%	61	100.0%	52	100.0%	55	100.0%	299	100.0%

Table A2

Table A2 Class wise distribution of occupation of family members from different social groups

	SC		ST		Thiyya		Upper caste		Muslim		Total	
	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Govt Employee	.0%	.0%	6.7%	.0%	3.6%	.0%	21.4%	8.3%	3.6%	.0%	6.8%	1.4%
Salaried employment	9.4%	.0%	.0%	.0%	7.1%	6.1%	10.7%	20.8%	.0%	.0%	5.0%	5.1%
Gulf emigrant	3.1%	.0%	.0%	.0%	10.7%	.0%	.0%	.0%	32.1%	3.7%	8.1%	.7%
Retired Govt employee	.0%	.0%	2.2%	.0%	.0%	.0%	10.7%	.0%	.0%	.0%	2.5%	.0%
Plantation worker	6.3%	.0%	.0%	.0%	7.1%	.0%	.0%	.0%	.0%	11.1%	2.5%	2.2%
Self-employment	12.5%	.0%	8.9%	.0%	17.9%	9.1%	32.1%	12.5%	21.4%	.0%	17.4%	4.3%
Own farming	21.9%	14.3%	17.8%	9.1%	17.9%	.0%	14.3%	20.8%	10.7%	3.7%	16.8%	8.7%
Agricultural labor	6.3%	47.6%	11.1%	15.2%	.0%	27.3%	.0%	.0%	14.3%	11.1%	6.8%	19.6%
Agricultural labor and farming	.0%	.0%	15.6%	36.4%	.0%	15.2%	.0%	.0%	3.6%	3.7%	5.0%	13.0%
Daily wage labor	37.5%	19.0%	22.2%	15.2%	28.6%	33.3%	7.1%	25.0%	7.1%	33.3%	21.1%	25.4%
Daily wage labor and farming	.0%	14.3%	.0%	21.2%	.0%	.0%	3.6%	12.5%	7.1%	22.2%	1.9%	13.8%
MNREGA	3.1%	4.8%	15.6%	3.0%	7.1%	9.1%	.0%	.0%	.0%	11.1%	6.2%	5.8%
Total	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%	100%

Table A3

Table A3 Social group and class wise distribution of households based on possession of land and type of land

		Own land				Type of land			
		Yes		No		Homestead only		Homestead and other	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	15	100.0%	0	.0%	5	33.3%	10	66.7%
	Comparatively Poor	14	93.3%	1	6.7%	10	71.4%	4	28.6%
ST	Better off	15	100.0%	0	.0%	2	13.3%	13	86.7%
	Comparatively Poor	13	86.7%	2	13.3%	2	15.4%	11	84.6%
Thiyya	Better off	15	100.0%	0	.0%	5	33.3%	10	66.7%
	Comparatively Poor	15	100.0%	0	.0%	9	60.0%	6	40.0%
Upper caste	Better off	15	100.0%	0	.0%	3	20.0%	12	80.0%
	Comparatively Poor	15	100.0%	0	.0%	6	40.0%	9	60.0%
Muslim	Better off	15	100.0%	0	.0%	5	33.3%	10	66.7%
	Comparatively Poor	14	93.3%	1	6.7%	10	71.4%	4	28.6%
Total	Better off	75	100.0%	0	.0%	20	26.7%	55	73.3%
	Comparatively Poor	71	94.7%	4	5.3%	37	52.1%	34	47.9%

Table A4

Table A4: Social group and class wise educational status of family members of households

			Illiterate		Lower/upper primary		High school		Higher secondary		Diploma		Graduate		Postgraduate and above		Total	
			Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Social group	SC	Better-off	3	6.0%	14	28.0%	19	38.0%	5	10.0%	0	.0%	6	12.0%	3	6.0%	50	100%
		Comparatively Poor	8	24.2%	7	21.2%	12	36.4%	6	18.2%	0	.0%	0	.0%	0	.0%	33	100%
	ST	Better-off	15	26.8%	14	25.0%	12	21.4%	5	8.9%	1	1.8%	5	8.9%	4	7.1%	56	100%
		Comparatively Poor	20	54.1%	9	24.3%	4	10.8%	3	8.1%	0	.0%	0	.0%	1	2.7%	37	100%
	Thiyya	Better-off	3	5.7%	8	15.1%	22	41.5%	8	15.1%	1	1.9%	7	13.2%	4	7.5%	53	100%
		Comparatively Poor	5	8.3%	11	18.3%	27	45.0%	4	6.7%	2	3.3%	8	13.3%	3	5.0%	60	100%
	Upper caste Hindu	Better-off	0	.0%	21	35.0%	11	18.3%	8	13.3%	1	1.7%	12	20.0%	7	11.7%	60	100%
		Comparatively Poor	7	14.0%	2	4.0%	28	56.0%	4	8.0%	5	10.0%	3	6.0%	1	2.0%	50	100%
	Muslim	Better-off	4	7.1%	10	17.9%	15	26.8%	16	28.6%	0	.0%	6	10.7%	5	8.9%	56	100%
		Comparatively Poor	7	12.5%	12	21.4%	26	46.4%	4	7.1%	3	5.4%	1	1.8%	3	5.4%	56	100%
	Total	Better-off	25	9.1%	67	24.4%	79	28.7%	42	15.3%	3	1.1%	36	13.1%	23	8.4%	275	100.%
		Comparatively Poor	47	19.9%	41	17.4%	97	41.1%	21	8.9%	10	4.2%	12	5.1%	8	3.4%	236	100%
Gender	Male		27	9.4%	61	21.2%	110	38.2%	31	10.8%	10	3.5%	30	10.4%	19	6.6%	288	100%
	Female		45	20.2%	47	21.1%	66	29.6%	32	14.3%	3	1.3%	18	8.1%	12	5.4%	223	100%
	Total		72	14.1%	108	21.1%	176	34.4%	63	12.3%	13	2.5%	48	9.4%	31	6.1%	511	100%

Table A5

Table A5 Distribution of households based on type of house and household facilities

		SC		ST		Thiyya		Upper caste		Muslim	
		Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
		Count	Count	Count	Count	Count	Count	Count	Count	Count	Count
Type of house	Pucka with govt support	7	2	5	5	4	7	2	0	0	6
	Pucka with own resources	7	1	5	0	11	3	13	13	14	5
	Semi pucka – own resources	1	6	4	0	0	0	0	0	0	2
	Semi pucka - govt support	0	5	1	2	0	5	0	2	1	2
	Thatched	0	1	0	8	0	0	0	0	0	0
	Total	15	15	15	15	15	15	15	15	15	15
No. of rooms	One	0	5	0	10	0	0	0	0	0	0
	Two	8	9	7	3	2	5	0	1	1	6
	Three	6	1	6	2	5	8	8	12	6	7
	Four or more	1	0	2	0	8	2	7	2	8	2
	Total	15	15	15	15	15	15	15	15	15	15
Source of drinking water	Own well	5	4	7	0	11	3	15	11	10	5
	Hill water through pipeline	4	4	2	7	3	4	0	4	5	6
	Public pipeline	2	0	1	3	0	0	0	0	0	0
	Well of neighboring house	0	0	5	3	1	8	0	0	0	4
	Public well	4	7	0	2	0	0	0	0	0	0
	Total	15	15	15	15	15	15	15	15	15	15
Primary source energy for ...	LPG	10	5	5	0	15	8	15	9	15	10
	Firewood	5	10	10	15	0	7	0	6	0	5
	Total	15	15	15	15	15	15	15	15	15	15

Table A6

Table A6 Distribution of households based on participation in Kudumbasree and possession of ration card

		Whether in Kudumbasree (SHG)				Possession of Ration card			
		Yes		No		Yes		No	
SC	Better off	11	73.3%	4	26.7%	15	100.0%	0	.0%
	Comparatively Poor	12	80.0%	3	20.0%	12	80.0%	3	20.0%
	Total	23	76.7%	7	23.3%	27	90.0%	3	10.0%
ST	Better off	2	13.3%	13	86.7%	15	100.0%	0	.0%
	Comparatively Poor	5	35.7%	9	64.3%	11	73.3%	4	26.7%
	Total	7	24.1%	22	75.9%	26	86.7%	4	13.3%
Thiyya	Better off	10	66.7%	5	33.3%	15	100.0%	0	.0%
	Comparatively Poor	12	80.0%	3	20.0%	14	93.3%	1	6.7%
	Total	22	73.3%	8	26.7%	29	96.7%	1	3.3%
Upper caste	Better off	3	20.0%	12	80.0%	15	100.0%	0	.0%
	Comparatively Poor	4	26.7%	11	73.3%	15	100.0%	0	.0%
	Total	7	23.3%	23	76.7%	30	100.0%	0	.0%
Muslim	Better off	2	13.3%	13	86.7%	15	100.0%	0	.0%
	Comparatively Poor	9	60.0%	6	40.0%	15	100.0%	0	.0%
	Total	11	36.7%	19	63.3%	30	100.0%	0	.0%

Table A7

Table A7 Distribution of households based on experience of food shortage and purchase of food grains

		SC		ST		Thiyya		Upper caste		Muslim	
		Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor	Better off	Comparatively Poor
Experience of food shortage in past six months	Yes, every month	0	0	0	1	0	0	0	0	0	0
	Some months	0	5	2	11	0	1	0	0	0	2
	No, no months	15	10	13	3	15	14	15	15	15	13
	Total	15	15	15	15	15	15	15	15	15	15
Change in quality/quantity of food during last 10 year	Increased	8	7	12	9	11	6	6	8	5	2
	Decreased	0	6	0	2	0	2	1	3	0	1
	Remained same	7	2	3	4	4	7	8	4	10	12
	Total	15	15	15	15	15	15	15	15	15	15
Purchase from PDS shop	Yes	10	12	8	11	9	14	0	13	3	15
	No	5	0	1	0	6	0	12	0	12	0
	Yes, using relatives card	0	3	3	3	0	1	0	0	0	0
	Yes, but not regularly	0	0	3	0	0	0	3	2	0	0
	Total	15	15	15	14	15	15	15	15	15	15
Items purchased	Boiled Rice	6	9	8	11	4	12	0	9	0	13
	Non boiled rice	2	0	3	0	5	0	3	3	3	0
	Both	2	6	3	2	0	3	0	3	1	2
	Total	10	15	14	13	9	15	3	15	4	15

Table A8

Table A8 Class wise distribution of provider sought for acute illness in episode one

	Better off		Comparatively Poor	
	Count	Row N %	Count	Row N %
Self-treatment	33	44.6%	41	55.4%
Govt AYUSH	1	16.7%	5	83.3%
Allopathic PHC	7	22.6%	24	77.4%
Private Allopathic hospital	24	77.4%	7	22.6%
Folk healer	4	66.7%	2	33.3%
Allopathic CHC	9	32.1%	19	67.9%
Private Allopathic clinic	32	64.0%	18	36.0%
Estate clinic	0	.0%	3	100.0%
Total	110	48.0%	119	52.0%

Table A9

Table A9 Distribution of social groups based on reason for consulting a care provider in case of acute illness

		Symptoms increase severity		Severity blocks day to day activities		Self-treatment did not cure		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	11	73.3%	2	13.3%	2	13.3%	15	100.0%
	Comparatively Poor	6	40.0%	8	53.3%	1	6.7%	15	100.0%
ST	Better off	2	18.2%	6	54.5%	3	27.3%	11	100.0%
	Comparatively Poor	5	35.7%	7	50.0%	2	14.3%	14	100.0%
Thiyya	Better off	7	43.8%	3	18.8%	6	37.5%	16	100.0%
	Comparatively Poor	3	25.0%	6	50.0%	3	25.0%	12	100.0%
Upper caste	Better off	7	53.8%	3	23.1%	3	23.1%	13	100.0%
	Comparatively Poor	12	70.6%	2	11.8%	3	17.6%	17	100.0%
Muslim	Better off	15	68.2%	4	18.2%	3	13.6%	22	100.0%
	Comparatively Poor	12	60.0%	2	10.0%	6	30.0%	20	100.0%
Total*	Better off	42	54.5%	18	23.4%	17	22.1%	77	100.0%
	Comparatively Poor	38	48.7%	25	32.1%	15	19.2%	78	100.0%

* Pearson Chi-Square Tests = 0.482; The Chi-square statistic is not significant at the 0.05 level

Table A10

Table A10 Preference for provider among different class groups in case of acute illness

	Near by		Free public provision		Quality service at public provision		Quality of care		Convenience		Preference to AYUSH and folk healer		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Better off	9	10.5%	3	3.5%	10	11.6%	33	38.4%	26	30.2%	5	5.8%	86	100.0%
Comparatively Poor	8	9.1%	20	22.7%	23	26.1%	20	22.7%	7	8.0%	10	11.4%	88	100.0%
Total	17	9.8%	23	13.2%	33	19.0%	53	30.5%	33	19.0%	15	8.6%	174	100.0%

Table A11

Table A11 Distribution of preference for provider and provider consulted in case of acute illness

	Nearby		Free public provision		Quality service at public provision		Quality of care		Convenience		Preference to AYUSH and folk healer		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
PHC	10	32.3%	12	38.7%	8	25.8%	0	.0%	0	.0%	1	3.2%	31	100.0%
Taluk hospital	0	.0%	11	39.3%	17	60.7%	0	.0%	0	.0%	0	.0%	28	100.0%
Govt AYUSH	0	.0%	0	.0%	0	.0%	2	33.3%	0	.0%	4	66.7%	6	100.0%
Estate clinic	2	66.7%	0	.0%	1	33.3%	0	.0%	0	.0%	0	.0%	3	100.0%
Folk healer	0	.0%	0	.0%	0	.0%	1	16.7%	0	.0%	5	83.3%	6	100.0%
Private Allopathic clinic	5	10.0%	0	.0%	0	.0%	28	56.0%	17	34.0%	0	.0%	50	100.0%
Private Allopathic hospital	0	.0%	0	.0%	0	.0%	18	58.1%	13	41.9%	0	.0%	31	100.0%
Total	17	11.0%	23	14.8%	26	16.8%	49	31.6%	30	19.4%	10	6.5%	155	100.0%

Table A12

Table A12 Social group wise distribution of patients took advise before consulting provider for acute illness

		No		Friends and family		Total	
		Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	9	56.3%	7	43.8%	16	100.0%
	Comparatively Poor	11	73.3%	4	26.7%	15	100.0%
ST	Better off	13	86.7%	2	13.3%	15	100.0%
	Comparatively Poor	8	57.1%	6	42.9%	14	100.0%
Thiyya	Better off	9	52.9%	8	47.1%	17	100.0%
	Comparatively Poor	14	63.6%	8	36.4%	22	100.0%
Upper caste	Better off	13	92.9%	1	7.1%	14	100.0%
	Comparatively Poor	12	60.0%	8	40.0%	20	100.0%
Muslim	Better off	14	66.7%	7	33.3%	21	100.0%
	Comparatively Poor	14	70.0%	6	30.0%	20	100.0%
Total	Better off	58	69.9%	25	30.1%	83	100.0%
	Comparatively Poor	59	64.8%	32	35.2%	91	100.0%

Table A13 Distribution provider sought in case of acute illness and advise taken before consulting the provider

	No		Friends and family		Total	
	Count	Row N %	Count	Row N %	Count	Row N %
Govt AYUSH	4	66.7%	2	33.3%	6	100.0%
Allopathic PHC	24	77.4%	7	22.6%	31	100.0%
Allopathic CHC	23	82.1%	5	17.9%	28	100.0%
Estate clinic	3	100.0%	0	.0%	3	100.0%
Folk healer	4	66.7%	2	33.3%	6	100.0%
Private Allopathic clinic	31	62.0%	19	38.0%	50	100.0%
Private Allopathic hospital	17	56.7%	13	43.3%	30	100.0%
Total	106	68.8%	48	31.2%	154	100.0%

Table A13
Table A14

Table A14 Mode of transport used to reach health care facility and provider consulted

	Private vehicle		Public transport		Walking distance only		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Better off	37	43.5%	38	44.7%	10	11.8%	85	100.0%
Comparatively Poor	22	25.0%	51	58.0%	15	17.0%	88	100.0%
Govt AYUSH	1	16.7%	2	33.3%	3	50.0%	6	100.0%
Allopathic PHC	2	6.5%	17	54.8%	12	38.7%	31	100.0%
Private allopathic hospital	21	67.7%	9	29.0%	1	3.2%	31	100.0%
Folk healer	1	16.7%	1	16.7%	4	66.7%	6	100.0%
Allopathic CHC	12	42.9%	16	57.1%	0	.0%	28	100.0%
Private Allopathic clinic	22	44.0%	26	52.0%	2	4.0%	50	100.0%
Estate clinic	0	.0%	0	.0%	3	100.0%	3	100.0%

Table A15

Table A15 Distribution of social and class groups by source of information for self-treatment

		Friends and neighbors		Parents and other old people in the family		Old people and educated young persons of family		Total	
SC	Better off	1	6.7%	7	46.7%	7	46.7%	15	100%
	Comparatively Poor	1	6.7%	7	46.7%	7	46.7%	15	100%
ST	Better off	0	.0%	9	60.0%	6	40.0%	15	100%
	Comparatively Poor	0	.0%	10	66.7%	5	33.3%	15	100%
Thiyya	Better off	1	6.7%	4	26.7%	10	66.7%	15	100%
	Comparatively Poor	0	.0%	6	40.0%	9	60.0%	15	100%
Upper caste	Better off	0	.0%	2	13.3%	13	86.7%	15	100%
	Comparatively Poor	0	.0%	5	33.3%	10	66.7%	15	100.%
Muslim	Better off	0	.0%	3	20.0%	12	80.0%	15	100%
	Comparatively Poor	0	.0%	8	53.3%	7	46.7%	15	100%
Total	Better off	2	2.7%	25	33.3%	48	64.0%	75	100%
	Comparatively Poor	1	1.3%	36	48.0%	38	50.7%	75	100%

Table 16

Table A16Distribution of patients suffered from acute illness based on treatment sought in the past and commonly followed treatment in the village

		Treatment sought in the past						Commonly followed treatment in village					
		Different treatment		Same treatment		Total		Same		Different		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	8	40.0%	12	60.0%	20	100.0%	12	60.0%	8	40.0%	20	100.0%
	Comparatively Poor	5	23.8%	16	76.2%	21	100.0%	14	66.7%	7	33.3%	21	100.0%
ST	Better off	7	35.0%	13	65.0%	20	100.0%	8	40.0%	12	60.0%	20	100.0%
	Comparatively Poor	14	56.0%	11	44.0%	25	100.0%	10	40.0%	15	60.0%	25	100.0%
Thiyya	Better off	9	42.9%	12	57.1%	21	100.0%	11	52.4%	10	47.6%	21	100.0%
	Comparatively Poor	12	50.0%	12	50.0%	24	100.0%	14	58.3%	10	41.7%	24	100.0%
Upper caste Hindu	Better off	3	14.3%	18	85.7%	21	100.0%	10	47.6%	11	52.4%	21	100.0%
	Comparatively Poor	4	18.2%	18	81.8%	22	100.0%	9	40.9%	13	59.1%	22	100.0%
Muslim	Better off	12	44.4%	15	55.6%	27	100.0%	8	29.6%	19	70.4%	27	100.0%
	Comparatively Poor	5	18.5%	22	81.5%	27	100.0%	22	81.5%	5	18.5%	27	100.0%
Total	Better off	39	35.8%	70	64.2%	109	100.0%	49	45.0%	60	55.0%	109	100.0%
	Comparatively Poor	40	33.6%	79	66.4%	119	100.0%	69	58.0%	50	42.0%	119	100.0%

Table A17

Table A17 Distribution of provider consulted in case of acute illness with treatment sought 10 years before and commonly followed treatment in the village.

Provider consulted foe acute illness during last 30 days	Treatment sought 10 years before						Commonly followed treatment in the village					
	Same		Different		Total		Same		Different		Total	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Self-treatment	42	56.8%	32	43.2%	74	100.0%	48	64.9%	26	35.1%	74	100.0%
Govt AYUSH	4	66.7%	2	33.3%	6	100.0%	4	66.7%	2	33.3%	6	100.0%
Allopathic PHC	27	87.1%	4	12.9%	31	100.0%	27	87.1%	4	12.9%	31	100.0%
Allopathic CHC	25	89.3%	3	10.7%	28	100.0%	15	53.6%	13	46.4%	28	100.0%
Folk healer	6	100.0%	0	.0%	6	100.0%	0	.0%	6	100.0%	6	100.0%
Private Allopathic clinic	20	40.8%	29	59.2%	49	100.0%	12	24.0%	38	76.0%	50	100.0%
Private Allopathic hospital	22	73.3%	8	26.7%	30	100.0%	9	30.0%	21	70.0%	30	100.0%
Estate clinic	3	100.0%	0	.0%	3	100.0%	3	100.0%	0	.0%	3	100.0%
Total	149	65.6%	78	34.4%	227	100.0%	118	51.8%	110	48.2%	228	100.0%

Table A18

Table A18 Distribution of provider consulted in case of acute illness with treatment sought 10 years before and commonly followed treatment in the village among different class groups.

Provider consulted foe acute illness during last 30 days	Treatment sought 10 years before								Commonly followed treatment in the village							
	Same				Different				Same				Different			
	Better off		Comparatively Poor		Better off		Comparatively Poor		Better off		Comparatively Poor		Better off		Comparatively Poor	
	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Self-treatment	21	50.0%	21	50.0%	12	37.5%	20	62.5%	24	50.0%	24	50.0%	9	34.6%	17	65.4%
Govt AYUSH	1	25.0%	3	75.0%	0	.0%	2	100%	1	25.0%	3	75.0%	0	.0%	2	100.0%
Allopathic PHC	7	25.9%	20	74.1%	0	.0%	4	100%	7	25.9%	20	74.1%	0	.0%	4	100.0%
Allopathic CHC	7	28.0%	18	72.0%	2	66.7%	1	33.3%	4	26.7%	11	73.3%	5	38.5%	8	61.5%
Folk healer	4	66.7%	2	33.3%	0	.0%	0	.0%	0	.0%	0	.0%	4	66.7%	2	33.3%
Private Allopathic clinic	11	55.0%	9	45.0%	20	69.0%	9	31.0%	5	41.7%	7	58.3%	27	71.1%	11	28.9%
Private Allopathic hospital	19	86.4%	3	13.6%	4	50.0%	4	50.0%	8	88.9%	1	11.1%	15	71.4%	6	28.6%
Estate clinic	0	.0%	3	100%	0	.0%	0	.0%	0	.0%	3	100.0%	0	.0%	0	.0%
Total	70	47.0%	79	53.0%	38	48.7%	40	51.3%	49	41.5%	69	58.5%	60	54.5%	50	45.5%

Table A19

Table A19: Social group and class wise distribution of provider consulted in first episode of severe chronic illness

		Self-treatment		Govt YUSH		Private AYUSH		PHC		Allopathic CHC		Folk healer		Private Allopathic clinic		Private Allopathic hospital		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	2	11.8%	0	.0%	0	.0%	3	17.6%	1	5.9%	1	5.9%	7	41.2%	3	17.6%	17	100%
	Comparatively Poor	2	14.3%	0	.0%	0	.0%	5	35.7%	3	21.4%	3	21.4%	1	7.1%	0	.0%	14	100%
ST	Better off	2	9.1%	0	.0%	0	.0%	5	22.7%	6	27.3%	5	22.7%	2	9.1%	2	9.1%	22	100%
	Comparatively Poor	5	23.8%	0	.0%	0	.0%	6	28.6%	6	28.6%	0	.0%	0	.0%	4	19.0%	21	100%
Thiyya	Better off	0	.0%	0	.0%	0	.0%	2	20.0%	2	20.0%	0	.0%	4	40.0%	2	20.0%	10	100%
	Comparatively Poor	2	10.5%	2	10.5%	0	.0%	8	42.1%	7	36.8%	0	.0%	0	.0%	0	.0%	19	100%
Upper caste Hindu	Better off	0	.0%	0	.0%	3	23.1%	0	.0%	0	.0%	0	.0%	5	38.5%	5	38.5%	13	100%
	Comparatively Poor	0	.0%	2	12.5%	0	.0%	4	25.0%	3	18.8%	0	.0%	2	12.5%	5	31.2%	16	100%
Muslim	Better off	0	.0%	0	.0%	0	.0%	2	16.7%	2	16.7%	1	8.3%	2	16.7%	5	41.7%	12	100%
	Comparatively Poor	2	14.3%	0	.0%	1	7.1%	4	28.6%	2	14.3%	1	7.1%	2	14.3%	2	14.3%	14	100%
Total	Better off	4	5.4%	0	.0%	3	4.1%	12	16.2%	11	14.9%	7	9.5%	20	27.0%	17	23.0%	74	100%
	Comparatively Poor	11	13.1%	4	4.8%	1	1.2%	27	32.1%	21	25.0%	4	4.8%	5	6.0%	11	13.1%	84	100%

Table A20

Table A20: Social group and class wise distribution of response in last episode of severe chronic illness

		Self-treatment		Govt YUSH		Private AYUSH		PHC		Allopathic CHC		Folk healer		Private Allopathic clinic		Private Allopathic hospital,		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	4	23.5%	0	.0%	0	.0%	3	17.6%	4	23.5%	1	5.9%	2	11.8%	3	17.6%	17	100%
	Comparatively Poor	5	35.7%	0	.0%	0	.0%	3	21.4%	2	14.3%	2	14.3%	0	.0%	2	14.3%	14	100%
ST	Better off	6	27.3%	2	9.1%	3	13.6%	5	22.7%	4	18.2%	2	9.1%	0	.0%	0	.0%	22	100%
	Comparatively Poor	8	38.1%	0	.0%	0	.0%	6	28.6%	4	19.0%	0	.0%	0	.0%	3	14.3%	21	100%
Thiyya	Better off	2	20.0%	0	.0%	0	.0%	0	.0%	2	20.0%	2	20.0%	1	10.0%	3	30.0%	10	100%
	Comparatively Poor	5	26.3%	3	15.8%	0	.0%	3	15.8%	3	15.8%	0	.0%	3	15.8%	2	10.5%	19	100%
Upper caste Hindu	Better off	1	7.7%	0	.0%	3	23.1%	2	15.4%	0	.0%	0	.0%	3	23.1%	4	30.8%	13	100%
	Comparatively Poor	4	25.0%	2	12.5%	0	.0%	1	6.2%	6	37.5%	0	.0%	0	.0%	3	18.8%	16	100%
Muslim	Better off	1	8.3%	0	.0%	4	33.3%	2	16.7%	0	.0%	1	8.3%	0	.0%	4	33.3%	12	100%
	Comparatively Poor	5	35.7%	0	.0%	0	.0%	2	14.3%	3	21.4%	0	.0%	2	14.3%	2	14.3%	14	100%
Total	Better off	14	18.9%	2	2.7%	10	13.5%	12	16.2%	10	13.5%	6	8.1%	6	8.1%	14	18.9%	74	100%
	Comparatively Poor	27	32.1%	5	6.0%	0	.0%	15	17.9%	18	21.4%	2	2.4%	5	6.0%	12	14.3%	84	100%

Table A21

Table A21: Provider sought for hospitalization among different social groups

		Govt Allopathic CHC		Private Allopathic hospital		CMC Calicut		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Social group	SC	5	38.5%	6	46.2%	2	15.4%	13	100.0%
	ST	6	50.0%	4	33.3%	2	16.7%	12	100.0%
	Thiyya	5	45.5%	6	54.5%	0	.0%	11	100.0%
	Upper caste	4	26.7%	10	66.7%	1	6.7%	15	100.0%
	Muslim	2	12.5%	13	81.3%	1	6.3%	16	100.0%
	Total	22	32.8%	39	58.2%	6	9.0%	67	100.0%

Table A22

Table A22 Distribution of provider sought for hospitalization with reason for consulting the particular provider

		Govt AllopathicHospital		Private Allopathic hospital		CMC Calicut		District Ayurveda Hospital		Private Ayurveda Hospital		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Reason for consulting Particularprovider	Nearest free public facility	15	100.0%	0	.0%	0	.0%	0	.0%	0	.0%	15	100%
	Availability of specialist	3	50.0%	3	50.0%	0	.0%	0	.0%	0	.0%	6	100%
	Quality care	2	7.4%	23	85.2%	1	3.7%	1	3.7%	0	.0%	27	100%
	Convenience	0	.0%	10	90.9%	0	.0%	0	.0%	1	9.1%	11	100%
	Reference	2	25.0%	1	12.5%	5	62.5%	0	.0%	0	.0%	8	100%
	Total	22	32.8%	37	55.2%	6	9.0%	1	1.5%	1	1.5%	67	100%

Table A23

Table A23 Distribution of hospitalization cases based on how treatment financed

		Self-paid		Govt insurance		Private insurance		Self-paid and borrowing		Insurance and Borrowing		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
SC	Better off	2	33.3%	2	33.3%	0	.0%	2	33.3%	0	.0%	6	100%
	Comparatively Poor	0	.0%	3	42.9%	0	.0%	1	14.3%	3	42.9%	7	100%
ST	Better off	1	16.7%	3	50.0%	0	.0%	0	.0%	2	33.3%	6	100%
	Comparatively Poor	2	33.3%	1	16.7%	0	.0%	2	33.3%	1	16.7%	6	100%
Thiyya	Better off	1	20.0%	3	60.0%	1	20.0%	0	.0%	0	.0%	5	100%
	Comparatively Poor	1	16.7%	2	33.3%	0	.0%	1	16.7%	2	33.3%	6	100%
Upper caste Hindu	Better off	5	71.4%	0	.0%	2	28.6%	0	.0%	0	.0%	7	100%
	Comparatively Poor	4	50.0%	2	25.0%	0	.0%	2	25.0%	0	.0%	8	100%
Muslim	Better off	7	70.0%	1	10.0%	2	20.0%	0	.0%	0	.0%	10	100%
	Comparatively Poor	1	16.7%	2	33.3%	0	.0%	3	50.0%	0	.0%	6	100%
Total	Better off	16	47.1%	9	26.5%	5	14.7%	2	5.9%	2	5.9%	34	100%
	Comparatively Poor	8	24.2%	10	30.3%	0	.0%	9	27.3%	6	18.2%	33	100%

Table A24

Table A24Mode of treatment financed for provider in case of hospitalization

		Self-paid		Govt insurance		Private insurance		Self-paid and borrowing		Public insurance and Borrowing		Total	
		Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %	Count	Row N %
Provider sought for hospitalization	Govt Allopathic Hospital	6	27.3%	11	50.0%	0	.0%	2	9.1%	3	13.6%	22	100%
	CMC Calicut	0	.0%	3	50.0%	0	.0%	1	16.7%	2	33.3%	6	100%
	Private Allopathic hospital	16	43.2%	5	13.5%	5	13.5%	8	21.6%	3	8.1%	37	100%
	District Ayurveda Hospital	1	100.0%	0	.0%	0	.0%	0	.0%	0	.0%	1	100%
	Private Ayurveda Hospital	1	100.0%	0	.0%	0	.0%	0	.0%	0	.0%	1	100%
	Total	24	35.8%	19	28.4%	5	7.5%	11	16.4%	8	11.9%	67	100%

Table A25

Table A25Distribution of households based on possession of health insurance

		Does the HH have any health insurance				Type of insurance							
		Yes		No		Public		Private		Both		Through employer		Total	
SC	Better off	11	73.3%	4	26.7%	8	72.7%	3	27.3%	0	.0%	0	.0%	11	100%
	Comparatively Poor	13	86.7%	2	13.3%	13	100.0%	0	.0%	0	.0%	0	.0%	13	100%
ST	Better off	11	73.3%	4	26.7%	7	63.6%	0	.0%	2	18.2%	2	18.2%	11	100%
	Comparatively Poor	9	60.0%	6	40.0%	6	100.0%	0	.0%	0	.0%	0	.0%	6	100%
Thiyya	Better off	11	73.3%	4	26.7%	6	54.5%	3	27.3%	0	.0%	2	18.2%	11	100%
	Comparatively Poor	14	93.3%	1	6.7%	14	100.0%	0	.0%	0	.0%	0	.0%	14	100%
Upper	Better off	12	80.0%	3	20.0%	4	33.3%	0	.0%	5	41.7%	3	25.0%	12	100%
caste	Comparatively Poor	12	80.0%	3	20.0%	8	66.7%	0	.0%	2	16.7%	2	16.7%	12	100%
Muslim	Better off	10	66.7%	5	33.3%	6	60.0%	0	.0%	4	40.0%	0	.0%	10	100%
	Comparatively Poor	14	93.3%	1	6.7%	14	100.0%	0	.0%	0	.0%	0	.0%	14	100%
Total	Better off	55	73.3%	20	26.7%	31	56.4%	6	10.9%	11	20.0%	7	12.7%	55	100%
	Comparatively Poor	59	78.7%	16	21.3%	55	93.2%	0	.0%	2	3.4%	2	3.4%	59	100%

Table A26

Table A26 Distribution of child in last five year going to Anganwadi among social groups

		Yes		Going to private LKG		No, Child not interested		Total	
SC	Better off	3	50.0%	3	50.0%	0	.0%	6	100%
	Comparatively Poor	4	80.0%	1	20.0%	0	.0%	5	100%
ST	Better off	3	100.0%	0	.0%	0	.0%	3	100%
	Comparatively Poor	2	50.0%	1	25.0%	1	25.0%	4	100%
Thiyya	Better off	2	25.0%	6	75.0%	0	.0%	8	100%
	Comparatively Poor	0	.0%	0	.0%	0	.0%	0	.0%
Upper	Better off	0	.0%	6	100.0%	0	.0%	6	100%
caste	Comparatively Poor	0	.0%	0	.0%	0	.0%	0	.0%
Muslim	Better off	0	.0%	8	100.0%	0	.0%	8	100%
	Comparatively Poor	1	100.0%	0	.0%	0	.0%	1	100%
Total	Better off	8	25.8%	23	74.2%	0	.0%	31	100%
	Comparatively Poor	7	70.0%	2	20.0%	1	10.0%	10	100%

Appendix 2: Interview schedule used for household survey

Questionnaire to study the development of health care resources, and the process which lead to health status disparities among different social groups in Pozhuthana Panchayath in relation to their status and developmental trajectories within the larger socioeconomic and political structure of the region

[A] Details of Respondent

1. Ward Name and Number: _____ Date:

2. Name of the respondent: _____

3. Respondent's relationship with head of household: ☐

Code: Self-1, spouse of head-2, Son or daughter -3, spouse of Son or daughter -4, grandchild-5, father/mother -6, brother/ sister – 7, other relatives-8, non –relatives-9,

4. Age: _____ 5. Sex: _____

[B] Details of household

1. Name of Head of Family (HOF): _____
2. Age: _____
3. Sex: *Male -1, Female -2* ☐
4. What is the religion of the head of the household? ☐

   *Muslim -1, Hindu -2, Christian -3, Others -4, if others Specify*_____

5. Caste and category of HOF? Caste: _____

   Category: SC-1, ST-2, OBC-3, Other-4 ☐
6. What is the occupation of head of household: _____
7. Does the household possess a ration card? ☐
   Yes -1, No -2
8. If yes type of card? *APL -1, BPL -2, Andhyodaya -3*

   Details of other family members ☐

Sr. No.	Name of member	Relation to HOF (code)	Sex (code)	Age (in years)	Marital status (Code)	General educational level (Code)	If NRK, Place of destination	Occupation	Average work days available in a month
1	2	3	4	5	6	7	8	9	10
1.									
2.									
3.									

4.									
5.									

(3) *Spouse of head-2, Son or daughter -3, spouse of Son or daughter -4, grandchild-5, father/mother -6, brother/ sister – 7, other relatives-8, non –relatives-9.;* **(4)** *Sex: Male-1, female-2*

(6) *Marital Status: Never married-1, Married -2, widowed -3, divorced/separated-4;* **(7)** *General Educational Level: Illiterate –1, Lower primary –2, upper primary -3, high school –4, Higher secondary-5, Diploma/Certificate course -6,Graduate -7,Postgraduate and above -8, Any medical courses -9, give details_____, Others -10.* **(8)** *NRK- Non Resident Keralite*

[C] Housing and utilities

1. Type of House: ☐
   Puccka build through govt. programme -1, Puccka build through own resource -2, Semi puccka -3, Thached -4.
2. House ownership: ☐
   Owned -1, Rented -2, owned by parents or close relatives [_____] -3, friends –4,
3. Number of rooms in the house: ☐
4. What is the source of drinking water for the household? ☐
   mark answer for primary source in a. and secondary in b.
   Own well -1, Pipeline -2, Well of neighbouring household -3, Public tap -4, Other _____5.
   Probe: any changes in the availability and source of water during the last few years_____
   _____
5. How far is this source from your dwelling? ☐
   Within premises-1, Less than 0.5km-2, 0.5 to 1 km-3, More than 1 km-4
6. Does the source of water for drinking and household use are separate? ☐
   Yes – 1, No - 2
   if yes source of water for household uses other than drinking?
   Own well -1, Pipeline -2, Well of neighbouring household -3, Public tap -4, Other _____5.
   _____ ☐
7. What type of latrine do you use: ☐
   Open ground -1, Water flush latrine -2, Other latrine - 3 [Specify_____]
8. What is the main source of lighting for your dwelling? ☐
   Electricity-1, Kerosine-2, Others-3_____
9. If electricity, how much was the last month electricity charge?_____
10. Primary source of energy for cooking:
    LPG -1, Fire woods -2, Electricity -3, Others - 4_____
    Main source ☐ Secondary source ☐
11. Waste management arrangements: ☐
    Treated and dumped in a pit-1, burning-2, collect and dispose service-3, no arrangement-4, others-5_____

[D] Food availability and consumption

Part I. Sufficiency of food

1. Did any member of your household have to go hungry due to food deficiency during past six months?

   Yes, every month during past six months.……1

   Some months during past six months ……2

   No, no month during past six months ……3

2. If the answer to the above question either 1 or 2, then during which months during past six months did any member of the household not get enough food every day? *[for incidents of hunger tick appropriate column in the below table], Probe: does this happen every year? What was the case few years before?*_____

_____

January	February	March	April	May	June	July	August	September	October	November	December

Part II. Food consumption and change in dietary variation

1. In last five years is there any changes happened in your household in per capita consumption of food?

   Increased.....1, decreased.....2, remained same.....3

   *Probe: changes in quality and quantity of food consumed, reasons for changes, whether home produce, purchase, free collection, or in return for any services*_____

_____

_____

_____

2. Whether the consumption of fruits, vegetables or animal products increased during the last 5 years? *Yes.....1, No.....2*

   Probe: changes in quality and quantity of food consumed, reasons for ~~increa~~sed consumption, how

   do you financed the increased consumption, whether home produce, purchase, free collection, or in return for any services _____

_____

____

_____

__

Part III. Food availability

1. During past six months did you buy any items at PDS shop?

   Yes…..1, *No……2*

   Probe: if no, why? did you give your ration cared to someone else for buying things from PDS?

   _____

   _____

2. If yes details of purchase made from PDS shop during the last six months?

List of items	How much are you entitled to buy per month? [Write 99 for don't know]		How much did you buy over last six months?		Name of the shop [Ration shop..1, Maveli shop..2, any other..3]	What price did you pay per unit	What was the quality? [Better than market..1, Same as market…..2, Worse than market..3]
	Unit	Quantity	Unit	Quantity		In Rs.	
Rice	Kg		Kg				
Wheat	Kg		Kg				
Sugar	Kg		Kg				
Kerosine	Ltr.		Ltr.				
Edible oil	Ltr.		Ltr.				
Any others _____	Kg/Ltr		Kg/Ltr				

3. How many days PDS shops normally open in a month? _____
   *Probe: working hours? Does the days are fixed for every month?*_____
   _____

4. How do you get information about the availability of products at PDS shops? ☐
   Available on all working days.....1, available on fixed days in a month.....2, during the last visit shop keeper informed the next availability.....3, enquire at the shop.....4, any other.....5, Specify _____

5. Does the PDS shopkeeper allow purchase of smaller amounts or insists on one time purchase of the entire quota? ☐
   Allows smaller purchases……1, Insists on one time purchase……2
   *Probe: if do smaller purchases, reason for not doing onetime purchase*_____
   _____

6. Did you get food on credit over the past 30 days? ☐
   Yes – 1, No- 2
   *Probe: why do you buy food on credit? Do every month you buy food on credit? What all you generally buy on credit?*_____
   _____

7. If yes, then from whom? ☐
   Shop keeper……..1 Employer……2, Others, Specify_____…….3
   *Probe: did you repay them, how do you repay – in cash or kind? In case of need who all are available to buy food on credit?*_____
   _____

8. What are major sources of household food items?
   Home production - 1, Purchase from PDS – 2, Purchase from market – 3, Through receipts in kind in exchange for goods and services – 4, Through free collection, gifts etc. - 5

First ☐ Second ☐ Third ☐

[E] Livelihood, ownership of assets and liabilities

Part I - Source of livelihood

1. Which are the sources of livelihood for your household (both in cash and kind)?

[Note: check all the relevant boxes on the left. Then mention three most important sources and write the codes in the boxes on the right, most important in terms of largest earning.]

☐ Own farm activities……...1
☐ Casual labour (farm and non-farm)……2 First ☐
☐ Salaried employment*…….4
☐ Petty business/trade/manufacturing…..5 Second ☐
☐ Major business/trade/manufacturing 6
☐ Other ……...7 Third ☐

** In Private/Public/Semi-govt./Non-govt. sectors.*

2. Does the most important livelihood source listed above account for more than 50 percent of your household livelihood? ☐

Yes……1 *No……..2*

Probe: if no, was the situation same last few years too? Details of earning, reason for countinuing the activity? any change in the important livelihood activities _____

_____

_____

_____

Part II - Assets – land holding

1. Does the household own any land? ☐
Yes……1 *No……..2*

2. If the answer to question 1 is yes, then what is the type of land owned? ☐
Homestead only……1, *Homestead and other land ……2*
Other land only……..3; Area of land _____

3. If household made any investment in the land, does return from land is: ☐

More than the investment ……1, Breaks even……2, Incurs losses……..3
*Probe: type of investment: agriculture, construction of building etc*_____

_____

Part III - Assets-Live Stock and Poultry

Do you own any animal and/or poultry		**How many do you own?**	**What were the cost of feeds for a month**	**What is the average price of the animal**
Live stock/poultry	**Yes/No**			
Cows				
Buffalo				
Goats				

Hens and Roosters				
Others_____				

Part IV- Durable goods owned by the household

Sl No	Item	Yes or No	How many does your household own
1	Radio		
2	Television		
3	Electric iron box		
4	Land phone		
5	Mobile phone		
6	Computer		
7	Fan		
8	Air conditioner		
9	Bicycle		
10	Two wheeler		
11	Car/jeep or any other vehicle		
12	Mixer grinder		
13	Refrigerator		
14	Washing machine		
15	Dining table		
16	Any other _____		

Part V- Indebtedness status

1. In the last one year, does any of your household members borrow (cash or in kind) from anyone? *Yes - 1, No - 2* [ ]

2. If yes, whom did they borrow from?
   Employer/Land lord -1, Trader/Money lender - 2, Relatives - 3,
   Another person of higher caste - 4, Another person of lower caste - 5
   Another person of same caste - 6, Credit group - 7, Banks - 8,
   Others - 9, _____
   Probe: reason for taking loan from particular source?_____
   _____
   1st [ ]
   2nd [ ]
   3rd [ ]

3. For what purpose was the loan taken?
   For agricultural inputs -1, For other livelihood resources -2
   For family function e.g. marriage -3, For treatment of family member -4
   For educational expenses -5, To buy durable goods -6
   To buy food -7, Other. - 8
   Probe: how do you manage similar situation earlier?_____
   _____
   1st [ ]
   2nd [ ]
   3rd [ ]

4. How much total loan does the household owe taken from all the sources?
   Write N.A. if no loan taken Rs. [ ]

5. Has the family had to mortgage land/ornaments/cattle/any other to secure the loan? [ ]

Yes -1, No - 2

6. Do any of your household settle a loan during the last one year?_____
   Probe: if any loan is settled, did you get any government support to settle the loan? Any grantee assets recovered?, any subsidy from the lender, any other support?. Repayment made in single settlement or not? _____
   _____

[F] Illness Details

Part – I: Details of illness in the last 30 days

(Include illness for which no treatment availed and illness for which treatment availed except inpatient care)

Individual Code (from sec. D)	If the family members suffer from any illness / injury over past 30 days, name of illness	No. of episodes/ injuries	Duration of episode/ injuries (in days)	Treatment sought from (Code) For episode			How much was spent for the treatment	How was the treatment financed?	Culmination of illness?
				1st	2nd	3rd			

Treatment sought from code: No treatment sought -1, Self treatment -2, Registered medical practitioner -3, Practitioner of indigenous system of medicine -4, Government allopathic doctor -5, Private allopathic doctor -6, folk healer-7, Others-8, please specify_____; Culmination of illness: Recovered .....1, Not recovered.....2, Death.....3

1. In the last illness episode do you able to manage it by yourself? *Yes -1, No -2* [ ]
2. Immediately after the onset what all you did yourself to manage the illness?_____
   *Probe: self treatment – any local medicine or medicinal food prepared, any religious practice followed or visited any religious place, use of any medicinal plants, had any medicine bought from the market; reason for doing so and knowledge about such practice, cost of self treatment*_____
   _____
   _____
   _____
3. Did you follow any different treatment for such minor illness/major illness/trauma services/ chronic diseases in the past?
   *Probe: changes in self treatment over the period- medicine used earlier and now, if there any changes source of knowledge about the practice, reason for change- effectiveness, cost, availability, any cultural or religious reasons, any other specify*_____
   _____
   _____
   _____
4. Was this is the treatment commonly followed in your village for such minor illness/major illness/trauma services/chronic diseases? _____

*Probe: what other people in your community do in case of the same illness? What about the other communities, any other group in your village following different ways to treat similar illness*_____

_____

_____

_____

_____

_____

5. If illness is not able to manage yourself even after self treatment, what did you did next?_____

*Probe: provider consulted, before consulting a provider any advice or interaction with friends or family, characteristics of the provider consulted – public, private or philanthropic, generalist or specialist, system of medicine, ASHA, sub centre, PHC, what treatment did the practitioner prescribed- medicine for how many days, any medical tests, any follow up visits advice, referral to any other facility, any shift from one provider to another, any preference of gender and religion of provider etc ,from among similar providers reason to visit this particular provider, Whether self treatment continued after consulting / shifting a provider? reason for stopping or continuing, did you convey details of self treatment to the practitioner, if yes did he asked or you yourself explained, response of the practitioner towards yourself treatment*_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

6. In your last visit, how long did it take you to reach the health care facility? ☐

*Probe: does it was the nearest one or not, if not why do you prefer to go there*_____

_____

7. How did you reach the facility? ☐

Private vehicle -1,Specify_____, Public transport -.2
Free Ambulance service -3, Private ambulance service -4,
*Walked -5, Others - 6,Specify*_____

8. Did you take all the medicine prescribed to you for the entire duration advised?_____

Probe: if not fully taken reason –not bought all medicines- lack of money, felt that by taking half itself will get relief, non availability of medicine, any other, bought all medicine but not taken all – felt recovery after taking few days, no relief felt even after started taking medicine, consult other practitioner, any other _____

_____

_____

_____

_____

9. From where you bought the medicines and done the laboratory tests, if any?_____
*Probe: From the facility itself, outside the facility, did you enquired about its cost before, did you compared the cost with that of any other provider*_____

_____

_____

10. Total expense incurred for your last outpatient treatment

Health care provider fee:	Rs._____
Medicines:	Rs._____
Tests:	Rs._____
Transport:	Rs._____
Others, specify_____	Rs._____
Total----------	Rs._____

11. Do you get any financial relief with regard to treatment related expenditure? ☐
Yes -1, No -2
If yes, then what was the source? Publically financed insurance -1, private insurance -2, Through any other publically provided scheme -3,), Others -4 specify_____
*Probe: How much relief did you get - complete relief or partial relief*_____

_____

_____

Part –II: Details of Chronic illness

1. Do any of your households have any long lasting or recurring health issue, which is not reported in the last 30 days and not availed any inpatient care during the last 6 months?
*Probe: details of patient – age, sex and gender, Illness – severity*_____
_____
_____

2. When the illness did first identified?_____
*Onset of illness, symptoms, time taken to diagnose*_____
_____
_____

3. What did you did when symptoms started to manifest?_____
*Probe: neglected for few days, self treatment – medicine used, knowledge about the medicine, whether any help taken from others; relief from self treatment*_____
_____
_____

4. Did you consult any health care provider?_____
*probe: first provider consulted, reason for consultation – no recovery from self treatment, any other; characteristics of provider-nearest one or not; treatment prescribed- medicines prescribed, duration of medicine prescribed, any medical tests, follow up visits advice, any referral; effectiveness of treatment, any other provider consulted – if yes reason; relief from treatment*_____

_____
_____

5. What all you did in the last episode of same illness?_____
*probe: a). self medication, provider consulted, medication as provider advised in the earlier visit, both self medication and treatment from a provider, b). any medical tests – if yes from where, do you did it with a prescription or not, if no reason for doing, did you showed the test result to someone, if no your conclusion from the result; c). cost of the medical test- did you ever compared its cost with any other institution provide the similar facility, from where you did the test*_____
_____
_____
_____
_____
_____

6. Total expenditure incurred for treatment during the last episode of the illness?_____
*Probe: Consultation fee_____, medicine cost_____, any medical tests_____, travel_____, any other_____; Source of financing expenditure- health insurance – public or private, others*_____

7. During the last episode of illness, how many days did you loosed work?_____
*Probe: loss of work days, how do you manage your expenses, do you borrow money from any one to manage the situation – from where, how much, did you able to return it*_____
_____
_____
_____

Part – III: Details of illness for which inpatient care availed

Individual Code (Code as used in section D)	If the family members suffer from any illness over past one year, which required hospitalization, name of illness	No. of episodes/ injuries	Duration of episode/ injuries (in days)	Treatment sought from (Code)			How much was spent for the treatment
				For episode			
				1st	2nd	3rd	

Treatment sought from code: No treatment sought -1, Self treatment -2, Registered medical practitioner -3, Practitioner of indigenous system of medicine -4, Government allopathic doctor - 5, Private allopathic doctor -6

1. In the last inpatient treatment, why do you get hospitalised?_____
probe: severity of illness, requested doctor to get hospitalise, doctor advised to get hospitalised, any other; duration of the hospitalisation- as provider prescribed, less days/ more days than the

*prescribed- reason; service available in the facility which you find most useful to you- eg. provision of free food, availability of comfortable space for bystanders, any other*_____
_____
_____
_____
_____
_____
_____

2. Did you, yourself take any measures to tackle the illness before you get hospitalised?_____
*Probe: if yes, what did you first did, symptoms, self treatment – source of knowledge, medicines or any other things used in the self treatment, how long, did got any relief; if consulted any provider- reason for consultation- characteristics of provider and treatment prescribed, whether got any relief, any referral*_____
_____
_____
_____
_____
_____

3. Reason for consulting the particular provider?_____
*probe: nearby availability- if not the nearest provider reason for not going to the nearest provider, low cost, reputed provider, any other, among the various providers with similar facilities nearby why do you choose the particular institution*_____
_____
_____
_____

4. If consulted More than one provider, why?_____
Probe: no sign of recovery, high cost, better facility with new provider, any other- if used multiple system of medicine and self treatment why – whether cross referral among different system of medicine by the provider or your choice; knowledge about the new provider-advertisement, did hospitalise in more than one facility, _____
_____
_____
_____

5. Does all the facilities needed for your treatment was available in the hospital?_____
Probe: did you went outside of the facility to do any medical tests etc _____
_____

6. How do the providers interact with you while you were hospitalised?_____
*Probe: relation of doctor, relation of other staff, your knowledge about the treatment undergoing, being shown respect, cultural norms, enough privacy, quality of surrounding, are you satisfied with the advice and description given by the doctor regarding your illness, do you able to clearly understand at what quantity and in what timing you have to take the medicines? Any action by the provider disturbed you*_____
_____
_____

_____
_____
_____
_____
_____

7. Cost of treatment?_____
Probe: Consultation fee_____, Medicine_____, medical test_____, nursing charge_____, food_____, room rent_____, travel_____, any other_____.
*[if bills of last treatment sought is available, bills will use to cross check], will you get the same treatment at a lower cost from any other facility nearby to you, if yes why don't you visit there, loss of employment, source of income to meet treatment expenditure – health insurance etc*_____
_____
_____
_____
_____
_____

[G] Health knowledge and source of information

1. What are the sources through which you come to know of various health related issues in your village like spread of any communicable disease etc?_____ ☐
*Health magazines – 1, Television / radio – 2, News paper – 3, ASHA – 4, sub centre – 5 PHC – 6, Others – 7, Specify*_____
*Probe: did you generally take any precaution in such cases, do you generally get any information or advice from anyone to tackle such issues- if yes from where*_____
_____
_____

2. Does any of your family members takes any medicines/eatables or practices any activity to improve or maintain good health? ☐
*Yes.....1, No.....2; If yes details:*_____
*Probe: regular exercise, yoga, any rituals, medicines or eatables prepared etc, if any medicines or eatables whether it is bought or prepared at home; when did started, whether takes seasonally or throughout the year or at any special occasion, Source of information about the medicine or practice, how long have been doing this, does anything else was using before – if yes details, its source of information.*_____
_____
_____
_____
_____
_____
_____

3. In case of self treatment and home remedies what is your source of information?_____
probe: source of information – family or community members, health programmes or magazines, any health providers- which provider, information about its dosage and period of use for children, adults

*and old age people; information about the availability of medicinal plants or other ingredients; outcome*_____

_____

_____

_____

_____

4. Do you find any system of medicine or any aspects of it [eg. vaccination] in contradiction to your belief? ☐
   Yes.....1, No.....2; If yes please explain? _____
   Probe: how do you find it is contradictory – someone gave details about the treatment and process involved in it, understood from any media, others
   _____
   _____
   _____
   _____

5. Does anyone from your household perform any rituals or treatment practice specifically followed / performed by any other communities as a health care measure?_____
   *Eg. Eatables prepared for the mothers after child birth among Hindus etc, If yes explain*_____
   *Probe: source of information about the practice, if you uses then do you make any changes in such practices according to your belief*_____
   _____
   _____
   _____
   _____

6. Do you notice the health related advertisements / notices? ☐
   Yes.....1, No.....2; If yes details _____
   Probe: who publishes it – local self government, health department, private providers, etc; content of such notices – related to self care, preventive measures etc; does such information are useful to you; what all attract you in advertisement?- example: health tips, cheap price for treatment, treatment facilities available, qualification and experience of the doctors etc

_____
_____
_____
_____
_____

---

7. Do anyone in your family read health magazines or watch health related programmes broadcasted in Television or Radio? If yes more details_____
   *Probe: whether they are helpful or not, does it talks about local health practices and self care – did you made use of them in your daily life?*_____

_____
_____

8. Do anyone from your family is part of groups working for pain and palliative clinic, treatment relief committees, hospitals management committee etc? Please explain_____
Probe: if not do you aware about Hospital management committee, and other committees locally constituted for health benefits of villagers, did they passes any health related information _____
_____
_____
_____
_____

9. Do any of your family members have health insurance? ☐
Yes.....1, No.....2;
*Probe: if yes publically provided or private, whether use of any system of medicine is covered under insurance or not, reason for taking health insurance, if not for all members why, source of knowledge about the health insurance, if ever claimed quality of service delivery*_____
_____
_____
_____
_____
_____

[H] Functioning of Anganwadi

[This section is only for the households with children of less than six years of age]

1. Do children of less than six years of your house go to Anganwadi? ☐
Yes – 2; No – 2

2. If no, what is the reason?
Aganwadi does not open regularly ……..1
Anganwadi is not available near to house.....2
There is no anganwadi worker ……2 First ☐
The care is not good at the anganwadi.....3
Any other reason……5 Second ☐
Fill in two reasons in the order of importance.

3. If a child goes to anganwadi is he/she served regular meals? ☐
Yes -1, No -2
*Probe: if no, do you know the reason for not providing meals, if yes, how many days in a week*_____

4. If yes, are the meals freshly cooked or they are ready to eat food items? ☐
Freshly cooked -1, Ready to eat -2
*Probe: food item included in the meals, did the quantity and quality is good*_____
_____
_____

5. Does the anganwadi worker ever visit your home? ☐
Yes -1, No -2

*Probe: if yes, reason for visit eg. to visit the child, report any communicable disease, to pass any information from the local authority, any other reason*_____
_____

Questions for households have adolescent girls or pregnant and lactating mother

6. Did the anganwadi worker provide any meals or any other services to the adolescent girls or pregnant and lactating women in your house?_____
   *Probe: if yes what did they deliver, how often, if any edible item provided quantity and quality of the item provided*_____
   _____
   _____

Appendix 3: Interview guide for key informant interview

Social, Economic and Political Dynamics Shaping Health, Health Services and their Access: A case study of Malabar region

A. Data have to collect to understand

1. The processes which lead to health status disparities between sub regions and social groups in the context of differential status and developmental trajectories of sub regions and social groups within the larger socioeconomic and political structure of the region and the state.
2. The development of health care resources among sub regions and social groups in the context of differential status and developmental trajectories of sub regions and social groups resorted to
    a. Health care as a local industry in the marketplace
    b. As a knowledge industry and
    c. as an essential public provisioning

B. Topics to be discussed

Settlement pattern

- Early settlers of the region, emergence of various social groups, lakshamveedu colony [One lakh housing colony], quarters etc – changes in the settlement pattern over a period of time.
- History of religious places – church, mosque, temple and other religious places
- Demarcation of forest and agriculture lands, changes in the agricultural area over the period, forest and small towns
- Access to towns and distance from settlements of various social groups, movement of people from earlier settlements to new places within the village

Social structure of the village

- Caste hierarchy in the village – socio economic status of different social groups, changes in earlier untouchable communities, occupational mobility, class consciousness – how does it changes over the period
- Aspirations – changes in the lifestyle/economic/social status of communities
- Marriage and sex ratio, demands in marriage, functions and celebrations

- Women and social life – restrictions in public places, atrocities against women etc, representation in social, cultural and political organizations – growth of female literacy
- Changes in the representation of various social groups in government jobs, social and political organizations and in higher education during the last three decades
- Political parties and trade unions, political leaders and social activists from different social groups and sub regions, organization of workers
- Presence of cooperative movement, library movement, peoples science movement etc in Wayanad district

Agriculture

- Changes in cropping pattern and reason for change
- Adoption of modern agricultural practices
- Majour crops cultivated – cash crops or food crops
- Irrigation facilities
- Agricultural land ownership
- Development of tea and coffee plantation

Availability of food

- Sources of food and how does it change over a period of time
- Food shortage at any period of a year, if yes how they manage
- Changes in the diet pattern over the years – what changes and why
- Is there cases of hunger due to lack of food

Livelihood

- Majour changes in the livelihood opportunities for various social groups
- Changes in labour opportunities of various social groups over the time
- Majour occupations of different social groups and working condition
- Work participation, unemployment and under employment – women, youth and others
- Household industries, handicraft, tourism and service sector and other majour industries

Migration

- Early migration of farmers to this regions and changes in agriculture and occupational relation
- Gulf migration, new trends in migration
- Seasonal and permanent migration by people of various social groups – in migration

- Impact of migration on livelihood opportunities, agriculture, labour and economy

Forest resources

- Access to forest resources now and earlier, deforestation and availability of forest resources
- Majour communities depends on forest resources
- Type of resources collected – whether it is an alternative source of income or not

Economic condition

- Family income, assets holds, changes in family income and assets before and after land reform
- Out of pocket expenditure of the households, debts and loans, consumption pattern
- Credit sources for different social groups and changes over the time
- Ownership of resources such as land, farm animals and poultry, source of employment, house, bank savings, ornaments etc.

Living condition

- Housing, sanitation, drinking water, availability of food and clothing – among various social groups - changes over the period – public support for its improvement
- Family composition, children, dependents
- Quality of services provided a decades before compared to present day – food grains from PDS shops, education in government schools and colleges, services in government hospitals and other public institutions

Education

- Literacy among social groups, professional education and higher education
- Availability of educational institutions, educational institutions run by various social groups, teachers and academicians from various social groups
- Changes in the educational status of different social groups

Functioning of social welfare programmes

- Mid-day meal scheme – provision of hot cooked meal, quality and quantity, access to children from different social groups
- MNREGA – participation from various social groups, process of applying for job card and getting work, per day wage, number of work days
- Social welfare pension – availability to eligible persons from different social groups, process of applying for pension, delay in provision, spending from pension

Health care situation of the village

- History of health care development in the village – public and private sector – various system of medicine – users of different system of medicine.
- Majour factor influenced health care provisioning of the region – lack of public provisioning, availability of medicinal plants, growth of private sector, Gulf migration, internal migration
- Common preference of people for health needs – maternity care, health problems of children, female and elderly, health problems which are high among particular communities, fever episodes, other majour health needs.
- Collective or individual initiative from people towards better health, blaming of doctors for bad treatment /negligence, avoidable health problems in the village
- Patients dignity, autonomy, confidentiality, prompt attention, basic amenities, choice of provider and facility
- Factors influencing treatment pattern, forms of treatment that where accessible and degree of access, experience of treatment, and belief about treatment systems and providers, religious belief and health, superstition and health problems
- Level of care – provisioning of primary, secondary and tertiary level care
- Spending in health – priority of people, out of pocket expenditure in health
- Effect of western medical practice on ayurveda and other indigenous medical practice, role of various organizations in spreading different systems of medicine, patients dependence or resistance towards particular medical system
- Caste hierarchy among traditional healers, doctors from various system of medicine, different social groups and training in medicine
- Women traditional healers – their caste, type of illness treated, characteristics of their patients, site of treatment provided.
- Respectable job – perception of people on medical professionals – case of allopathic doctor, traditional healers and practitioners of other system of medicine, their social mobility and income
- Perceived quality of care in diagnosis, treatment and medicine under various system of medicine. Perception on medicines which is not packed, not containing any certification and details about the medicine (normally given by local healers like Vydhyan)

Health care system as a knowledge industry

- Medical education – various systems, cost and social background of students, hereditary training
- Allopathic system versus other systems of medicines – overdependence and subjugation, home remedies, side effects of medicines, personal health habits of people, lifestyle management
- Health awareness – health promotion activities, the lay understanding of medicine and treatment, use of multiple system of medicine by patients
- Knowledge of patients about their illness – before comes to provider and after
- Health discourse: casual talks in the village, information from government organizations, advertisement and information from private providers, academic discourse
- Health consciousness of people – health programmes, magazines, media and advertising
- Indigenous knowledge – use in health and other fields like agriculture and daily life

As an industry in the local economy

- Majour private providers in the area and their origin, starting of range of services, diagnostic technologies
- Emergence of large number of pharmacies and its effect on self medication
- Commercialization of medical technologies, consumerism, patients shop between different hospital and doctors, cost of treatment.
- Changes in patient provider relation in recent years
- Practice of providers – regular practice - duration of work – sites of work, treatment place and facilities available, practice at more than one site, referral of patients, type of patients and health problems treat
- Hierarchies among medical professionals – within each professional categories like doctors from different system of medicine, traditional healers - between different category of professionals like doctors and nurses - between professionals of various social groups
- Professional development of health care professionals among different system of medicine
- Insurance schemes – public and private, affordability of treatment cost and its impact on livelihood of households
- Changing nature of charitable works in health care, functioning of cooperative hospitals – cost , quality

- Medical ethics, consumer protection, trust between providers and patients – how each change over the period

As a public provisioning

- First public health care facility in the region, its growth and development
- Health needs of the people and the way services are organized, changing priority of state government
- Availability of essential medicines, diagnostic facilities, doctors and other health care professionals
- perceived quality of service provided, case load of the hospitals and management of the hospital

Local level planning in health care

- Public participation and functioning of Hospital Management Committee – at CHC, PHC, Taluk and district hospital level
- Panchayath level committee regarding provisioning of safe drinking water, total sanitation, waste management; discussions related to the functioning of sub-centre and PHC in gramasabha meetings
- Functioning of village health sanitation and nutrition committee or Ward Health and Sanitation Committees (WHSC) and decisions made related to health and nutrition.
- Participation and functioning of health workers like Health inspector, Junior Public health nurse, ASHA, Anganwadi worker, Kudumbasree workers in the village.
- Local participation in the setting up of private health care facilities in the region, health workforce to the private facilities, setting up of pharmacies and laboratories

Topics related to health seeking pattern of villagers in the context of the prevailing socio economic and political condition, and health care resources available to them.

Illness details

1. Relation of occupation and social life of people with the origin of illness
2. Identification of the illness, how do people confirm the illness – was it similar in the previous years too.
3. Severity of illness and time of treatment sought
4. Details of rest taken, stress due to illness – its impact on income and employment

Pathway of care utilization

1. Immediate response to the illness

2. Self treatment – changes over the period, use of home remedies and use of medicines bought
3. Time of treatment avail from a provider after symptoms started manifesting
4. Delay in treatment seeking – does the delay decreased as more and more facilities developed in the recent years
5. Continuity in treatment

Preference to public or private sector

1. Whom do various social groups generally consult in case of health issues, does it remain unchanged
2. Changes in treatment seeking in relation to growth of health care facilities
3. What all generally people from various social groups considered while choosing the provider

Quality of services in public and private sector

1. Concept of quality and utilization of various providers available
2. Satisfaction with treatment provided by various providers in the village
3. Where you feel people are more respectfully treated
4. Whether public or private providers are more accessible, any changes in the providers generally consulted over a period of time.

Cultural and religious determinants of health care seeking

1. Any preference to doctor or institution affiliated to particular religion or caste
2. Preference to approach a male or female doctor
3. Religious practices performed to cure the illness among various social groups and how does such practices exist now compared to earlier periods
4. Acceptance to religious practices to cure illness from various social groups – inter religious performance of such practices

Expenditure on health care

1. Source of payment for various social groups and class groups
2. Does health expenditure of families increase over the period, if so why
3. Coverage of health insurance and its utilization
4. Any financial burden due to spending on health care
5. Local level initiatives like treatment relief fund etc

C. Key informants and respondents selected

Key informants includes from various sections, thus among the topics listed above most suitable will be discussed with different key informants according to their expertise and experience.

1. Health care providers
    a. Doctors, nurses, lab technicians, pharmacists of both public and private sector from Allopathic, Ayurveda, Homeopathy, Unani and any other systems of medicine.
    b. Other health workers like Public health inspectors, ASHA and Anganwadi workers
    c. Traditional healers, religious leaders who performs any practices to cure illness
2. Government officials and elected representatives
    a. District Medical Officer, Head of District and Taluk hospitals, Medical officers of CHC and PHC, manager of cooperative hospitals
    b. Panchayath Secretary, District and Taluk Panchayath President, Panchayath members, Village officer, Agricultural officer, Assistant Educational Officer, Managers of cooperative, private and public sector banks in the panchayath, school teachers.
3. Political leaders and social activists
    a. Local political leaders of all majour political parties in the state, Local leaders of other political organizations in the region, trade union leaders
    b. Social activists from various social groups in the region, activists of civil society organizations, religious leaders of various social groups in the region, other old aged persons who have knowledge about history of the area
    c. Leaders of local libraries and clubs, representatives of SHGs, neighborhood groups etc

Appendix 4: Institutional Ethical Review Board Certificate

INSTITUTIONAL ETHICS REVIEW BOARD
Jawaharlal Nehru University
New Delhi-110067

IERB Ref. No.2018/Student/181

Name of the Ethics Committee: IERB-JNU

Title of the Faculty Proposal: "Social, Economic and Political Dynamics Shaping Health, Health Service and their Access: A case study of Malabar region"

Principal Investigator: Mr. Nandu Kannothu Thazha Kuni (Ph. D Student) C/o Supervisor Prof. Ritu Priya Mehrotra CSM&CH/SSS/JNU

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Collaborators' Name: NA

FOR OFFICIAL USE

The proposal was reviewed in a meeting held on 18th December, 2018 at 4:00 PM. The following members were present:

1. Prof, Ravinder Gargesh Acting Chairperson
2. Advocate Omika Dubey, Member
3. Ms. Vibhuti Sharma, Member
4. Prof. Paul Raj, Member
5. Prof. Ashwani Pareek, Member
6. Dr. Sushil Kumar Jha, Member
7. Prof. Amita Singh, Member Secretary

The committee resolved to

[ ] Approve - indicating that the proposal is approved as submitted;
[ ] Approve – after clarifications – indicating that the proposal is approved if the clarifications Requested are provided to the satisfaction of designated committee members;
[✓] Approve after amendment/s – indicating that the proposal is approved subject to the incorporation of the specified amendments verified by designated committee members;
[ ] Defer – indicating that the proposal is not approved as submitted but it can be reassessed after revision to address the specified reason/s for deferment;

[ ] Disapprove – indicating that the proposal is not approved for the reason specified.

Comments:

Member Secretary,
IERB, Ethics Committee

Prof. Amita Singh
Member-Secretary
Institutional Ethics Review Board
Jawaharlal Nehru University
New Delhi - 110067

Date of Approval: 20.03.2019 (after acceptance of revisions)

*(1st part to be filled in by PI and presented at the time of Review (Periodic, Continuing, Interim)).