SOCIO-ECONOMIC STATUS AND HEALTH: A STUDY OF A VILLAGE IN UP

Dissertation submitted to Jawaharlal Nehru University in partial fulfilment of the requirements for the award of the Degree of

MASTER OF PHILOSOPHY

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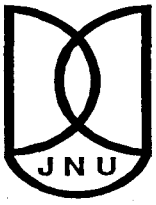

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CERTIFICATE

This dissertation entitled "**Socio-economic Status and Health: A Study of a Village in UP",** is submitted in partial fulfilment of six credits for the degree of MASTER OF PHILOSOPHY of this University. This dissertation has not been submitted for any other degree of this University or any other university and is my original work.

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We recommend that this dissertation be placed before the examiners for evaluation.

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Dedicated

to

Pious Memory of

Chacha and Taai

&

The Poor People

Suffering From a Host of Diseases and Dying

Silently

Due to Lack of Health Care

Contents

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Shiv Kumar

List of tables

MAPS

ABBREVIATIONS

ANC	-	Ante- Natal care
ANM	-	Auxiliary Nurse Midwives
BCs	-	Backward Castes
CHC	-	Community Health Centre
CIOMS	-	Council for International Organisations of Medical Services
DStO	-	District Statistical Office
HFA	-	Health For All
IMR	-	Infant Mortality Rate
MCH	-	Maternal and Child Health
MO	-	Medical Officer
NCAER	-	National Council of Applied Economic Research
NFHS	-	National Family Health Survey
NHP	-	National Health Policy
NHDR	-	National Human Development Report
NMBS	-	National Motherhood Benefit Scheme
NSS	-	National Sample Survey
OBC	-	Other Backward Caste
PDS	-	Public Distribution System
PHC	-	Primary Health Centre
SC	-	Scheduled Castes
SES	-	Socio Economic Status
SRS	-	Sample Registration System
TB	-	Tuberculosis
U5IMR	-	Under Five (5) Infant Mortality Rate
WHO	-	World Health Organisation

Chapter I

INTRODUCTION

Understanding the Problem:

The health and well being of a population is an important element for progress and development of a nation. The popular phrases - 'health is wealth' and 'healthier nation is wealthier nation' emphasise their importance at individual and community level. Therefore wealth of a nation is linked with health of the nation – healthy condition of its population. The health of a nation can be best assessed by health status of its people.

India has made considerable progress during last fifty-five years. The five decades of public health and development initiative successfully changed the life condition of overall population in general. This improvement of health condition is reflected in the popular health indicators of country. India has doubled its life expectancy from 32 years at the time of independence to 64.6 in 2000. This increase in the life expectancy is the outcome of the decline in crude death rate from 27.4 deaths during independence to 8.7 deaths in 1999 (SRS). Similarly, Infant Mortality Rate (IMR) of India became half, from 146 infants' deaths per 1000 live birth at the time of independence to 70 in 1999. The improvement in IMR is directly linked to the decline in the birth rate. It

became 26.1 births per thousand populations in 1999 from 39.9 births in 1947.

Apart from these strong positive shifts also occurred in the field of health infrastructure and epidemiology of diseases. Recently, released National Health Policy (NHP-2002) – second in fifty-five years of independence – stated that these moderate health achievements are 'noteworthy successes over time' in India. Yet the above successes are low and limited in comparison to other countries which started with same condition and diseases. Other health parameters also showed very low changes during the same period. High rate of infant mortality, malnutrition, TB, leprosy and water borne diseases are still common and contribute to a high level of morbidity and mortality in the population. Many basic illnesses that have radically declined in large parts of the developing world in recent decades, continue to be common in India (National Health Policy –2001 Draft).

These health achievements in the field of health status and health infrastructures are unevenly distributed between poor performing and best performing states and within their population. Orissa and M.P. have more than double death rates than Kerala. State wise variations are vast in IMR and U5IMR. IMR in Kerala was 14 in 1999 whereas it was 90 in M.P. and 97 in Orissa at the same period of time. Similarly Kerala shows 18.8 U5IMR, whereas M.P. and U.P. show 137.6 and 122.5 respectively

during the same time. Maternal Mortality Rate (MMR-2000) was 87 in Kerala against 707 of U.P. and 468 of whole India. When we further expose these aggregate data, on the basis of gender, class, region and other socio-economic groups we find presence of more fatal inequalities in health. So it is clear that vast inequalities are the common feature of present health scenario of India and these health achievements at an aggregate level 'conceal more than what it reveals' (Iyer and Sen-2001).

Communicable diseases are seen to be responsible for more than half of the 'burden of disease' in India. Notably the burden of disease falls very unevenly on different sections of the population. Indeed health inequalities are very sharp in India in comparison with many other countries even poor ones. Particularly, class differences in health achievements are large by international standards – (Dreze & Sen –2002).

The state and region wise disparity is much more as itself manifested in health indicators provided by different government agencies under various social and political pressures. The new NHP – 2002 also acknowledges the existence of wide disparities due to uneven development and that national average of health indices hide wide disparities in public health facilities and health standards in different parts of country. Continuous negligence of health matter in development issue and low level (0.8% of GDP) of public expenditure on health in India are aggravated by (i) highly inefficient use of available resources and (ii)

sharp inequalities in access to health care based on region, caste, class and gender [Banerji (1996), NCAER (2000), NHP-2001].

Further, these health statistics and information are inadequate. These are silent on certain prolonged inequalities in the area of morbidity – mortality prevalence and they do not reveal availability of various health services, accessibility of health care, utilization of health services, cost of care and untreated morbidity; by the socio-economic characteristic of population. These social characteristics of population with special reference to health inequalities, are more relevant in a backward, vulnerable rural region of the country. Due to low health chances of those who are in the low level of social strata in above regions their pathetic condition deserve the special attention of health researchers and planners.

Health inequalities are not limited to one or two countries. This is a worldwide phenomenon found in all countries developed and developing, with or without a national health services. Worldwide average life expectancy at birth was 65 years in 1995. However it was 77 years in developed world, 64 years in developing world and 52 years in least developed countries. The life expectancy gap between developed and developing world has narrowed to 13.3 years in 25 years but the gap between least developed and other developed countries has widened from 7 years to more than 13 years during the same period (WHR-1996).

WHO also made effort in the direction of 'Health for All (HFA)' by provision of primary health care till 2000. After two decades of 'HFA' WHO affirmed strongly in CIOMS conference (1997) that a global health policy centered on equity is necessary to the achievement of 'Health for all in the 21st century' by considering health as a basic human right.

It is unfortunate that after five decades of development and health planning, the long cherished dream of ' right to adequate health care facilities to people, near to their location of habitat, irrespective of their paying capacity' (Bhore Committee, 1946), has remained a distant goal. Health services, which are committed to provide basic health care to all, especially the most needed ones, became uneven and inaccessible to them. Critics see this health service system in India as an expression of socio-economic inequalities (Qadeer 1985). Infact, lower socio-economic status works as barrier itself to access basic health care and attain a considerable health status due to nature of health care services available to them.

After 1990s with the implementation of structural adjustment policies above dreams became never getting reality. In the name of health care reform, health care expenditure is under attack and government is withdrawing away from the responsibility to provide health care to all. Trends, such as increasing concentration of income and wealth among a small proportion of population; widening the gap

between rich and poor and decline in wage growth and employment (Chauhan, Antia & Kamdar – 1997) have demanded renewed attention on inequality and its consequence for health and well being of a population.

In this background, the present study attempts to explore the inequalities in health by socio-economic status in rural northern India from public health perspective focusing on curative and preventive aspects of people's health and utilization of health care services.

Rationale of the Study:

The driving force behind this study was my deep interest in rural health and illness of rural people and my basic training in the field of Clinical and Social Psychology. During my course work in public health I often read, and realised increasing health inequalities among Indian population – rich and poor. It is increasingly recognised that the most vulnerable section, despite their greater health needs; are having less access to health services and show low on various health indicators. Therefore, this problem – inequality in health and use of health care services – deserves an immediate attention, because this is most unacceptable situation related to life and death of a vast population, struggling for existence. In this study the researcher limited oneself to focus on socio-economic dimension of inequality. The main relevance of the study is to contribute in the understanding, that how socio-economic status and increase in the cost of treatment affect the health seeking

behaviour of rural people, particularly the rural poor. This study may help the further research and future action to improve the health of worst off and to narrow the health gap in society.

Objective of the Study :

The broad objective of this study is to understand the relationship between socio-economic status of the people's health and the use of health care services especially in rural Northern India.

The main questions of the study are:

- To understand the general health problems/needs of the village.
- To see the effect of socio-economic condition on health status of people.
- To examine the relationship of socio-economic status on the pattern of health care utilization.
- To analyse the health seeking behaviour of the people having different socio-economic condition.

Methodology

People's health conditions and their respective use of health care services are broadly linked with the socio-economic background of people and cultural context of community. A field study was conducted, in the Basnehta village of Allahabad district of Eastern Uttar Pradesh, on the selected samples of 47 households. Data was collected at the both – qualitative and quantitative level. A social psychological approach was

used to collect primary data with the help of a structured interview schedule, health narratives and non-participant observation. The focus was on the wider socio-economic backgrounds, health problems and type of health services they used on individual level, and on village health problems by village leaders and health care providers of the study area, at community level.

Indicators:

Different definition and indicators are used for the operational measurement of the study variables. These are discussed here in brief.

In the study, health is measured by condition of negative health as indicated by morbidity i.e. presence of one or more illness or disease as appeared by their reported symptoms. This negative health status is based on subjective perception of individuals. In the present study duration of illness ranges from the day of study to one month of the study.

A chronic illness was defined as any illness persisting for more than one month. An acute illness was defined as the one which led to being sick for three or more days. Utilization of health services for household is that during sickness where they go for treatment for curative care. For preventive care we limited oneself to prenatal care of women during last pregnancy and delivery and vaccination of last children.

In the study a *'household'* was defined as the people living in a same house, sharing the food prepared in the same *'Chulha'* and has

common land for cultivation simultaneously. The term *'family'* has often been used synonymously with the term *'household'*.

People's socio-economic conditions are determined on the basis of their household. Household socio-economic status is defined by socio-economic scale that was made on the basis of ownership of cultivable land, type of housing and caste of household. Other socio-demographic conditions and household things are also collected as subsidiary information to above indicators.

Data Required:

In the present study, required data on wide range of variables, was collected at different levels. These includes:

General physical aspects of village, its location, settlement, pattern of housing, environmental condition. Social and political organisation of village, village life and condition of poors, women, children, aged, social and political, and other village institutions, caste structure, and social relations, economic and allied activities and main occupation. Socio-demographic characteristic of village, its population, size, density, sex ratio, literacy.

Major problems of study village at community level, place of village health problem and felt needs in overall village problem, solution of these problem on community level.

Major health problems of study area at aggregate level in general, and specific health problems of women, children, aged, and main prevalent diseases of study area in particular. At the time of health problems where the villagers go or what health services they choose by health personnel of study area.

Socio-demographic conditions, available facilities, land holdings, living standard on the basis of household things in each household. Health condition and use of curative health services of each individual in the households if possible death in the previous year, use of preventive care, measured as prenatal care of MCH during pregnancy, availability and accessibility of prenatal care, a vaccination and reasons for not receiving ante-natal care at the time of pregnancy, and health of children and women during that time.

People's perception of causation of illness and health and their response to restore and maintain them; limitation of daily activity; assessment of illness on their one's life and family. Role of health beliefs and others in taking decision of health care.

Tools and Techniques used in Data Collection:

Several methods are used to collect above-mentioned required data. Selection of specific field technique depends upon the nature and the level of the study problem and special situation of individual and community of study area, to obtain reliable information.

Base-line Survey was done first of all households to draw a vivid picture of village and collect the general information of the village. It covered all the households of the village with the help of elderly and knowledgeable persons of each hamlets/caste of village community. The information on the total households and their compensation, total population and its distribution, caste, cultivable land, any white collar job in the family, highest educational standard in the family, type of housing and are they produce their own food grains enough for annual consumption of whole family, was collected in this survey.

This base line survey helps in two ways. First it helps in the selection of household on the basis of their economic categories and second, it helps in administration of scheduled questionnaire to concern households by making a initial rapport and accepting environment.

Systematic interaction, probing interview, direct observation and direct interview were used to collect the primary data on socio-economic and demographic characteristics of all households.

Four *interview schedules* were used to (i) collect the village health problems/needs by administering on village leader and health personnel of study area; (ii) in getting information of individual socio-economic-demographic characteristic and their households and their perceived health problems and use of health care services. Finally, a maternal and child health (MCH) schedule was used to see the use of prenatal care

during pregnancy as measure of preventive care (See Appendices-A,B,C,D).

Health Narrative was taken for the in-depth exploration of peoples perception of health and disease, their experience and impact of illness, purposefully; by one individual, who suffered the illness or by the most significant relatives who give care or support most of the time to the person in each households. *Cross Checking* of every information was done at all possible level.

Observation and Informal talk used at all times to validate the quantitative and qualitative responses and health narratives. Informal talk with village people in general and respondents in particular help in establishing good rapport and reducing the initial resistance and inhibition. Any useful information came during field study was recorded precisely to understand and interpret the response of person in their real context.

Secondary sources such as the village level census and available records, health centres information and available literature, district handbook and gazetteer, other related literature and publication of study area were also used to portray the total picture of study area.

The study was conducted in the month of December 2001 and till mid January of 2002. Before the actual field survey, the base line survey and adequate field visits were conducted in the mid October of 2001.

Process of Data Collection:

Selection of the study area:

Since this study attempts to explore and understand inequality in health and use of health care services by different socio-economic group within limited time span, only one village was chosen. Very often insight obtained from a single village reflected the condition of majority of Indian villages because of the many well-known common denominators like poverty, social inequality, caste structure, poor health services and insanitary living conditions (D. Banerji, 1982). Due to common characteristic of various variables (like background history, geographical & ecological characteristics and broad socio-cultural context) inter group comparison was possible at the appropriate level in the single village.

While selecting the village, its population, size and social stratification, proximity and tangibility to public health services, researcher's familiarity and convenience with area particularly their language and culture are the main determining factors behind the selection of study village. Because of researchers interest on the persistent inequalities in the rural health, of India and familiarity and closeness with eastern part of Uttar Pradesh; the researcher has chosen the Basnehta village of Allahabad district. This village has a well connected road, a sub-center in the village, a PHC near 3 km distance and

medium population size and a Panchayat made up of single *Gram Sabha,* easy for coverage and representative study. Due to availability of higher health institutions in Allahabad, possibilities of inequalities of health and use of health care services at tertiary level also were assumed.

Selection of the households in the village:

Total 20 percent of households of village are selected on the basis of economic categories based on base line survey. In base line survey each household is divided in well off, middle and poor category on the basis of land holding with combination to white collar jobs in households or other main occupation, and production of food grains enough for the whole family annual food consumption. Table 1.1 shows caste wise economic categorisation of all households.

In the 225 reported households, 74, 96 and 55 households lies in poor, middle and well off families respectively. Due to time constraints and dealing with wide range of variables at a time 20 percent sample were decided as appropriate representative to all households. Given nearly proportionate representatives to all castes in each economic category, at all possible level, 47 households were selected. In which 16, 18 and 13 are from poor, middle and well off categories respectively. In the selection of households proper representation was also given to each *Basti* (hamlets). Only in the case of unavailability or unwillingness of household member to co-operate with researcher the another household

of same SES group, same caste and of same settlement was selected as sample household.

Selection of the respondents

First the village representatives of village head and Panchayat member were contacted directly. After discussion on the purpose of study, the interview schedule for village was used to collect their view on concern issues.

From each selected household, if present all family members were generally contacted to get information on health problems, education, age and occupation. For household information generally senior and/or educated member of family were asked. In the absence of some family members information has been collected from other available family members. In this case, female members were generally taken for the information of small children and young women. Children present during study give valuable information about inhibitive individual and by cross checking.

For the MCH schedule, information on prenatal care and mother and child health condition was asked to the all women.

The health experiences of a chronic illness were taken from one family member, who within one year faces major health problems. This health narrative was taken mainly from individual who suffered the disease or by the most significant relative, who give care or support to him.

Table 1.1: **Distribution of Households in Different Economic and Caste Categories Based on Preliminary Base Line Survey.**

Poor*	**Middle****	**Well off*****
Aheer= 17 Thakur = 02 Harijan = 17 Pasi = 24 Bhat = 04 Nai = 02 Kumahar = 04 Brahmin = 01 Mushar = 03	Aheer = 46 Thakur = 05 Harijan = 11 Pasi = 16 Bhat = 4 Nai = 06 Kumahar = 03 Brahmin = 04 Kahar = 01	Aheer = 34 Thakur = 03 Harijan = 00 Pasi = 00 Bhatt= 04 Nai = 00 Kumahar = 01 Brahmin = 14 Kahar = 01
Total= 74 (32.88%)	96 (42.66%)	55 (25.44%)
Number of selected households 16	18	13

* Landless wage labourer with less than 1 acre of land or/and does not produce enough food grain sufficient for one year; houseless or grass hut.

** Land up to 4 acre; artisan or small business in village with up to 2 acre land; *Pucca* house and able to produce food grains sufficient for one year, works as migrant worker in other cities as temporary basis in private sector.

*** More than 4 acres of land, government services with minimum 2 acres of land and *Pucca* house, big business: ownership of shops, contractor, milk suppliers etc. With *Pucca* house and produce sufficient food grain for family.

Socio-Economic Status (SES) Index

Field study was done on the basis of preliminary baseline survey of economic categories. However, this categorization was rearranged, systematically latter by choosing and adding precise measures of socio-economic conditions. Due to this process, a new socio-economic scale evolved and the previously placed household intershifted between new categories. Mostly previous middle economic groups now shifted in poor SES group. One landless lower caste household with fourth-class government job also shifted from higher economic status to lower socio-economic status.

In the process of analysis researcher first evolved composite three point socio-economic scale by combining the total cultivable land, type of house and caste categories. The households were placed in their respective socio-economic status, on the basis of their cumulative index number, which is generated in the following manner:

Firstly, the land holding groups have been divided into three-point scale:

The landless and marginal peasant (0 to 2 *Bigha* land) gets one point;

The small and middle peasant (2 plus to 5 *Bigha* land) gets two points;

The big farmers (more than 5 *Bigha* lands) get three points.

Secondly, the types of house available to household have been divided in to four-point scale:

Those are houseless or have grass hut gets one point.

Those have *Kaccha* house gets two point.

Those have semi-*Pucca* house gets three points.

Those have *Pucca* house gets four points.

Similarly, the caste community has been divided into a four-point scale:

The Scheduled castes (Pasi, Chamar, Musahar) are rated with one point; because of the lowest social position in present village structure.

The backward caste (Nai and Kahar) is rated with two points.

The Other Backward Castes (Aheer) are rated with three points.

The Upper caste (Brahmin, Thakur and Bhat) is rated with four points because of their highest social position.

Finally, these scores were added to find a cumulative score between 3 to 11. These scores were reorganized to place households in three-class socio-economic scale as follows:

Poor class: those with 3 to 6 points (21 Households)

Middle class: those with 7 to 8 point (14 households)

Well off: those with 9 to 11 point (12 households)

All the data in chapter 5 was analysed with references to these SES categories. 21,14 and 12 families come in this poor, middle and well off SES categories respectively.

Limitations of the study:

In present study, in spite of intensive effort to reduce the biases and methodological errors there are enough space for improvement and control. First of all a single village study cannot be a proper representative of whole area, hence we cannot generalize the study findings; further policy conclusion would need a more detailed study than what has been attempted here.

The socio-economic indicators taken like land as equivalent to income and wealth have their own limitation; specially when the type of land pattern of cropping and the person depends on the land was not equal.

Discussion of female health problem by a male researcher, and reliance on the other family members for the health condition of children, aged and other unavailable or unwilling members, obviously affected the quality of collected data. Over-estimation and under estimation of health problems and health seeking process might be possible because of memory laps and less awareness towards seasonal variation.

Time was a major constraint. It restricted the depth, duration and size of the study, which would give more reliable and valid information when expansion was possible. Crosschecking was not always possible, at all level.

Deep qualitative exploration of illness experiences by a respondent's narrative was conducted within a limited number of cases voluntary and often it was incomplete. Further in one occasion we cannot understand the whole health experiences completely. Difficulty also arises in articulation and sharing of suffering experiences with researcher.

Presentations of Chapters

This dissertation is divided in six chapters. Chapter one gives an over view of introduction and methodology of research problem. Chapter two discusses the conceptual understanding of socio-economic inequalities in health. It reviews the relevant literature in the area of inequalities in health status and illness, access of health services and utilization of health care services.

Chapter three presents an over-view and profiles of the study area and its population with regard to geographical location, physical settings, demographical characteristics, social and political structure, village institutions & developmental schemes, agriculture and related activity, land holding, occupation and overall socio-economic characteristic of the village on the basis of secondary data, observation, interview and base line surveys.

Chapter four deals with the village representatives and health care providers' view on their health problems/needs, disease and general pattern of use of health care.

The fifth chapter deals with the main findings on the socio-demographic profile, use of curative health services, morbidity pattern and burden of illness in surveyed population. It also discusses the use of prenatal care services used by mother and children during pregnancy and after birth. This chapter finally discuses the differences in health seeking behaviour in their socio-economic context and also analyses it by using socio-economic experiences of peoples. Finally, chapter six deals with the conclusions and observations drawn on the basis of the study.

Chapter-II

UNDERSTANDING SOCIO-ECONOMIC INEQUALITY IN HEALTH

It is well recognized that health condition of a population is depends upon availability of a wide range of basic amenities. It includes food, safe drinking water, hygienic living condition, proper housing and sanitation, adequate wages and income for livelihood and health care facilities. Health services are just one of the inputs required to improve the health status of a population. The health status of the population is reflection of its socio-economic development (Bandophadhyay and MacPherson 1998). Just as health condition is influenced by socio-economic condition to a greater extent, similarly health services are shape by socio-economic and political forces in the society.These forces play important role in influencing decision, regarding policy and planning of research and priorities in implementation (Zurbrigg, 1984). Infact, these factors shape the health care system in accordance with their interest. Thus, we can say that the health status of Indian people is closely linked with their social structure: caste class and hierarchy, economic condition and ability to influence the political and institutional structure of the society.

In this background, it becomes clear that roots of ill health are linked with the hierarchal structure of society and uneven distribution of resources among population. It is necessary before proceedings further, to become clear about conceptual basis of term used in this study and their inter-linkages with reference to health inequalities. In this chapter we deal with the health in a broader social Context, Equity and health and social inequality and health. At last one effort was made to give evidences of social inequalities in health from micro studies and national and international survey and reports as a part of relevant literature related to the focal theme.

Concept of health: In a broader context

Clarification of concept of health and illness is the starting point of any discussion of health in wider social domain. Starting with popular and most common definition of health among health researchers and scholars given by WHO (1974) we can say that 'health is a state of complete physical, mental and social well being and not only absence of disease and illness'(Park& Park 1991). This definition of health viewed health as a broader concept, including 'physical', 'social' and 'mental' aspects of health.

Thus health is multidimensional theme and one cannot be healthy, if lacking any one aspect of health. This holistic notion of

health looks health as an ideal, as a goal, rather than a real condition. It is difficult to define, measure and achieve to this goal in a comprehensive manner. 'It also ignores the fact that health or well being has a range and cannot be an absolute quantity or quality. Health in a reality, then is a social concept evolved and determined by the perceptions of a group or community and therefore differs from community to community' (Qadeer,1985). Hence, health is a physiological and psychological state but it is also, fundamentally, social state. Health is a state of being that is subject to wide individual, social and cultural interpretation. It is produced by the interplay of individual perceptions and social influence (Jones 1994).

Despite of above limitation WHO official definition of 'health' expanded the restricted domain of health. From tradition to development of modern medical science, health is seen as 'a absence of disease'. If one is free from disease, we can say that the person is healthy. Modern medicine is often accused for its preoccupation with the study of disease and neglect of the study of health (Park and Park 1991). WHO definition of health is outcome of a realization in 1960s and 1970s that health can no longer be viewed merely as physical states. This realization may be attributed to the recognition of the social change and development in decline of mortality, demands for positive health and preventive care

through rational social organization and rational individual behaviors (Black report-1982). This holistic approach to health, highlighted health as a positive goal, achieved by personal and social change as well as by medical advance (Linda 1994). This sense of health as action and adaptation is captured by WHO as 'a resource for living' with emphasis on social and personal resources (WHO 1984). This WHO definition connects to a social model of health, which emphasizes the environmental causes of health and disease. Health is seen as being produced not just by individual biology and medical intervention, but also by conditions in the wider natural, social, economic and political environment and by individual behavior in response to that environment. The 'health field concept' also gives importance to the environmental determinant of health with behavior, biological and health care. However, the emphasis on the physical and biological basis of health continued with little effort to bring out the significances of its social basis (Qadeer 1985). This broader contextual framework of health is the basis of social inequality of health. But before this, it is necessary to understand the place of equity in health.

The negative end of health spectrum concerned with the 'death and disease' has been used most as the measure of health. The popular measures of health are mortality rates, sickness-absence rates and restricted-activity rates-short term (acute) and long term

(chronic) disease rates, calculated from medical records or self-reports of complaints (Black Report-1982). Laypersons own reports of illness are also consider a valid measure against doctor's records. Illness is defined as the subjective experience of symptoms of ill health and has been measured in the health and life style survey (Health Divide 1992). Improved health of a community is measured as life expectancy, calculated from mortality rates.

Equity in Health

It is widely accepted that there are natural differences in health of the population. Human beings vary in the health as they do very in other aspect of life (Health Divide –1992). One question is that at what level these differences are justifiable to their physiological characteristics and genetics, and at what level to the environmental surrounding in which he/she live and gets the chances of health or ill health. Undoubtedly, the physiological characters play their role in the health but they are mostly fixed for the individuals by their genetics. Only environmental factors affect their physiological characteristics previously determined by their hereditary factor. Then health difference might be attributed to unfair or non-supportive environmental surrounding. In this context the 'equity in health end health care' needed to attain a maximum possible level of health for all.

In health terms ideally everyone should have a fair opportunity to attain their full health potential and, more pragmatically none should be disadvantaged from achieving this potential if it can be avoided. (Whitehead, 1990). So 'equity in health' requires reducing unfair and unavoidable disparities in health outcomes between different groups. The approaches to diminish disparities in health status required desegregation of data on disease and death; going beyond from maximization of health measures to narrowing of disparities; new methods to identify inequality and equality based planning and implementation of health services (Bankowski 1997).

This equality in health requires 'equality in health care' including equity in social and economic sphere through fair resource allocation on the basis of need. Although all have equal rights to health care, but all have not equal needs depending upon their health status and life condition. So equity in health care requires 'equal access of available care for equal need, equal utilization for equal need, and equal quality of care for all' (Health Divide 1993).

Equity in health put certain questions and issues to assess its position. Is people's economic condition and wealth; social position, caste and racial origin or gender affects the chances of maintaining health? Are the certain groups, region, are disadvantage of health care? Are the resources fairly distributed around the country? These questions

are the put for ward always in achieving equity in health. By this way, equity focuses on the well being of those in greatest need. For this purpose, generally, an equitable health policy is proposed. An equitable health policy would be one that identifies who is worst off and arranges health resources with special attention to them (Veatch 1997).

Pursuing equity in health status and health care means moving towards higher standard for all-bringing every one up to at least the lowest denominator (HFM, 1999.Vol-25/No.2). But it does not mean equitable health policy makes the worst off health status nearly equal to better off. Even it may happen that equity in health possible on the price of decline in aggregate health level of population. In this context efficiency in health planning becomes important to produce as much good as possible with a given unit of resource with out conflicting with equity. Then, the health policies should pursue equity and efficiency simultaneously, with preference of equality to health status with everyone at high status than equality with everyone at low status. 'An intriguing formula that integrates both efficiency (utility) and equity would be striving to maximize the mean health status devided by the variance' (Veatch 1997). Improving aggregate health indicators doesn't require that all in society be equally healthy. But it is equity in health that gives fair opportunity towards health for all in 21st century.

Social Inequality and Health

The contemporary Indian society with a democratic constitution for more than five decades of legal commitment to 'equality of status and opportunity' with justice, liberty and fraternity to all of its citizens. These constitutional guarantees, however, not translated into practices and therefore, inequality are reflected in various social political and economic spheres of Indian people. Not only inequality is persistence in status but also it is still persistence in equality of opportunity. Equality is fundamental concept of justice. It postulates some basic rights or human rights for all irrespective of their race, caste, colour, sex or region. Equality of opportunity, legal equality, equal satisfaction of basic needs, equality to each according to his merit, to each according to his need, and political equality are the common goal proposed as instance of egalitarianism (Oppenheim and Inig Kristol, 1968).

On the basis of origin, generally, inequality in human is of two types: Physical and Social. Physical or natural inequality is established by nature or genetics. In spite of a single species, all men's are unequal in their physiological characteristics and in bodily strength as reaction to their environment. Another, social inequality is found because of different privileges that some man enjoy than prejudice of other. Simply it is said that social inequality is the consequence of unequal rewards or opportunity for a long period. Social inequality includes all sorts of

inequality in a social context. 'Actually the deeper roots of social inequality are to be found in economic inequality. However, social inequality includes both the economic and political inequality' (Kumar, 1982).

Socio-economic equality postulates the right to equal satisfaction of basic needs. It implies state provision of health as essential social services. As a tool to attain equality, democracy has been proposed to ameliorate man made, socially nurtured inequalities that has restricted for others the avenues that lead to income, education, status and advancement. In this context it can be said that 'the issues of inequality and participation are particular crucial in India, where social divisions (based on class, caste and gender among other sources of disparity) are pervasive and tended to take a heavy toll on both economic development and social-opportunities'(Drez & Sen 2002).

Until last decade poverty rather than inequality was the focal point among researchers. Poverty is much more than economic deprivation for a minimum caloric intake. It can also mean a denial of opportunities and choices (as basic to human development); to lead a long healthy creative life, a dissent standard of living, freedom dignity, self-esteem and respect of others (WSEA 1995). Further this report stated that poverty is a result of a prolong inequality, social political and economic discrimination of the person of a class, cast, region or race.

The concept of class is common in the debate of social inequality. It is a form of social stratification of the society. 'A social class is segment of population sharing broadly similar types and levels of resources, with broadly similar styles of living' (Black Report-1982). A class system is based primarily on economic differences between groups. It means groups have unequal access to and control over possessions and material resources (Jones 1994). Class is also based on the other social classification. Caste in a given village can sometimes be representative of India's class structure. Caste and class represent to a large extent the same social reality (Sharma, 1997). Different scholars have emphasized different aspects of inequality. 'Income' end 'occupation' are more common factors used to measure and study inequalities. Type of housing, education, style of consumption, social origins, and employment status are other popular measures of socio-economic inequality. Other measures like land, caste, and educational status are also used in measurement of socio-economic inequality.

After discussing the concept of equity and inequality in a broader social context, it is worthful to discuss the impact of inequality on health and health care of a population. When we implicate this concept of inequality in health, it expressed explicitly the distribution of health or ill health in a population has for many years. Individual of a population differ in their health status and availability, accessibility and participation

in health services on the basis of their socio-economic class and status, caste and race origin, and on the basis of region, gender, age and occupation (Jones, 1994, Qadeer 1985).

Here, the differences between individuals are not attributed to natural or physiological factors but it focuses on social-political-economic determinant of social inequalities. Social category or classes have not only unequal resources but they also passes unequal social power. So, the provision of health services, access, takes up and treatment is uneven across the different social categories and classes (Jones, 1994). The popular neo-liberal interpretation of income inequality in health reflects both lack of resources held by individual and systematic under investment, across a wide range of community infrastructure (Lynch 1998). Investment in Indian health care system is the one of the appropriate example of this type of health inequality (Dreze & Sen, 2002, Rao, 1999). Another psychosocial environment interpretation in contrast to neo-liberal interpretation, views health inequalities as a result of perceptions of relative income, and focus on the role of shame trust, social cohesion and social capital as key indicator of health inequalities.

The popular Black Report (1982) made an effort to explain, that how social circumstances can affect health, in two ways. According to cultural /behavioral explanation inequalities in health evolves because of, lower social groups have adopted more dangerous and health damaging

behaviors than the higher social groups, and may have less interest in protecting their health for the future. The second, structuralist/materialist explanation emphasizes the role of the external environments: the condition under which people live and work. They do more dangerous work, have poor housing and have fewer resources available to secure the necessities for health and to use the available health services (Black Report-1982). However, new research support that environment dictate individual health behaviours and these explanations are interrelated. An Analysis of health status of Indian people, beyond use of medicine by Qadeer (1985) founds the social basis of ill health. 'In all the cases it is poor who get hit the hardest and who have the least access to information, doctors, drugs, hospital care transport and life support system' (Qadeer 1989). However, the social production of disease is otherwise ignored in the health research. Following are the few available evidences of inequalities in different sections of health with focusing on socio-economic class and care context.

Health inequalities: Evidences form studies

There is enough evidence of persistence of health inequalities in both national and international level. Health status and illness, accessibility and availability of health services, utilization of health

services are major area of manifestation of health inequalities; shown by national and international studies.

However, impact of class differences on different aspect of health has not been properly emphasized in wider domain of health research. In India our National Sample Survey (NSS) and Sample Registration Scheme (SRS) do not focus much upon class (socio-economic) differentials of health. Only few research & regional studies deal with this issue. Although, National Family Health Survey (NFHS) try to see the impact of class and caste and other social differential on health but this especially deals with maternal and child health. It does not see socio-economic differences on the other aspect of health like morbidity, mortality and use of health care, in general.

Table2.1-Differentials in Health Status among socio-Economic Groups			
Indicator	**InfantMortality /1000**	**Under5 Mortality/1000**	**%children Underweight**
India	70	94.9	47
SC	83	119.3	53.5
ST	84.2	126.6	55.9
Other Disadvantaged	76	103.1	47.3
Others	61.8	82.6	41.1
Source : National Health Policy (NHP-2002) Govt. of India, New Delhi.			

Table 2.2- Infant and child mortality by background characteristics, INDIA, 1998-99				
Background characteristic	**Neonat-al Mortal-ity**	**Infant Mortality**	**Child Mortality**	**Under-five Mortali ty**
Caste/tribe	**URBAN**			
Scheduled caste	40.1	60.4	25.2	84
Scheduled tribe	35.6	57.6	23.4	79.6
Other backward caste	35.3	51.2	16.3	66.6
Other	29.8	43.5	14.1	57
Standard of living index				
Low	48.8	76.1	39.1	112.2
Medium	34.6	51.5	17.6	68.2
High	24.1	33	6.6	39.4
Total	33.5	49.2	17	65.4
	RURAL			
Caste/tribe				
Scheduled caste	56.2	88.1	43	127.3
Scheduled tribe	55.1	86.9	48.8	131.4
Other backward caste	54.7	82.2	32.7	112.2
Other	45.1	69.3	25.6	93.1

Standard of living index				
Low	56.5	90.2	45.8	131.8
Medium	50.7	76	28.8	102.6
High	37.4	52.1	11.7	63.2
Total	51.7	79.7	34.6	111.5
TOTAL				
Caste/tribe				
Scheduled caste	53.2	83	39.5	119.3
Scheduled tribe	53.3	84.2	46.3	126.6
Other backward caste	50.8	76	29.3	103.1
Other	40.7	61.8	22.2	82.6
Standard of living index				
Low	55.8	88.8	45.2	130
Medium	47	70.3	26.1	94.6
High	30.9	42.7	9.1	51.5
Total	47.7	73	30.6	101.4
Source :Based on the 10 year period preceding NFHS-II Survey, 2000, INDIA (p. 186-87)				

Inequalities in Health status & Illness

The persistent inequality in economic, political and social structure of country reflect as inequitable development of health services (rural – urban and private-public) result in uneven burden of disease and illness among different section of society. Amartya Sen (2001) health inequalities are very sharp in India, in comparison with many other countries, even poor ones'. He further comments that 'the low level of public expenditure on health in India (that is 0.8% of GDP, and only 6 country have poor figure in 142 countries) is aggravated by (1) a highly inefficient use of available resources and (2) sharp inequalities in access to health care based on region, class, caste and gender'.

The well known 'Black Report(1982)' on Britain drew attention to marked differences in mortality rates between occupational classes for both sexes at all stages. Men and women in class V that is lowest occupational class with unskilled manual job had a two and half times greater chances of death before reaching retirement age than their professional counter part in occupational class – I.

Another study of Canada a country with universally insured health care system, shows that socio-economic characteristic is strongly related to health status of population. The individual of middle income neighborhood had higher mortality than individual residing in the neighberhood of high income group. (Roos & Mustard,1997).

Inequality by gender is also common in all societies. Black Report (1982) notes that the risk of death for men in each occupational class is almost twice that of women. Education and age are also significant for maternal death. It suggests that, gender and class are highly significant which have different influences on the quality and duration of life in modern society. A study of mortality burden in the Australian population attributes to socio-economic inequality is large and concludes that death rates were highest in most disadvantaged area equivalent to lowest socio-economic status

(Turrell, and Mathers,2000). Several other studies in Britain, US & other European countries continually show marked inequalities in mortality between different socio-economic group [Lynch(2000),Moss (2000), Borrel (1999), Blexeter (1996).

The recent 'The health Divide" (1993) report on health inequalities in Britain confirm much of what the Black Report said in 1980s with the addition of extended analyses on several issues, such as health inequalities in women's. Looking at woman in employment, it was found that women generally were in non-manual jobs . They had lower mortality than those in manual jobs. Further large difference mortality by husband's social class. Death rates over one and half times high in women married to manual workers than those married to men in non-manual occupations (Health Divide –1992).

There are growing evidence of strong health inequalities among different groups –disadvantages and lower caste than other – in the area of infant mortality. India human development report (1999) shows marked differences among social groups like SC, ST & general population. Children of women belonging to scheduled castes and other backward castes have higher rates of infant mortality than children of women belonging to 'other castes (NFHS-2,UP). NFHS-2 data shows strong regional differences in rural and

urban child mortality. Child mortality is higher ,almost double in rural areas in urban areas. Household condition and mother education show strong impact on infant and child mortality. All indicators of infant and child mortality decline substantially with increase in the household standard of living. Similarly mothers who one educated till high school has lower infant death of their children than that of illiterate mothers (NFHS-2).

All the estimates of MMR (SRS 2000, WHO-1999 & NFHS – 98/99) show that more than 1,00,000 women in India die every year form the causes related to pregnancy and child birth. Both NFHS –I & NFHS-2 show that rural MMR is much higher than urban MMR but this survey is silent on class differentials of MMR.

A study on tribal in the Orissa, by using land as equivalent to income, fond that even within a tribe the mortality among the landless surviving on daily wages was higher than among those who either own land or had the security of a job (Sahu 1981).

Not only mortality but morbidity also shows strong class gradient. However it depends upon subjective reporting and measure to assess them. Underestimation due to social stigma or intentional concealment, failure to report or recognize and overestimation of prevalence without clinical verification these data becomes problematic and less reliable(NFHS-2).

Morbidity data given the Black Report (1982) of Britain shows that, likewise mortality, inequalities between occupational classes are more pronounced and the gradients more uniform, in the case of chronic sickness than in the case of acute or short –term ill health. In the same lines Health Divide (1992) analysis of studies shows that lower occupational groups have been found to experience early and more illness which is both chronic and incapacitating.

One study of European urban area (1999) conclude that the prevalence of 'chronic illness' and perceived health status of 'Bad' or 'Very Bad' increases with lower social class, although not in such a clear manner. The differences were more important and visible in woman. The women in lower class suffer more than women in other class (Borrell-1999).

Reported morbidity rates are often positively associated with socio-economic status; determined by a host of socio-economic and environmental factors. As reviewed by Iyer and Sen(2000) `district level studies vividly illustrate the relationship between reported morbidity and socio-economic indicators'. According to India Human Development Report-2000 estimates both short term morbidity and major morbidity are disproportionately higher among the vulnerable population groups including wage labourers, minorities, and those with low levels of income (NCEAR—1999).

Reported morbidity among women as quoted by Iyer and Sen (2000) may be significantly biased because they themselves do not know or cannot acknowledge it, or because of biases on the part of informants or survey enumerators. Full extant of women's morbidity becomes evident only when women are addressed one to one by women researchers after initial rapport building. The Madhiwalla et.al.(2000) found that morbidity rates were consistently higher among disadvantaged groups of women; migrants, scheduled castes and minorities in rural areas and among poorest in urban areas.

However, one contradictory finding was shown by Ravindran (1996), that neither caste nor land ownership made a significant difference in illness. Only occupational status of parents shows a significant difference. Children of mother work on farms and, father work as coolie labourers show more presence of illness.

NFHS-2 data also show urban – rural and gender difference in the prevalence of most common disease like Malaria, Asthma, T.B., and Jaundice. Traditional cultural beliefs which consider women as secondary citizen and give minimum right to decide her destiny, predictably lead to their even greater ill health burden. Lower class women are the most vulnerable group in the health. It bears the triple burden child bearing, child rearing and household labour – in addition to outside work. Such additional physical load is a major

cause of ill health and higher mortality and morbidity in women (Zurbrigg, 1984).

According to Susan George (1976) analysis and review, in all classes the poorest men exert their authority over the only people even more oppressed than they – that is their women. It has been observed and reflected in several Indian and international studies that "women, in general, suffer from high level of anemia, low percentage weight gain, repeated acute infection major chronic diseases (such as tuberculosis and breast cancer) and inappropriate management of diseases all resulting in high maternal and infant deaths. ST's have the highest prevalence of diarrhea and fear. Diarrhea is low among women and decreases with rising in come, literacy rate of adult and level of development of the village' (NCAER, 1999).

Inequality in Access to Health Services

Access to health services is a function of both of the resources available to community as well as its distribution across social groups and individuals. Generally wealthier nations and more powerful groups within countries are likely to have greater availability of and better access to health services. Within a given social setting and a provision of the healthcare services, individual access to health care services is determined by distance, availability,

affordability and adequacy of services (WSEA- A health profile - 1995). Access to health—as one prerequisite for good health – includes three components: location access, economic access and social access (Krishnan-1999).

Both Black Report (1992) and Health Divide of Britain(1993) highligh poor provision of health services in more deprived areas especially for elderly and manual groups. A study of conditions of work and life of agricultural labourers in Orissa, observes that due to distance, timing finance and social barriers health services are inaccessible to agricultural laborers (Daspatnaik,1998).

Urban areas & economically development regions have attracted a larger share of heath resources, while economically backward and remote areas have remained underserved (Krishnan ,1997). According to Duggal (as quoted by Iyer & Sen 2001) in 1991 a mere 32% percent of all hospitals, 20% of all hospital beds and no more than an estimated 41% of all trained doctors were found in rural areas where over 70% of the population lived. This can be attributed to proffessional, commercial and class interest of health care providers and exploitative socio political forces existing in the society (Zurbrigg ,1982).

There are notable differences in physical access of various services in the rural areas where three- fourth of the country

population is living. Availability & accessibility of safe drinking water and sanitation facility in rural area is much below than that of urban area. Only 14 per cent of rural populaton has access to sanitation facilities against 70 per cent of urban population (CBHI,1998). These have serious negative health implication for rural poor and disadvantaged peoples.

Several European studies reveal that need is not always the crucial factor in the population at level of health care but System capacity and supply (and also demand for care) are important factors in accessibility in health services.. (Comron & Noralow 1999) The health services offered by various organisations seem to nourish inherent class biases as far as their accessibilitie are concerned.(Qadeer,1985,Bannerji,1982,Djurfeldt &Lindberg 1975).The marginalization of the poor in the provision of health care have become the privilege of the upper and middle classes(Qadeer 1990).A village study of south India reveals that rural people especially lower castes and old women use traditional health services near to them.(Mathews, 1979).The socio-economic status also influence practitioner's behaviour in public health care system. For example,recives unofficial payment by health personnel's and they provide preferential treatment they to the people those who have power and contacts. (Rohde and Vishwanathan 1995).

Information on gender inequalities in access to health care services are mainly covers maternal care and family planning services. There are substantial variations in contraceptive prevalence among different socio- economic groups. Contraceptive prevalence is almost twice as high in urban area as in rural areas. It is higher among urban women, women living in hill region, and women, who have completed minimum high school education (NFHS –2/98-99).

Traveling a long distance to health care services is another problem which affects the rural health. It not only affects the actual use of health care services but also its effectiveness. Almost 20 percent of illness cases of the rural house-holds had traveled more than 10 K M distance for treatment. (NCAER 1992, P. 13). Opposite to this, in the urban areas, in 80% of cases, the treatment was available within 1-2 K M; in the rural area only 39 percent of the illness cases have access to medical help at such a short distance (NCAER, 1992). Development of roads and transport facilities are important determinants for availability and utilization of institutions.They also influence the willingness of staff to work in that region. (Chauhan, Antia & Kamdar 1997).

In addition to public health services, private and voluntary bodies also play a significant role in providing health care services to the people. These sectors got much momentum in 1980sand

90s.Their numbers increased to many times than public health centres during this period. But the trends show that most of these centres are located in developed regions (Baru,1998).

A study on Non Governmental Organisations (NGOs) working on rural health in Maharashtra observe that NGOs tend to select relatively more developed areas (Jesani,Duggal&Gupte,1996).

The locations of public health facilities like P H Cs are often determined by political rather than spatial convenience of the users. So hospitals in public sectors are concentrated in areas of influential people and elites—Middle and Upper Middle class localities (Baru,1998). Baru also points out that corporatisation of hospitals in U S A led to inflationary pressures on the cost of health care. It also caused to increase inequalities among different sections of population in access to health care. The same can be attributed to the Indian health sector as well, especially after introduction of health sector reforms accompanied by new economic policies in 1990s.

Inequalities in Utilization of Heath Care Services

Utilization of health care services is determined to a large extent by their availability and acceptability. Inequality in the availability and use of the health services is another major problem found among different social categories and regions. Richard Titmuss argued in Black Report that high income groups people

know how to make better use of the services. They tend to receive more specialist attention; occupy more of the beds in better equipped and staffed hospitals.

The data of NSSO of India show marginal rural-urban differences in treatment sought. Howere due to aggregate nature of data it does not tell about socio-economic class and gender differences in seeking treatment. The data of NSSO,shows decline in hospitalization in rural area and increase in urban area may be due to cost of care. National and state level studies show that significantly lower sum of money are spent on the treatment of women and girl children in the household for both hospital and non hospital care (Das Gupta 1987 Sunder 1985, NSSO 1998, Quoted by Iyer & Sen 2001).

The Utilization of health services were constrained by economic status except for well of categories. Men's illness have serious implications for women's health. Women depend mainly upon local practisioner and their follow up is inadequate (Soman,1992). In rural areas, it has been seen that number of hospitalized cases in a public hospital decreases with increases in their income(Baru 1998). This may be because of the poor infrastructure of public hospital in rural areas .So, the poor , who can not afford private hospital, are forced to go to these public

hospitals. But once their income increases due to one or another reason, they too prefer to go for private hospitals(Krishnan 1998).

The Black Report(1982)clearly indicates that both in the case of outpatient and in patient care were more used by working class than by the middle class. Health Divide also highlight this difference in the quality of care, which appeared to favor higher occupational class. Similar finding was also shown by Ravidran(1996) in his study on Tamilnadu village where occupational class not sex and socio–economic status makes difference. Children whose fathers are owner-farmers or engaged in non-foam employment are less likely to be ill and more likely to get medical help than children of wage laboures.

A study on an urban locality of Canada (Rous & Mustard 1997) shows that individuals form poor neighborhood much more likely admitted to the hospital for medical conditions but less likely to undergo surgery (specialist care) than the people from high income neighborhood. It shows that specialist physician provide hardly any care to low income neighborhoods in spite of there high health needs.

Iyer & Sen(2001) have extensibly reviewed and analysed various surveys, especially NSSO and community studies to see the difference of cost of care and untreated morbidity. They conclude

that expenditure on care in the private sector were expectedly higher, especially for inpatient care. Both rural and urban people use private health care extensively for out patient care. In case of untreated morbidity is higher among rural people, particulary among womens in comparision to their counterparts in urban areas. Iyer & Sen (2001) on the basis of their analysis of NSSO data comment that after health sector changes the proportion of those who are unable to access care because of "financial reasons" went up significantly in both rural & urban area. In fact, this indicates worsening disparities between economic classes in the extent of untreated morbidity.

Inequalities appear to be greatest and most worrying in the case of the preventive services (Black Report 1982). Health Divide also highlight the much lower use of preventive services by lower social groups. Severe under utilization by the working class is a complex result of under provision, of cost, (both financial and psychological) of attendance and perhaps of life style towards well being (IBID).

NFHS-2 survey highlighted the socio-economic difference in maternal & child health and preventive care. According to this, children of educated mothers have taken three times more vaccination, than the children of illiterate mothers. Children of scheduled caste, scheduled tribes or other backward castes families

are less likely than other children have received recommended vaccinations. These differential use is also confirm by some other micro studies (Ravindran; 1996, Bisaria;1994,Gumber;1998).

The standard of living of the household has a strong positive relationship with vaccination coverage. Children belonging to the high living standard and landed household show that they are more vaccinated than their counterpart (NFHS-2,98-99; Ravindran 1996). These finding are relevant in light of universal Immunization programmes.

Antenatal care also shows strong class gradient as shown by NFHS surveys. The proportion of births for which the mother received antenatal checkup was more than twice or high in urban areas than in rural area. And by caste, the SC/ST mothers received half the antenatal care in compression to others (NFHS-2, 98-99). According to India Development report -2000 utilization of antenatal care services are widespread in Kerala and Tamilnadu, whereas only one–third of mothers receive this service in Rajasthan, MP, and Bihar. Further not more than one-fourth of mothers receive Prenatal care (PNC) in rural India (NCEAR-1999). IFA (Iron & folic Acid) supplementation is much below for birth to disadvantaged women with low standard of living and mothers of higher order births.

From the above discussion it is clear that there are wide spread inequalities existing in the all sphere of health; especially in its utilization, access and availability. It also varies across caste, class, gender and regions; other wise it varies among different socio-economic groups. Hence, it demands an in depth understanding of the socio-economic condition of the population and its relationships with the health situation. For that purpose it is important to look upon the socio-economic profile of the population.

Chapter III

PROFILE OF THE STUDY AREA

Basic Socio-economic and Demographic Features of Uttar Pradesh

Uttar Pradesh is the most populous state in India having a population of 166052589 (2001 census). It covers about 7 percent (240928 sq. km) of the total area of India. Only China, our own country India, Brazil, USA & Indonesia have population greater than population of UP. The state has more than one-sixth of the total population and one-tenth of the land area of the country. On the basis of region, Uttar Pradesh is divided into four regions namely, Western, Central, Bundelkhand and Eastern. Every region has distinct socio-economic, caste, land and cultural characteristics apart from different local dialects of Hindi.

Administratively the state is divided into 70 districts and grouped into 17 divisions. Further, the region is divided into 809 blocks and 300 tehsils. In Uttar Pradesh there are 51826 village Panchayats and 97134 revenue villages. The population size of districts is ranging from 4941510 of Allahabad district to 800592 of Chitrakoot. The area of districts are also varying. Lakhimpur (Khiri) has 7680 sq. km. area, where as Sant Ravidas Nagar (Bhadohi) has 1057 sq. km. Area.

Population growth in U.P, is higher than in all India. Its growth rate was 25.80% against 21.34% of India. The total population of state in 1971, 1981& 1991 was 88.3 million, 110.9 million & 139.1 million respectively. The present population density of U.P. (2001) is 689 in comparison of whole India, which is 324. The continuous increase in population density of state from 300 in 1971 to 689 in 2001 exerts an increasing pressure on availability of land, employment and other developmental process.

In spite of vast fertile gangetic plains and long tradition of social political movements Uttar Pradesh is one of the most backward states of the country. It comes into BIMARU category of states (Diseased / Backward states of India). It falls below both in human and material development than all India average. The census 2001 shows improvement in the sex ratio in the favour of women from 876 in 1991 to 898 in 2001. However, still it is much below than that of India's sex ratio 922. There are 87.46 million male and 78.58 million female in the total population of U.P.

Uttar Pradesh is one of the most educationally backward states of India. According to 2001 census, the literacy rate among the population age 7 and above was 57.36 showing an increase of 15.76 from last decade 1991. Again here it is below the national level literacy rate of 65.38.

Further it also shows a long gender gap in literacy. Only 42.98 women are literate while men show 70.23% literacy rate.

U.P. is basically a rural state. According to the census of 2001, 79.22% of population live in rural areas. So, rate of urbanisation is low in the state. The percentage of the total population living in urban areas increased from 1991 to 20.78 percent in 2001. However, the level of urbanisation is lower than for all India (27.78 percent Census 2001)

Caste is the crucial in the widespread social political-cultural sphere of the people of the Uttar Pradesh. The old Chaturvarna system is now functioning on the line of new caste categories names as forward caste, backward castes, scheduled castes and scheduled tribes. According to the newly released report of Samajik Nyay Samiti(August 2001) Backward Caste and Scheduled Caste form 54.05 percent and 21 percent respectively. The ST population of the state is 0.6 percent only. As per Samajik Nyay Samiti, Chamar & Pashi in Scheduled caste and Aheer, Kurmi, Lodh and Jats are the main castes in backward section which prevaile the main beneficiary of reservation. Bhuksa, Tharu, Kharwar and Mahizkar are main scheduled tribes, mainly habitated in Tarai region, Sonabhadra and Banda district in state.

Agriculture is the backbone of the state economy.72.2% of the workers in the state depend upon agriculture . Income derived from agriculture and animal husbandry contribute highest (41.5%) in state

Domestic product (Agrocensus 1990-91). However, the agriculture sector provides livelihood to about 64 percent of the labour force, contributes nearly 26 percent to GDP and accounts for about 18 percent share of the total value of the country's exports. Uttar Pradesh has 12 percent cultivable land in country which provides food for 16.17 percent of population of country. Uttar Pradesh grows Kharif, Rabi and in some parts Zayed crops. The major agriculture products include wheat, rice, sugarcane, potatoes, vegetables and pulses. The state ranks third in India in terms of the per capita production of food grains and the rate of growth of the production of food grains. Multicropping use of extensive fertilizer and modern implements of agriculture is continuously encouraged due to less chances of expansion of land for agriculture activity.

According to 1990-91 census, 52.1 percent of land holding are below 0.5 hectare and 21.7 percent holdings are between 0.5 and less than 1.0 hectare. Similarly, there are uneven distributions of land across peasants. Most of the peasants (73.8%) are marginal, having less than one hectare of land. They occupy 31 percent of total land while 10 percent big peasants have 45 percent of total land. The distribution of average size land holdings shows regional variation, which is 0.67, 0.85, 1.09 &1.71 hectare in East, Central, West and Bundelkhand region respectively. In western region only 66% of peasants are marginal farmer, while it is 82% in eastern U.P. is agriculturally backward Only

60.4 percent of its area is irrigated in comparison to 80.8 percent area of western Uttar Pradesh..

In spite of large human and agricultural resources, Uttar Pradesh is economically lagged. The proportion of various economic sectors in the economy of the state has changed little over time. The contribution of Agricultural sector, declines from 43.7 percent in 1991-92 to 36.3 in 1999-2000. While the share of manufacture sector decreased slightly from 20.3 to 19.3 percent during the same period. However, tertiary sector shows considerable increase from 36 percent to 44.4 percent at the same time. According to an estimate of planning commission (1999-2000) 31.15 percent of state population falls below poverty line, while according to Lakadawala formula, there is 40.56 percent BPL population.

Uttar Pradesh is not much industrialized. Textiles, cement, fertiliser, sugar, metal-pots and handicrafts industries are the main industries of the state. Industrial sector provides work to 8 percent of population in the state economy but significantly it contribute 20% to state economy. Regoinal disparities are also prevalent in the industrialization of state. Nearly half of the large and medium-size of industries is concentrated in Western region of state.. Bundelkhand region is least industrialized part of the state.

Health Situation

U.P. in terms of social development indicator, like medical facilities, birth rate, death rate, infant mortality rate, literacy rate, per capita income, electrification of villages, per capita power consumption etc. stands much lower among major states of the country. Life in Uttar Pradesh is short and uncertain, especially of women and children in rural area. In overall crude death rate and infant mortality rate , state stands on worst three states in India with Orissa & M.P These rates are 10.3 and 85 respectively in country as against of 8.9 and 71 (1997). The women of state bearing more children (4) and the birth rate of states (33.5 percent) is highest in the country. Rural IMR of State (89) is much more than urban (66). Nearly two third of women still marry before reaching the legal age of 18 years (NFHS-2). Uttar Pradesh has the highest level of infant mortality of any state except Meghalaya (1998). Despite the improvement in child survival in recent years, 1 out of 12 children in Uttar Pradesh still dieing in the first year of life, and 1 out of 8 die before reaching age five.

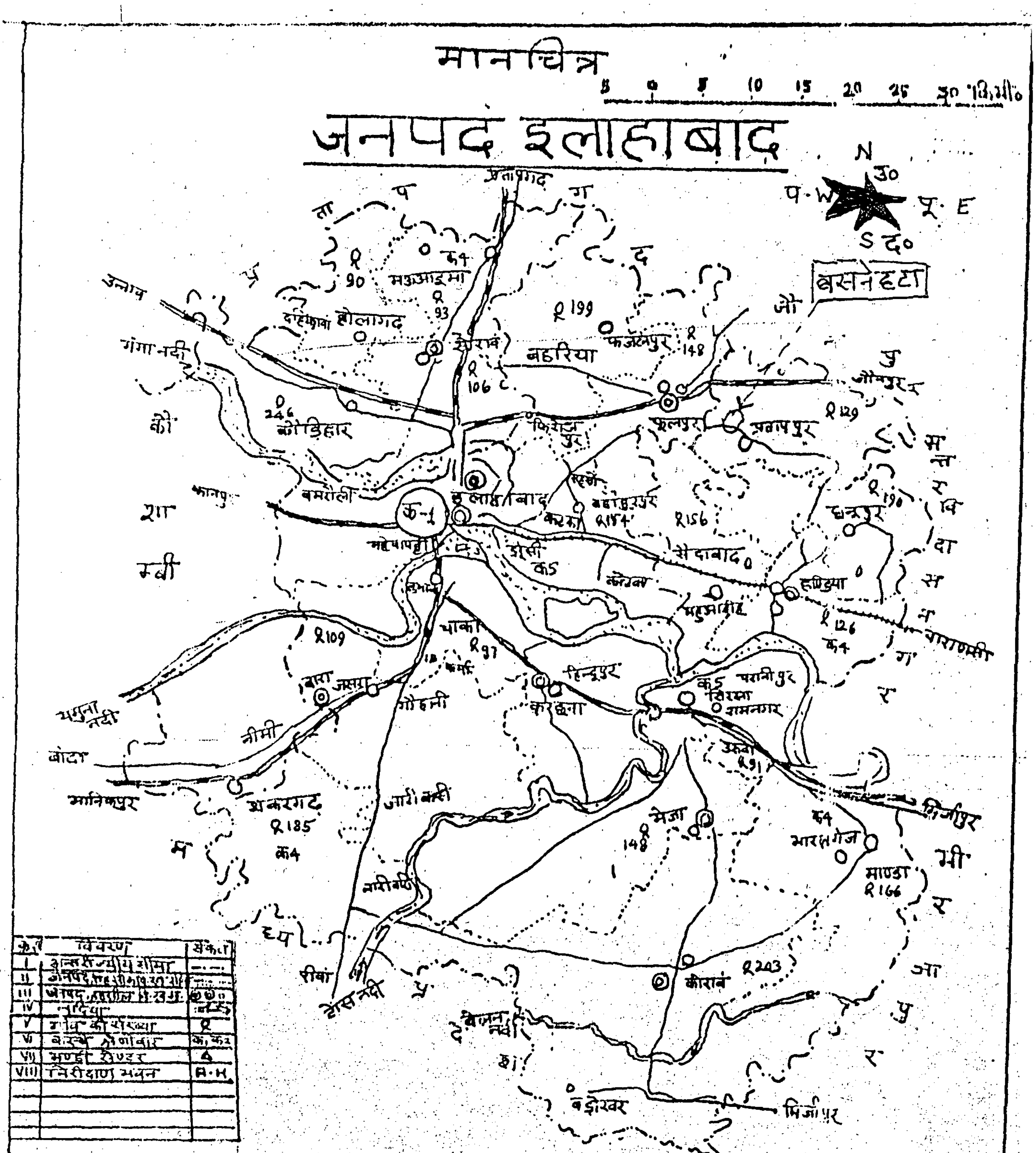
Poor nutrition is still a serious problem in Uttar Pradesh. 52 percent of children under age three years are under weight, 56 percent are stunted and 11 percent are wasted. Under nutrition is much higher in rural areas than in urban areas and is particularly high among children from disadvantaged socio-economic groups. Nearly, three quarters of

children below age three are anaemic (NFHS-2). Anaemia is a serious problem among women in every population group with prevalence rates ranging from 35 to 58 percent. More than one-third (36 percent) of women in UP are undernourished (NFHS-2). In the state, MMR is 931 on per lakh population as against of 540 death of India (NFHS-2) which is very high in women in rural areas and women in disadvantaged social group.

There is one sub – centre for the population of 5000 and one PHC for 30000 population in rural area . However, community health center(CHC) in the state serving more than three times population, than that of stipulated population of 1 lakh. There are 3761 PHC, 262 CHC & 20153 sub-center in 1996 (NHDR-2001). Population per bed in the state was 2563 as against of India 1498 in 1996 (NHDR-2001).

Description of the district

The district of Allahabad also known as" Praygraj"is situated at the bank of river Ganga and Yamuna. It lies in the south-eastern region of Uttar Pradesh. It foirms tail end of Allahabad division of the south . The district is bounded , on the north side by Pratapgarh and Jaunpur, On the east side by the Sant Ravidas Nagar (Bhodhoi) and disrict Mirzapur and



मानचित्र
जनपद इलाहाबाद
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बसनेहटा
उन्नाव
गंगा नदी
कौशाम्बी
कानपुर
यमुना नदी
बाँदा
मानिकपुर
प्रतापगढ़
मउआइमा
होलागढ़
सोरांव
बहरिया
फूलपुर
प्रतापपुर
जौनपुर
इलाहाबाद
बमरौली
करछना
सैदाबाद
हण्डिया
वाराणसी
चाका
हिन्दुपर
जसरा
बारा
शंकरगढ़
मेजा
माण्डा
मिर्जापुर
भारतगंज
कोरांव
टोंस नदी
रीवां
मिर्जापुर
विवरण

Kausambi lies south east and south west side of Allahabad. The southern boundary of district is formed by sate of Madhya pradesh.

The district of Allahabad is most populous district of U.P. according to 20001 census, total population of the district is 4941510 persons including 2625872 males and 2315638 females. The number of women on 1000 men in 1991 was 873 which increased to882 in 2001 whereas state sex ratio increased to 898 . compare to density if 1991 which was 719 in 1991, the present density increased 911 in 2001Decadel Growth rate show considerable decline from 30.78 in 1981-91 to 26.72 in 1991-01. The literacy rate of district is 62.89 percent in 2001, in which 77.13 males and 46.61 percent females were literates. In last ten years overall literacy rates of district increase by 17.89 percent.(Provisional Census 2001).

Topographically, the district may be divided into three parts: The *Trans Ganga* tract or Gangapar plain; The Daoab (now this part is separated as a new district Kausambi , only Allahabad city and their sub-urban parts comes in this region) and the Trans Yamuna tract or the Yamunapar. These are formed by two main rivers, the Ganga and Yamuna. The Trans Ganga part consists of the Soraon, Phulpur and Handia tehsils with poor sandy soils, especially in riverbanks with loams and user lands. The tehsils Sadar (city) comes in the Doab tract. The

trans Yamuna tract lies to the south of the Yamuna and comprises the Meja, Bara and Karchhana tehsils. This forms a part of bundelkhand region. The region of Vindhyan series of the Deccan plateau also lies in this tract. Whatever forest all in this district are comes in this region. (The Encyclopedic District Gazetteers of India)

According to information obtained from District Statistical Office (DStO), Allahabad district is made up of 7 tehsils and 20 community development blocks. It has 218 Nyay Panchayat, 11 towns and 3074 villages (in which 2799 are inhabited villages and 275 are uninhabited village) (DStO-1999). The urban population of the district is 21.04 percent. It was 19.89 in 1991.

In terms of availability of amenities most of the villages have drinking water, (100 percent coverage), electricity (80.08 percent), metallic link road (65.05 percent), education (70.9 percent) and medical facility (62.83 percent) as one or more amenities as per the 1991 census. While only 10.45 percent of the villages have market, 14.04 percent have post office and telegraphic facilities and 31.25 percent have communication facilities. The district it will linked with other cities and part of country by rail, road, water and air.

Average family size of the district was 6.0 (1991), in both rural and urban area, showing higher preference for children (or greater growth rate). According to 1991 census 24.5% of population lives in urban area,

which is above the state average. Less than one-third of population (30.4 percent) is under main worker category. But the dependency of persons on per main worker is more in rural area. 24.8 percent of main worker belongs to one-fourth of urban population of district, while 32.2 percent of main worker are from three-fourth-population district, living in rural area. Agriculture and related activities are major contributors in field of economy and employment of the district. Cultivates and agriculture labour form 41.25 and 22.7% of the main worker of the district.

After agriculture, industries/entrepreneurs, both based on family and non-family; trade and commerce; transport and communication makes considerable contribution in the income and employment of the district. (DStO-2000). The most important commodities manufactured and exported from the district are bidis, carpets, tooth powder, air compressors, locks, stones, rice, vegetables, guava, potatoes, mangoes, ornamental tools and food grains. The percentage of manufacturing sector to total net output in the district is 28.59 against the state average of 15.27 showing thereby higher degree of industrialization in the district (District Gazetteers-1999). Large scale manufacturing units are located in urban areas mainly in Phulpur, Naini, and Jhusi. Small scale village and cottage industries; largely run by members of the households, produce handlooms, gur, khandsari, edible oil, pottery and leather goods, dal, rice flour, printing and binding of books, furniture, food stuff, polythene bags,

ice and sport goods. After 1995 there is a decline in number of units of industries due to closing and shifting of industries.

Nearly two-third area of district is cultivable, but of which one-third area produce two or occasionally more crops in a year. According to the District Agriculture Census-1998, 370175 hectares of land was cultivated, out of 547384 hectares total land of district (DStO-1999-2000). The Cropping intensity of district was 154 percent showing continuous higher rate. The main harvests of district are Rabi and Kharif. Among cereals, wheat, paddy, bajra, barley and jowar are the main crops of the district cover more than three fourth of total cropped area. However cash crops cover only 5 percent (1997-98) of total cultivated area. Pulses, gram, arhar are important crops. The per head per annum production of cereals and pulses are 166 Kg and 17 Kg (1999) respectively in the district. Scientific method of cultivation and improved agricultural practices are increasingly being accepted by farmers of the district, although traditional pattern of cultivation is still common, specially among small and marginal farmers. In some areas intensive cultivation of cash crops, specially vegetables are the main basis of livelihood and advancement of small land holders.

As per agricultural census (1977) there was 5.07 lakhs land holdings; with average size of 0.97 hectares, however, the average size of land holding has decline to 0.7 hectares in 1995-96. During the same

time, (1995-96) 91.4 percent landholding are small and marginal but it forms 57.3 percent area of total land holding, Nearly 70 percent (1998-99) of land is irrigated through canals, tube well, pump sets, and ponds. Most of the electrified tube wells/pump sets are concentrated in the trans-ganga region of district.

As per records of DSt O (1998-99) only 3.7 percent area of district reported as forest area. Majority of villages of the district are electrified, nearly 88.7 percent till 1999-2000. Rural electrification is more in the Gangetic plain of the district, than to hilly trans-yamuna par to district. The per Capita consumption of electricity is declining from 279 kwh (Kilo Watt Hour) in 1997-78 to 270 in 1998-99. However this electricity consumption is more against state average of 207 in (1994). Only 27.2 percent of electricity is goes to agriculture and even this is declining drastically in recent years.

Health Facilities:

District has good number of health Institutions in both Public and Private sector in comparison to other districts of the region. In the district there are 140 health centers and dispensaries (1999). Three-fourth of these are government/public in nature. There are special centers like; one medical college, 2 leprosy hospitals and 3 T.B. hospitals running by government.

Modern, techno-centric money based health centers and dispensaries of western medicine are concentrated in the urban area, in the service of well off population. 2793 beds serve one-fourth of urban population while 741 beds serve three-fourth of rural population. Noticeably, beds are 37 times more available to urban population than to rural population. In rural areas paramedical staff is less than doctors (168 paramedical and 188 doctor). However, in urban area paramedical staff is nearly three times more than rural area. In the case of traditional health services (Ayurveda, Unani & Homeopath) their inclination is more towards rural areas. However, Homeopath is second most available system of health in the urban areas. There are 90 Family and Maternal Child Welfare Center functioning in District Allahabad in which 59 centers are located in rural and 31 in urban areas of district (DStO-2000).

Educational Status:

Although the overall literacy rate, by 2001 census shows a remarkable increase of 17.89 percent from 54.8 in 1991. But the available data of literacy (1991) shows too much gap between rural-urban literacy in general and rural-urban female literacy in particular. Urban literacy is nearly two times higher than rural. Urban female are four times literates than rural females (61.4, 14.5). Even in the rural area male-female literacy gap is too much. Probability of rural male literacy is four times

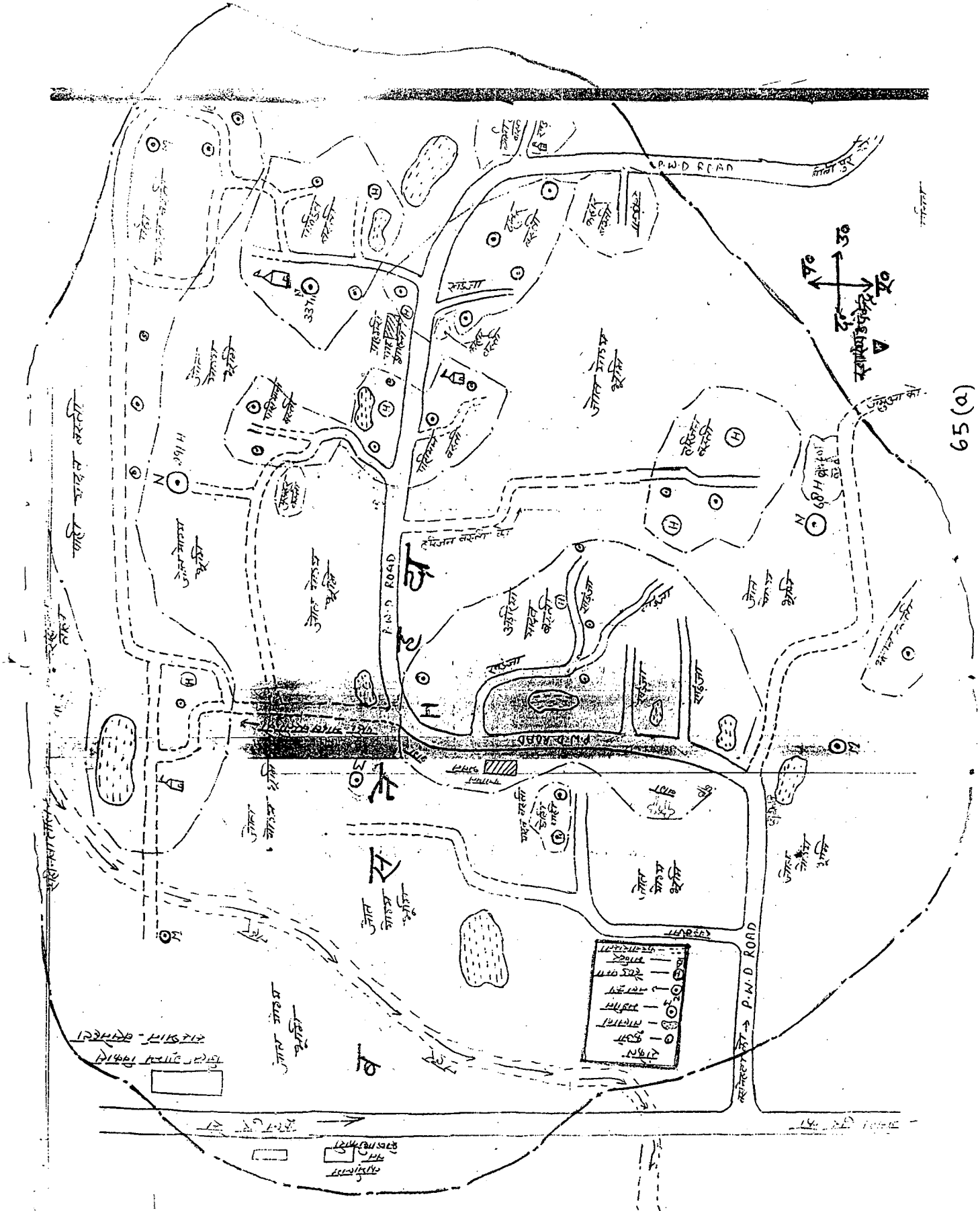
higher than that of their female counterpart (56.4, 14.5). Furthermore, probability of being literate is less in the backward regions and backward SC/ST people of district, more severe so among their women.

As per as DStO (1999) information, the district has 1500 informal educational centres, 846 Anganwadi Kendra, 2190 Youth Organisation and 2273 Mahila Mandals respectively. These centers or organisations work seldom in the backward areas and their presence is equal to none. In the district the number of junior basic, senior basic, higher secondary school and college level on per lakh population is 39.6, 12.1, 4.74 and 0.3 in Mach 2000.

District of Allahabad has been enjoying the status as a center of Education and intellect. Till March 2000, there were 1922 junior basic schools, 586 senior basic schools, 230 senior higher secondary schools, 16-degree college and one university. After 1999 two deemed universities and one Open University have been established in the district.

The Village Basnehta

The Basnehta village is selected to study the impact of socio-economic condition on the health status and health behaviour of people. It is located at 42 km away from Allahabad, district headquarters. It is located at 3 km distance from west side of development block Pratappur. This is 9 km away from nearest popular town Phoolpur- a tehsil and



MAP OF THE VILLAGE - BASNEHTA

65(a)

block headquarter with urban characteristic. People of this village/area come to Phoolpur for services like health care, rail and road transportations, consumer things, agricultural inputs and occasional jobs. It also works for weekly markets, where villagers come to sell their agricultural produce. So this town Phoolpur is the nearest nerve center of the village.

Some Basic Facts of Village Basnehta:

☆ Total Area – 407.58 hectares.
☆ Panchayat Bahvan – One
☆ Aanganwadi Center – One (without building)
☆ Total established hand pumps – 9
☆ Number of ponds – 4
☆ Number of wells – 20
☆ Government tubewells – 3
☆ Public tubewells – 2
☆ Public pumpset – 6
☆ Water Canal – 2 Km (needs cleaning)
☆ Link toads (2 km, pitched roads)
☆ Khadanza Road = Total 1356 meter
☆ Kuchha road = 5250 meter
☆ No. of telephone = 4
☆ No. of tractors = 7
☆ Primary school = 1
☆ District Rural Training Institute
(Jila Gramya Prashikshan Sansthan) = 1
☆ Health Sub-center = 1 (functioning in neighbour village)
☆ Bio gas Plant =1
☆ Smokeless Chulaha = 1

Source : District Census 1991-2001 from Village Information Register

Population and Demographic Profiles:

Covering an area of 408-hectares the Basnehta has total population of 1592 (Provisional Census 2001). Of them, 815 are males and 777 are

females. The village has 1218 population in 1991 census and 804 in 1981. So, in last twenty years village population had increased exactly two times. There is not much in or out migration. Only 9 families come here and one family left this village within the same period. In this village, there are 403 persons belong to scheduled caste category, which is 25.3 percent of total village population (Provisional Census 2001). All the inhabitants of the village are followers of Hindu religion. There were 909 females per thousands males in 1991 and 953 in 2001. In both the cases sex ratio has been higher than that of the state. (See table no. 3.1).

Table 3.1 – Demographic Characteristic of Village Basnehta.

Indicator/Year →	1981	1991	2001
1. Total Population	809	1218	1592
Male Female	638 580		815 777
2. Sex Ratio	909		953
3. Total SC Population	324 (26.6 % of total population)		403 (25.31%)
Male Female	154 170		203 200
4. Sex Ratio 'P'	1103		985
5. Population below 6 year Total Male Female	286 (23.48%) 154 132		----
6. No. of household	188		233

Source : District Census 1991-2001 from Village Information Register

Literacy and Education:

The literacy ratio of village is depressing in comparison of district and state (See table 2). The number of total literate person is 697 and rate is 43.78 in 2001(Provision census-2001). It increases nearly 14 percent from 29.06 percent during ten years. But the gap between male and female is high. Males (58.28 %) have more than two and half time higher literacy than females (23.42%). The gender gap of literacy was higher in 1991 when only 6.37% female were literate in comparison to 49.68 percent literate males. Within ten years, female literacy has jumped to 17 percent whereas male literacy increased only 8 percent. Data on age, caste and level of education category wise literacy is not available. However, one can say that rate of literacy is lower among adult women and SCs than children. Recently rate of school going children has increased. There are no graduates among SCs. Very few women have high school education. Relatively more persons with higher education comes under higher and backward castes. There are no technical graduate, diploma holders or person with professional or science graduate according to base-line survey.

Table 3.2: Showing Literacy Rate of Village Basnehta

	1991	Percentage	2001	Percentage
Total Literates	354	29.06	697	43.78
Male	317	49.68	475	58.28
Female	37	6.37	182	23.42

Source : District Census 1991-2001 from Village Information Register

There is one primary school, informal education center and training institute in the village. There is no private school or college in the village. The middle school, high school and Intermediate College and Degree College are located in the neighboured villages, town and city. There is no separate girls school or college in the village or in their adjoining villages. The nearest girls intermediate college is located at 8 km distance from the village in the Phoolpur town.

The Primary school is located at Northern part of the village near Basti of Thakur's. It has Pucca building with two rooms, one office and one verandah. One female and one male teacher are appointed there. The enrolled strength of the primary school is nearly 150. Most of them belong to the lower caste and poor. Scholarship and food grains of mid day meal, are main incentive to attract the little ones to the school. Poor quality of education, less personal care of teacher to the students, irregularity in opening of school, lack of space, water facility and motivational support to children, are negative sides of primary school. Children from educated and high standard families go to private school in the adjoining villages. Generally in private schools functioning in the area, teacher are untrained even high school failed, no proper building & space for entertainment. There is no adequate arrangement for girls who want to go to school. Other informal center of literacy and education are not functioning at any level in the village .

Settlement Pattern and Vegetation

As shown in the map of the village, the village population is not localized at one or two places. Rather than it is disperse in seven main settlements. These pockets of population are known as 'Purva' (hamlets), have their unique arrangement and social linkages. These 'Purvas' have some common feature of caste, occupation, or ecological settings.

These 'Purvas' are known or named on the basis of major caste or occupation found in that particular area. These are as Babhanauti, Bhatan, Pashiyan, thakuran, Chamrauti, etc. Two Purva named as 'Chotti Pahi' (small one) and 'Bari Paahi' (big one) are relatively newly established, Settlement of big basti, shifted toward new one due to many reasons. The lack or decline in availability of land and space, pressure of population, their conflicting relations with neighbours and alienation in old settlement are main push factors to leave the old settlement Contrasting to these, proximity to their agricultural land or occupation place, chances of expansion on new acquired land, closeness to their caste and family groups are major pull factors for this type of internal shift of village population within their limited physical territory. These `Purvas' are outcome of expansion of one or two families. Later on some other families and caste groups also join to them and made the full-grown new hamlets.

The land of this village was made up of mainly loam and Usar. There is no forest and water stream (Jheel) on the village records. But, indeed the one-third land of the village is drowned in water. So, only one crop could be cultivated on this land. Gradually, rapid increase in the village population, demands more land to feed them, construction of new shelter and need of enough space for social and economic activities. That has affected adversely the flora and fauna of that area. The majority of vast, open, empty, grazing land converted into low quality cultivable land. Due to increase in the level of ground water the ecology of whole area has changed drastically. It affects the vegetation, cropping pattern, disease pattern and dwellings of human beings.

In the village, 15.4 hectare land had been left as Talaab (9 ponds) which constitutes very small part of the village. Yet, another interesting feature of this village is that there are minimum two or more ponds in or around each settlements. Often these were made during digging of land for house and road construction and to make plane and heightened the door surface and courtyard. These water bodies near to human habitat have serious implication for their cattles life, cleanliness of setting in many ways, as a common annual source of water, and over all on their effect on community health sanitation.

The common trees found in this village are Neem, Babool, Mango, Mahuva, Bamboo, Sheesham, Jamun, Ber etc. Various variety of Acasia

are found on the bank of 'Sahinwa Taal' and their water-draining canal. Forest department tried to plant the trees many times in the village but it has not been succeeded to make any change.

The land surface of settlements is normally wet and full of moisture. According to villagers this is because of water logging in settlement area and rise in the level of ground water.

Communication and Linkages

The village is well connected to its block and district headquarters. The development block headquarters lies in the east of the village at 3 km distance. The Gorakhpur -Allahabad State Highway passesd through nearest town Phoolpur. Again one pitch road starting from Phoolpur passes through Pratappur, to which this village road is connected. Till last March 2001, there are 1352 meter Khadanza and 5250 meter Kachha path. .Kachha path is filled with mud and dust in different weather. So, it is difficult to go from one settlement to another by motor vehicle or bullock cart. The village, has no post office, bus or railway station. Nearest railway station is in Phoolpur, which is 8 km away from the village. Bus, Jeep and other carriers are available to 2 km away nearest ` Besnehta Tiraha' in day time. Trolley, Tractor , Cycle and Scooters are other common sources of travelling and transportation. . There are 4 telephone connections. Television, newspaper and phones are modern modes of communication used by few wells off families of the village.

Agriculture, Land and Irrigation:

Agriculture and allied activities are the 'means' and furthermore 'ends' of life of villagers. People obtain food, shelter, cloth and other basic amenities and acquire freedom, power, social pressure and other societal gains by agriculture, land and other sources of livelihood in the village. But, as it realised that role and part of agriculture in village economy is declining. Nowadays, the families totally depending on only agriculture have stunted status.

According to available information to Lekhpal, on the total land of 407.58 hectare, 350 hectare land are cultivable. Of which only 176.5 hectare land was cultivated. This is the half of the total cultivable land. Rest of half of land is used as cattleground, grazeland, Khalihhan, Aabadi, basti, paths, wasteland, social forestry, gram samaj (GS), playground, school ground etc. One – third of this cultivable land is usually submerged in water for more than 6 months in a year.

Nearly three-decade ago ' Chakbandi'was held. By this Chakbandi small and scattered landholding are fused together on one place and then alloted to the peasants. It makes agriculture beneficial and convenient, because peasant can invest more in adopting modern tool, seeds and ways of irrigation at one place by their own arrangement. After 'Chakbandi' residual land named as 'Gram Samaj Bhoomi' Usar and other lands have been alloted to the poors and scheduled caste families. Marginal and

smaller farmers constitute more than the 90 percent of cultivators. According to estimates of 'Lekhpal' (the village level government employees who keep the records of land and revenue) only 8 percent peasants are big farmers (having more than 3.5 acres land). Most of the Scheduled Caste families belongs to the marginal peasantry, very few SC are small farmers (more than one acre and below 3.5 acre land) while no family of forward caste falles in marginal peasants category. However backward caste are lies in all three categories: marginal, small and big former category. Nearly, small and big peasants occupy 80 percent of land holding. Land holdings are becoming smaller size because of population growth and division of families. Pace of population growth is high among backward castes and division of family in scheduled castes. On the other hand big farmers are joint families, in which no further family division takes place in last two-three generations.They have also alternative source of income other than agriculture.

Rabi, and Kharif are the main harvest. Kharif crops has harvested in more area than Rabi. Paddy, Bajra, millet, arhar, flex, hump and vegetables like chilly, spinach, cauliflower etc. are main crops of the Kharif. However, paddy alone cover more than three-fourths of sowed area of Kharif. Paddy is cultivated even on marshy, submerged or Usar lands and give excessive contributions to the farmers. Wheat, mustard, potato, pea grams and vegetables are major crops of Rabi. In which

wheat covers more than two third sowed area . The third harvesting season Zaied is also grown in small areas/pockets near to available source of water (tubewell, pumpset, ponds, well). In Zaied, mainly green fodder, Chari, urad, moong, sugarcane, dhancha (as biofertilizer) and vegetables liked cucumber, pumpkin, bhindi, watermelon are grown. The portion of pulses in the food grain production is declining sharply. This is happening, because of two reported reasons. One is that, the yield of pulses on per hectare is low against cereals and cash crops and second is due to wetty soil and water logging in rainy season.

Farmers are increasingly accepting scientific methods of cultivation. Gradually, they are favouring the use of fertilizers hybrid seed(high yielding variety seeds), multiple cropping, dry farming, modern equipment of irrigation and also insecticides and pesticides. These practices are common mainly among the farmer who are able to invest, have a relatively enough land with good quality and able to bear loss in case of failure of expected product. So, use of these modern practices of agriculture depends mainly upon farmer's economic status, size and quality of land holdings and their belief and availability of these things.

Nowadays, the improved agriculture implements are replacing the old ones. In 1981 there were only two government tubewells while in 2001 there are 3 government tubewells, 2 private tubules, 4 pumpingsets and more than half dozen water pumpsets, makes nearly whole village

cultivated land irrigated. Thresor, meston, harrow, plough, spray machine, tractor, trolley etc. are also owned by farmers particularly by big ones, individually or jointly. There are six tractors in the village and dozens of carts in 2001. Tricycle, rubber trolley, tackling the place of wooden bullock-cart in transportation of agricultural produce. They are also used to transport patients of poor farmers in immediate need and emergency.

Animal Husbandry:

Animal husbandry is an integral part of the farming and village economy. Live stocks provides draught power for transportation and ploughing of field; milk for personal use and selling. Above all it provides cow dungs as a precious by product for fuel and fertilizer. Buffaloes, cows, ox, pigs, goat and hens etc. are main live stock reared by the villagers. There are few cattles with every family. The ratio of milching cattles is less than that of total. Well off families bought milch cattles (especially cow and buffaloes)and sold non-milch cattles. Where as poor and backward family with large family number keeps more cattles, cows and buffaloes with more number of small offspring but only few are milching. These people invest their plenty of time in service and search of food for their pets. Pashi's families reared pigs, or hens and goats mainly and only few keep cow and buffaloes. While forward cast people and Aheers of village have, new and high milching varieties of

cows and buffaloes. Women and children, particularly poors, spent their time in grazing and feeding of cattles and small livestock. In return they obtain milk and money from these livestock which is usually handled by women head of the family.

Gradually this occupation, considered one time as second source of income and status after agriculture, loosing its charms and place in village life and economy. Now it is not perceived as cost-effective, hygienic in small and rich families. Shrinking grazing land, lack of animal care, loss of precious pets due to diseases, disappearing public ponds, and unwillingness and unavailability of children and women to caring them and high cost of green fodder are the factors responsible for its decline.

Village Dairy is not functioning well at the time of study. . In late 1980's and early 1990's the Dairy of Basnehta village was one of the best and biggest milk center collecting more than 600 litres milk per day. This Cooperative Dairy adopted modern method of animal husbandry at that time.

Occupation and other Economic activities of Village life :

Primarily, agriculture and allied activities are the base of economy of the village. But now in this village other areas are also opening as new arena of work and income.

Table 3.3: Workers by occupation category

S.No.	Variables	Number	Percentage	Remark
1.	Total Population	1218		
2.	Total main workers. Male Female	390 265 125	32% 67.94% 32.05%	% of total population. % of total main worker.
3.	Marginal wokers	53	4.35%	% of total population
4.	Non-worker	775	63.62%	% of total population.
5.	Cultivators	217	55.64%	-do-
6.	Agricultural labour	88	22.56%	-do-
7.	Manufacturing, Processing, servicing and repairs in households	25	6.41%	-do-
8.	Construction	12	3.07%	-do-
9.	Trade & commerce	10	2.56%	-do-
10.	Transport, storage & communication	7	1.79%	-do-
11.	Other services	31	7.94%	-do-

Source: Village wise worker detail (based on Census 1991)

In traditional way peoples were engaged in pot making, animal husbandry, fisheries, construction work of roads and houses. Marginal farmers and landless poor work in the field of other farmers.

According to the latest information available (Census-1991) nearly two third population falls under non-worker category. Nearly one-third persons are main worker in which 67.9 percent are males and 32.1 are females. It shows that men are the main worker or earner, controlling the economy of family. Most of the working population that is nearly 78 percent is involved in agriculture, 55.65 percent are working as cultivators while 22 percent are working as agricultural labour.

Marginal farmers and landless persons work in the field of other farmers. They receive wages as cash or in the form of food grains. Women and girls of these families work as agriculture labour in the field

from 7 a.m. to 5-6 p.m. and earn 6 kg paddy or wheat per day depending upon the harvested crops.

Nearly 8 percent of total workers work in the tertiary sectors jobs. But no doubt, its contribution is more than 3-4 times in village's total income than their proportion. Manufacturing, processing and construction are little but important occupation. Their share in the village economy is increasing. Very few (1.8 percent) are engaged in transport, storage and communication.

Livestock, forestry, fishing, hunting etc. are not the primary occupation of villagers as reported in District census data of village wise worker details (1991). But these are the main common subsidiary occupation specially livestock in all families and fisheries among scheduled caste families. The ratio of marginal worker to total main worker is noticeable.

Men mainly work as cultivators in field and or as manual worker in construction of buildings, roads, brick kilns, transportation of agricultural produce, in ploughing, threshing of crops. Women do all work at home like cooking of food, caring of children and pets, cleaning and washing of house & courtyard; along with outside work of harvesting, weeding, cutting, storage, and collection of agriculture products. Their working hour starts early in the morning (usually at 5 a.m.) continue till late night (10 p.m.). Arrangement of fuelwood and water are part of their duties.

Besides agriculture works, males of poor families go out side for work in neighbour villages, towns and cities. A good number of the adult working population of this village has been migrated towards larger cities like Delhi, Gujarat, Punjab, Maharashtra and Madras etc. They works there as manual worker or semi skilled worker in the factories like textiles, handlooms, and in diamond cuttings, or as auto-drivers. Some also have their own small scale businesses and shops. They send money to their families in the village. This money-order economy is basis of affluences of some families and livelihood of many families. Nowadays, these `Perdesi' people (migrant worker) are coming back to the village and want to do some own work. Construction activities in the village have opened the door of business and seasonal jobs. There are minimum two or more shops in each hemlets. Number of shops in village is increasing in nearest road crossing, markets and towns. "Shaadi,"`Bimari' and `Ghar' (Marriage, illness and house) are three major intensive money demanding events to which each person has to spend irrespective of their caste and conditions.

Socio- Political Structure and Panchayat:

According to Jaati Sarvekshna-2001 backward caste (55.64 percent) and scheduled caste(30.88 percent) constitute the majority of population of 'Basnehta'. 'Aheer' caste alone constitutes nearly half of the total village population. Others are Pasi(20.2%), Chamar(9.82%),

Brahmin(6.41%), Kumhar(4.17%), Bhat(3.88%), thakur(3.11%), Nai(1.88%), Kahar(1.35%), Chaurasia(0.88%) and Mushar(0.88%).

Table 3.4: Caste Comparison of Village Basnehta

No.	Category/Caste	Family No.	Total Population	Percentage of Total Population
1.	General Category	36	228	13.42%
	Backward Category	119	946	55.64%
	Scheduled Caste	78	525	30.88%
	Scheduled Tribe	0	0	0
	Total	233	1699	100%
1.	Pashi	44	343	20.2%
2	Chamar	33	167	9.82%
3.	Mushar	01	15	0.88%
4.	Aheer	100	805	47.38%
5.	Kumhar	10	71	4.17%
6.	Nai	6	32	1.88%
7.	Kahar	2	23	1.35%
8.	Chaurashia	1	15	0.88%
9.	Thakur	10	53	3.11%
10.	Bhat	10	66	3.88%
11.	Brahmin	16	109	6.41%
	Total	233	1699	100%

Source: Based on Caste Survekhan by Samajik Nyay Samiti (Aug 2001)

Caste is still an important factor in village life. The village's social structure is based on this caste structure. Aheer due to half of the village population is considered to be a dominant caste of the village. But there are many sub-groups among Aheers. They are divided on the basis of eating relations, work, marriage, panchyat issues, selection of village headship, conflicting old family relations, and other differential interest. Aheers, Brahmins, and Thakurs are the main land owning caste groups. Generally each caste group has separate settlement. Thakurs and Brahmins had been owned the most of the best cultivable land before

"Chakbandi' The caste restriction on eating relations have started declining. Upper castes and backward caste invites SCs on social functions. But rarely Brahmin and Thakurs other vegetarian people prefer to go and take food of non-vegetarian SCs, Pasi & Chamars. Many high caste and backward caste people allow them (SCs) to enter their houses. But social distance is still maintained during ceremonies. For example, they sit on ground, separate line is observed for them during eating in groups. No village development staff/official go, eat and stay at their place. The one family of 'Musher' caste in the village has no land. This family totally depends upon the other village families for their work and food. It collects left food in ceremonies and food grains in field during threshing. These lower caste peoples generally provide labour force for the village. So, generally their bargaining power and acceptance in larger society is increasing.

Village Panchayat and Village leader play a crucial role in the development and decision making at local level. The village panchayat is an elected body made up of a Pradhan(head) and eleven members. These eleven member elect a *Up-Pradhan* (subhead) between themselves. From the beginning of panchayats till 1990's higher castes (Brahmins and Thakurs) enjoyed their reputed status both in panchayat and other areas over the majority of villagers. Ownership of majority of land holdings, political approaches, relationship with local officials, knowledge of 'law'

and developmental schemes and their religious superiority help them to dominate over others. They protect their own interest and their adjoining groups; in the distribution of GS (Gram Samaj) land, in choosing the site and beneficiaries of primary school, khadanza- roads, handpipes and other resources and benefits available from governments.

Table 3.5: Showing beneficiaries of various schemes & developmental programmes

S.No.	Schemes	Beneficiaries	Remarks
1.	Antyodya Anna Yojana	Total 5 card	4 SC and one Bhat family in which two household heads are widow women.
2.	Annapurna Yojana	Total 6 card	4 SC and 2 BC families.
3.	National Maternity Benefit Scheme (NMBS)	2 Pregnant women	Both belongs to two backward class family.
4.	Widow Pension	0	0
5.	Viklang Pension	Two person	these are husband-wife of a backward caste.
6.	Public Distribution system (PDS) (i) Above poverty Line cards (APL) (ii) Below poverty line cards(BPL)	398 cards 376 cards 22 cards	1565 units 1470 units 95 units
7.	Self help group	2 groups (11 members in each group) Total 22 members	One self help group named 'Krisak Svayam Sahayta Samsoh' have all Aheer (BC) member and another Bheem Rao group have 11 chamar (SC) member. Generally these members belongs to BPL or poor socio-economic families.

Source: District Census 1991-2001 from Village Information Register

After the implication of new Panchayati Raj Act in1990s, the village Panchayat headship reserved for Backward Caste. The majority OBC caste 'Aheer', failed to achieve their political superiority due to their internal conflicts. In the last Panchayat election held, 7 candidates were from 'Aheers' and one from 'Nai caste. 'Nai' caste person occupied

the village headship with support of other higher and lower caste groups. The present panchayat is headed by 'Nai' and sub headed by a 'Pasi' caste person. There are 3 Aheers, 2 Pashi, 3 Chamar, 1 Bhat, and 1 Kahar member in village. Panchayats election was not held on the basis of party or ideology. The political participation of the villagers are average. Generally percentage of voting remains within the 45 to 60 percent. Besides of these elected representatives, each caste, Purva, and larger family-groups have their own leader. These influential leaders take part and show keen interest in village politics; and have more communication within and outside the village groups than that of others.

The village Panchayat has many comittees like Shiksha Samiti, Svasthya Samiti, Jal Prabandhan Samiti, Lok Nirman Samiti etc. headed by a senior panchayat member. But these comittees are on paper. No one is aware about the role and responsibility of these Panchayat Comittees. One government staff at village level named 'Gram Vikas Adhikari' has been appointed to help the functioning of Panchayats and Committees in the village. Pradhan and Gram Vikas Adhikari are two powerful people in the village. They work according to their own interest and understanding.

The role of women member in Panchayat is only limited to sign on decisions taken by male members. They are discouraged by their male counterparts and family persons to participate in the Gram Panchayat's

meetings. Many times they are not informed about Panchayat meetings and decisions are made without taking their opinion.

Health, situation and facilities:

Majority of the village population is suffering from both minor and major health problems. The health conditions of persons vary depending upon their economic conditions. In general, women, children, aged, disabled and poor are more prone to poor health status, disease and discomfort.

Early marriages and immature pregnancy, lack of proper health care and nutritional support from family make condition of women pathetic. Women are totally depending on their elder family member, regarding the decision of health problem and treatment (own and children). The lack of awareness and health education, less familiarity with outer world and indifference nature of family members affect health status of women. Anaemia, reproductive health problems and malnutrition are common problems. Skin disease is common in the area due to poor physical and unhygienic conditions. The cholera outbreak is reported in northern part of village in last rainy season, which had taken the life of three 'Pasi' children. The rate of mortality declining sharply, however it is high among Chamars and Pasi than others. But morbidity is increasingly found more in all sections of village. People suffer from fever, cold, headache, jaundice, weakness and asthma generally.

Mosquito, flies and poisonous insects are found in plenty number in all parts of the village.

Unhygienic conditions of habitat surrounded of both Kuchha and Pucca houses; open defecation in the field or in the cover of trees; lack of proper drainage system of refused water; muddy and dusty roads; open collection of buffalo-dungs and manures contribute to the illness and health hazards of the village. Open wells, and shallow hand-pipes are common source of drinking water. Water obtained from these sources are dirty, muddy, and mixed with rotten leaves and excreta. Rarely they are made chlorinated and cleaned.

Facilities of medicine (both modern and traditional health) are available in the village or outside in adjoining villages or town on private and public basis. A nurse from the Kerela is working as a private medical practitioner with the help of her husband, in the village from the last two years. She gives treatment of all minor injuries and ailments .She mainly assists in the delivery of women and care of children. Easy accessibility and availability at any time make her popular among women and poor. More than half dozen of private non-trained medical practitioners are working in adjoining villages and markets. There are several big nursing home of allopathic and few clinics of homeopathy, and Unani in the nearest town Phoolpur, at 8 km distance from village. Traditional healers are losing their importance. They are few and

working on the voluntary. People go to them only in the case of sudden sickness, in the case of failure of treatment, or in chronic cases. It depends upon personal and family health practices and beliefs.

There is one Sub Center in this village. But this is working in neighbour village, adjacent to study village's Harijan Basti, in a single hired room of a high caste-private practitioner. It covers 6 villages and the population health sub-center is 4497 (Census 1991). The sub-center has only one staff at present. She is female health worker (ANM). She is a higher caste hot-tempered lady, accomplishing her health work with the help of her husband. This Sub-Center provides only preventive health care – vaccination and immunization – once in a week to women and children. The services and coverage of sub center is not impressive and infrastructure and availability of necessary items are insufficient. The PHC of sub center is at 3 km distance from the village but medical officer seldom visits to the Health Sub Center. Due to lack of drugs and satisfactory treatment, patients prefer to go to private practitioner.

There are two trained Dais to assist the ANM in the village and work as contact persons for eligible couple and children. But Dais are not functioning and perhaps very few know about them. This village is also covered under Integrated Child Development Scheme(ICDS) and has two Anganwadi, one in Aheer basti and one in SCs (Pasi plus Chamar) settlement. Presently, Anganwadi in 'Aheer Basti' is functioning on the

open air under a matric educated local women. It provides raw nutritional food to the pregnant women and children. A local lady is also working as Family Planning health worker under SIPSA from one year to motivate the eligible couple to use family planning methods. The promotion of child health care and pre-school education is generally ineffective and unsatisfactory.

There is no tradition of registration of birth and death rates, data on numbers of eligible couples, infants, pregnant women or any other vital statistics. It is too difficult to find data of vital statistics at the village level. There is lack of coordination between different personnel working for the improvement of health of the village population. The ANM, trained Dais Anganwadi worker, school teacher, village head, head of village health committee, and family planning worker rarely inform about their programs and functions and seldom seek any help from other health workers or community leaders. ANM and Medical Officer (M.O.) with other health worker come in the field only at the eve of national health and family planning programmes.

At last we can say that study village display their difference in caste composition, settlement pattern, distribution of land among different caste groups and occupation. Gradient of difference is more in the high and low caste groups, and high and low socio-economic households. Differences also occur in the context of social and familial relations,

education and literacy, and population below poverty line. Higher Caste groups and higher socio-economic status households are enjoying their better position in comparison to their low living counterpart. Both cooperation and competition coexist together at all level of village life. At the time of serious health problems, accident or injuries peoples expressed their sympathy and social support to concern family. This process of belongingness at the time of life threats depends upon family, friendship, location and caste closeness of suffering families. At this time people comes close at community level and other's health concern become shared issue among them. Local health providers are also attached to these issues as 'liberator' from life threats. This issue has been addressed in the next chapter of the dissertation to understand the people's health at community level.

Chapter IV

Health of the Rural People: Perception of Village Representatives and health Care Providers

Villages are soul of India. They constitute three fourth of the country's population. In spite of lots of effort by the government and other agencies, to improve the living standard of rural people, they are entangled in the trap of backwardness, poverty and ill health.

Doctors for the villages (Taylor, 1976) analyses the need for research in rural health and emphasizes, "Improving the health of village people is fundamental of India's development objectives. It is good economics because of the clear-cut relationship between health and productivity, especially where agriculture dominates economic production. It is good politics because most voters are rural people and better health care is a primary demand". Thus, improvement in health is concern with the improvement in the efficiency in the production and consequently wealth of the nation. In this context, an effort was made to understand the health problems and needs of village.

It is not possible to understand the health problems and needs of a village population by a social scientist in short visit. He does lack needed medical skill and proficiency. In a given time and resources to understand health problems of the village under study, we depend on

village representative's/leader's perceptions. The information was collected through a face-to-face interview schedule. Village leaders and representatives are influential, powerful and better-known persons of their community. They are able to influence the functions of institutions and health services available in that area. As decision makers, they along with local health workers involve in identifying health needs; planning; managing and monitoring health activities; and mobilisation of required resources through village health committees (Chandok, Nath, Gupta; 1980). 73rd amendment of Indian constitution authorised this role; of health and sanitation, family welfare, women and child development, drinking water and public distribution system (PDS) issues to Gram Panchayats (Article 243 C and 11th schedule of the Indian Constitution; 1992).

The perception of both Panchayat and personnel – at grass root level is important. The representatives and leaders express felt needs, and unmet health needs of local community. Their views can help us to understand effectiveness of health services in the village. The perception of health personnel is also elicited as expert view about the health problems. Needs of villagers are indeed helpful in understanding 'Actual Need' of village people. In this discussion the basic question is that – is there a significant difference between the beliefs about the health problems/needs of peoples and health care providers? How these beliefs

are set in motion and determined by socio-economic- cultural background of people of both sides (Spector 1996). The answers to these questions are helpful to reorient health priorities and in fulfilment of unmet health needs of local population.

Village Representative's Views about People's Problems

In addition to above mentioned objective, the one underlying query of this study is to know to what extent the village representatives and leaders are aware of their people's problems and needs particularly related to health of the people. It will be helpful to understand that how socio-cultural background influence the perceptions about village problems at community level. Obviously, this perception manifest in their casual attribution of health problems and action behaviour needed to overcome these problems.

In this connection, questions on village people in general and health problems in particular were asked to 13 village representatives/leaders with help of an interview schedule. Of these representatives four are present and past Gram Pradhans (Panchayat heads) and rest are current Panchayat members. Health problems/needs of children, women and aged were focussed on the question of village health problems/needs. The other core questions were that according to

them "which sections of population is suffering more and what action plan the village representative suggest for the solution of the problems?'

The respondents frequently mentioned the following as the major problems of the village. These are:

- Lack of educational facilities, especially higher secondary schools for girls.
- Lack of health facilities or lack of hospital and clinics to provide health care particularly for children and women in emergency.
- Problem related to water logging or lack of cleanliness of water
- Drainage canal of village/ sanitation and drainage..
- Lack of full time and part time employment for both male and female.

Besides these they also mentioned the following problems:

- Lack of toilet facilities.
- Poor quality of primary education and absence of teacher in school.
- Total absence of link roads and presence of bad Kachha ways.
- Low price for agricultural products.
- Lack of mutual harmony, agreement and presence of jealousy among neighbours.

- Poor health of cattle's and absence of proper health facility to care and treat them.
- Lack of electricity in Harijan Basti.

The major perceived problems of villagers come under the provision of education, employment, health and drainage facilities. These problems are closely related with poor living standard of villagers. The perceptions of problems were also guided by the personal experience, contact with others, their socio-economic background and individual preference. According to one metric educated woman member who is now enjoying second term of the Gram Panchayat unemployment, and lack of toilet for women are important problems of villagers. However, another illiterate Panchayat member, wife of a government teacher with a small family; responded that there was no problem in the village. Everyone is fit and fine. This can be attributed to her less social contact and lack of belongingness to the village .She accepts the current situation of village as evitable and unchangeable.

Health Problems/Needs: As Perceived by Village Representatives:

Responses of the village representatives and leaders give a vivid picture of health problem related needs and problems of the village population. According to them health problems are releated with the following issues:

- Lack of health care centre in the village or neighbourhood.
- Shortage of health personnel to deal with local health problems timely.
- Prevalence of (serious) communicable diseases like: cholera, malaria and gastric problems.
- Lack of safe drinking water, no bleaching and cleaning of wells.
- Insufficient water drainage system, poor sanitation and unhygienic living condition.
- Lack of proper food and nutrition to poor, especially to their pregnant women and children.

In addition to above, there are few less frequent health problems such as houseless ness, illiteracy, ignorance, too much faith in Bhoot-Pret (traditional treatment), and health problem of adolescent girls. According to their perception lack of health centre, safe drinking water and water drainage systems are more acute problems.

In fact, perception is releated to one's own experiences. In the study, at the time of reporting of health problems of village, representatives and leaders show difficulties to recognize the health problem of total population. It is difficult for them to identify the different health problems faced by all or majority of villagers. Their experiences are drawn from their family, neighbourhoods or relatives. Their responses are general and unspecific about the nature of health problems. It was difficult for them, to highlight the health needs and

problems specially related to children and women of the village. Most of them feel ignorant and wanted more time to respond appropriately. Surprisingly, women representatives were severely lacking of awareness, even it related to health of children and women. Their experiences are confined to their own physical problems or problems related to their family members.

They expressed their views related to the following three aspects:

(a) Pre and Post maternal problems;

(b) Physical problems and illness;

(c) Problem of availability and quality of health facilities to women of that area.

Representatives see the pregnancy as a problematic stage in the life of rural women. The sickness cycle of girl started with the marriage in sixteen. Within 10 years of marriage, between the age of 15 to 25 years, she faces frequent pregnancy, complications in pregnancy, surgical operations, hospitalization, morbidity, treatment, irregularities in menstruation and serious gastro-urinary infections and many other life threatening experiences.

Unavailability of health facilities is emphasized by them. Village leaders believe that lack of health centre in the village, shortage of trained Dai in their area and difficulty in maternal care due to unawareness and

less availability of health services are the main reasons behind the illness of women.

Weakness, body pain, anaemia, heavy workload in household and field, and inadequate food consumption are reported as physical health problems of women. Women's incompetence to recognise and report her illness, lack of toilet facility and open space are mentioned as important health implications for women. Lack of money or poor economic conditions and unavailability of financial assistance for maternal care is considered as a significant contributor in the poor health care of women.

Children's health is mainly reported in association of women's health problems and health care. There is lack of health facilities for children. Different diseases like malaria, cholera, diarrhoea, gastroentitis and unspecified fever are perceived as major illness. Physical impairment in eye, ear and tooth are common in the village children. Lack of proper education is explained as the main cause of children's problem in the village. Lack of proper elementary schooling and absence of schools for girls are the major problems repeatedly expressed by most of the representatives and village leaders. Costly child care and treatment, lack of child - special health personnel and clinics, and decline in the children participation in games and physical exercises are other health related issues recognised by the representatives.

After discussion of problems and needs, questions were asked regarding the problem faced by the most suffered section and their action plans to overcome them. Different leaders choose different measures for selecting the most suffered group. However, socio-economic backwardness and deprivation of basic amenities emerged as main measurement. Harijan (Chamar) and Mushar are labelled as most suffered and deprived group by majority of village leaders. Few other leaders perceived that the most suffered group lives lower socio-economic status and found in each caste. Similarly some other member perceived aged, women, particularly widowed as most suffered group in the village. Noticeably, one-third of the Panchayat members, give no response or say no one is suffering or unspecifically tell that all have equal suffering. Both present and past village heads identified suffered group by specifying the field in which or by which they are deprived. Probably, such view may be due to their superiority in education, less contact with other groups of village .

Lastly, we asked the leaders: "what measure should be taken to overcome these problems or to satisfy these needs?" The formulation of these action plans should be emerged with the consonance of rural people's wishes and aspirations. The following are the main action plan recommended by many village representatives:

i) Establishment of a school and college to provide higher secondary & degree schooling to children and youths, especially girls.

ii) Construction of Pukka link road among different Basti and connecting each Basti to pitch roads.

iii) Establish a health centre in the village; within the reach of villagers especially women, children and aged.

The other recommended action plans are: employment generation in the village, development of proper water-drainage to preserve land from water logging, self-drinking water, and the self-help group to empower the people in general. Provision of playground is also recommended as part of their action plan. Few representatives said that there is no need to prepare new plans. Best way is to implement government programmes already launched to uplift the condition of poor. Noticeably, their two Harijan representatives told that they have no plan, because no one can change their conditions.

Health Providers of the Study Area:

It is also important to understand the views of health care providers of the study area. They are the professionals and expert personnel having required knowledge and skill to deal with the day today health problem of the community. Their perception of disease, health problem and needs of specific groups of that area gives authentic picture

on health conditions of general population of the locality. These health providers are usually aware of personal and social problems of the people. So they are able, may be in part, to account a client's inability to cope up any kind of medical regime.

The people of study area use both the private and public health care facilities. The village sub-centre, nearest PHC and district hospital and special health centre are the main government services they use. But their role on the curative health problem in the village is disappointing. Village representatives expressed that in the village, health care means 'private health care'. They seldom use public health services of sub-centre, PHC and CHC. Indigenous practitioners also help people to get cure, but they are not working openly on full time basis as professional health care providers. They treat some minor health problem and the diseases which is attributed to bad evil on the basis of popular folk traditions of that area.

In this study, an attempt is made to contact all the health personnel in the village and adjacent area (mainly market, road crossing and nearest towns) where people of this village go frequently. The personnel working on the government health centres are trained and qualified. They are available at a location at a fixed time schedule in a day. There is no adequate staff in these public health centres. Even the available personnel are busy in other supporting activities instead of treating the

patients. In the private health care there are both qualified and non-qualified personnel. They are working as independent medical practitioners. Some private practitioners are trained as paramedical or in other system of health care but they are practicing as 'Doctor' of western medicine. Trained and qualified private practitioners set their clinics or hospitals in developed area or towns, where minimum facilities like electricity, roads, telephone, and communication are available. Their quality of care and emergency services are well equipped and they are available almost throughout the day.

At the same time, non-trained, non-qualified doctors are working in remote areas and villages, near to the location of people. There are marked differences reported between qualified and non-qualified health professionals in terms of their training, knowledge, expertise, practice and attitude towards disease they treat. Over use of injections (of saline drip popular as glucose) multiple medications for a given problem rapid relief from illness rather than total cure of disease are common features of their health care practices. These non-qualified, 'Jhola-Chhap' doctors are initial contact point for villagers. They also act as linkage between village people and higher level health care providers. By virtue of their rural location, cultural familiarity and attention to non-medical demands and expectations of the patients, they are more acceptable to rural people.

Interview schedule has been used to get information from health care providers. Out of this thirteen, six are trained medical doctors, one is ANM, and six are non-trained, private practitioners. Out of the six doctors, three are working in PHC, one in private clinic, and two in nursing homes of which one is female gynaecologist. The ANM is working in the sub-centre of village, and one female paramedical practicing independently in the village for the last two years. The other non-qualified practitioners are experienced with other doctors as paramedical and now they are working separately in the adjoining village area for many years.

Health Personnel's Perception of Health Problems in Study Area:

After taking the general background information of personnel age, sex, education/training, experience and work place the questions were asked on the health problems of the study area. These questions are related with the health problems of women, children, aged and cause of deaths in the village area.

The major health problems as reported by health personnel are: Serious communicable diseases (T.B., Cholera, Malaria, Gastroentitis and Jaundice) Diarrhoea diseases, poor health care (especially child and

maternal health care) facilities, respiratory problems, fever-cough-cold, bad location, and poor housing and lack of education and awareness. What is important here is that the views of non-trained personnel are similar to the views of village representatives. They generally perceived the total lack of health facilities (specially related to the child delivery and maternal health and emergency services) and lack of health centre and school; and bad housing and location as major health related problem.

However' the trained doctors (both private and public) emphasise on the poor availability of health facilities. According to them health problem of villagers are the outcome of lesser awareness of people regarding health problems and health care, less acceptance of available health facilities, lower condition of personal hygiene, sanitation and disposal of excreta.

The main causes of death in the village area as reported are: communicable diseases (mainly T.B., Cholera, malaria, jaundice, gastro), ageing, malnutrition and poverty, infections, diarrhoea, and inaccessibility of proper health care. Cardiovascular and brain disorder, accident and injuries are also cited as causes of deaths among adults.

In response to the questions on the prevalent diseases of the village, health personnel gave mostly the names of communicable diseases like TB, Cholera, gastro-urinary/sexual and reproductive health

problems and malaria. Other diseases reported were asthma and breathing problems; diarrhoeal disorder, aches of head, back or body; and various symptoms of unspecified fever.

From the above discussion it is clear that most of the health problems are associated with the specific problems of women, children and aged. This is clear that this section of population is suffering more from diseases Malnutrition, diarrhoeal disorder, respiratory problems (especially pneumonia and whooping cough), fever and cold; infections and lack of preventive care (vaccination and immunization) are common health problems of children as reported by health personnel.

Women and children health problems are somewhat viewed as linked. Due to this they are presented jointly. Anaemia and physical weakness, pain (body/head/back) and gastro-urinary, gastro-genital problems were much reported as women health issues. Low level of Ante-natal care (ANC) and Post-natal Care (PNC); less accessibility of medical services, unawareness and social backwardness in accepting family planning services and hypo-protein condition are other reported health problems of women.

Both trained and non-trained health personnel have similar perception on problem of the aging. The difference was only in labelling the problem. Trained doctors are using appropriate disease name or medical terms to present health problems of aged while non-trained

health personnel are using only general symptom or social psychological cause of illness.

The main old age problems are: Osteo-arthritis, asthma, eye/cataract problem, lack of family support, poor economic condition, weakness, infection, and hypertension.

Pattern of Health Care Utilization : Perception of health personnel

In this section, we shall examine the use of health care process of local people in regime of available health care services. Health seeking process of rural people reflected in effort to contact with rural health care services and providers. Health seeking process starts with the perception of illness by individual. Before going to medical help several individual and group factors intervene with this process. Cost of treatment with effectiveness of treatment play a decisive role in the continuation of a medical help from a health care provider (Rohde and Vishwanthan; 1995).

In the present study, to understand the pattern of health care utilisation we depend on perception of health care providers. No other source is available to know or check the background characteristics like socio economic status, education, and sex of patients and where they go for treatment. We assume that health providers due to their familiarity of local people and community they generally know about the beneficiaries.

The village Health Sub-Centre is located in the adjacent village of the study area, near the 'Harijan Basti'. As discussed earlier in village health profile, it provides only preventive care (vaccination and immunization) and work as the lowest functionary unit for state and national health programme at village level. Women of backward castes and middle socio-economic families go more to sub-centre than scheduled caste or higher caste families. Main beneficiaries of the sub-centre are women and children going for ante-natal and post-natal care. Illiterate women who constitute majority of rural women visit more in number to sub-centre than literate. (Those literate women of higher and middle class family go to private clinics and maternity centre for health care which is some what better in quality).

According to the doctors of PHC, only 20 to 30 percent of population generally use Public Health Services. In this, SC-BC and lower middle class persons tend to use the PHC services, meanwhile higher caste and upper class people hardly use these facilities. Both, the male and female use PHC services. In the view of doctors children and adults are main beneficiaries of health services. Majority of the people of the study area use private health care services.

According to the opinion of non trained private practitioners of that area mainly SC and BCs of the locality use their services. In comparison to them, upper caste people hardly seek their services. On the other hand,

trained private medical practitioners expressed that people across the caste seeks to their health services.

In class wise utilization pattern generally it seems that lower, middle and higher-class people use both (trained and non-trained private) services. But perception of private health personnel shows that there is different inclination by different class, lower and middle are inclined towards 'non-trained' while higher class are inclined towards 'trained' private health services and more.

Utilisation pattern of health service by women is not much clear. They go to both trained and non-trained private practitioner mainly for curative health services. People of all age groups individual visit to trained health personnel clinics and hospitals.

Above discussion about the health of rural people give a comprehensive picture of the village health problems and need. Both peoples and providers see the health problems in their own way.

The people perceive their problem in a wider context with emphasis on education, employment, drainage facility and health services. Clearly it is evident that their understanding of village health problem at community level is determined by their socio-economic background, education, experience of socio-political activities and awareness about others health condition in the village. Representative show less emphasis on health problems than others village problem. They

also do not see their much role in the village health, because this was never happen earlier.

The representative views about health problem were mainly connected to their socio-economic and ecological conditions of village. Village representative see their health problems beyond the lack of health care, focusing much on the other aspect of peoples health like sanitation, toilet facility, unhygienic living condition, food and nutrition, safe drinking water and awareness. Non-trained practitioner views are more close to village representative. There is much of gap regarding knowledge of health problems between peoples and providers.

Discrepancy has also exposed about the health services between the peoples and providers. Representative complaint that they are not getting adequate facilities, while health personnel react that due to their ignorance villagers are unable to get the available health facilities. They attribute cause of health problems towards people's side. Finally, in utilization of health services, Public health services show much of differences on the basis of socio-economic condition of seeking help than that of private health personnel. These issues become more visible when we take this topic on individual and family levels. This perception of health problems and health care use at community level should be substantiated through individual and family level by focusing on socio-economic context of the people.

(Repeat 109-110)

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Chapter V

SOCIO ECONOMIC CONDITION AND HEALTH

Economic and social sectors play important role in shaping people's health. Any reasonable discussion on socio- economic condition and their overall impact on people's health, requires a clear-cut selection and measurement of socio- economic variables. Generally occupation, income, wealth, type of housing, education, style of consumption, are used as basic characteristics of class and inequalities (Townsend and Davidson, 1980). As discussed in detailed in methodology, 'land', 'caste' and 'type of housing' have been chosen as socio- economic inequality in rural area. These indicators have been incorporated to get a general socio-economic status (SES) of each household. Data on socio-demographic characteristics viz. caste, sex, age, education are discussed here.

Socio-economic context of the surveyed households:

Caste is perhaps most visible form of social stratification in India. Very often when we talk of social stratification in India we concentrate exclusively on the caste system (D.Gupta 1991). In the study the households were selected on the proportion of caste in each SES. The selected sample of 47 household, represent the 9 caste groups out of 11 castes.

Caste Composition of Surveyed Population:

The distribution of households on the basis of the caste categories reveals that Backward Caste, 'Aheer' constitutes about nearly half of the selected household; while, scheduled caste form one-fourth of the rest includes upper caste, and few other Backward Caste (OBC) families. Table – 5.1 also reveals that many of BCs and OBC families belong to the middle or well off families. Two-third of upper castes are relatively well off. While all SC households have low SES.

Table 5.1: Distribution of Caste Categories in by SES

SES/Caste	SC	BC	OBC	Upper Caste	Total
Low	12 (57.14)	6(28.57)	2(9.52)	1(4.76)	21 (100)
Middle	0(0)	11(78.57)	1(7.14)	2(14.29)	14(100)
Well-off	0(0)	7(58.33)	0(0)	5(41.67)	12(100)
Total	12(25.53)	24(51.06)	3(6.38)	8(17.02)	47(100)

(The numbers in the brackets shows their relative percentage)

Land Ownership:

Land ownership is considered as good indicator of status and class in rural settings. Table-5.2 shows the distribution of cultivable land among different SES groups. 36.2 percent of the households have 2 to 5 Bighas. Two third of High SES households have more than five Bigha land. Fifty percent middle SES households fall in the category II of land ownership. Majority of low SES families have less than 2 Bigha land.

Table 5.2- Total /cultivable land by SES				
SES/Land	0-2 Bigha lan (Category I)	+2-5 bigha lan (Category II)	More than 5 bigha lan (Category III)	Total
	Cultivable	Cultivable	Cultivable	
Low	18(85.71)	2(9.15)	1(4.76)	21(100)
Middle	5(35.71)	9(64.29)	0(0)	14(100)
High	0(0)	6(50.0)	6(50.0)	12(100)
Total	23(48.93)	17(36.1)	7(14.89)	47(100)

Source of Water by SES in each household by SES:

In general majority of village people depends upon, well water. After well, hand pumps is major source of drinking water. It supplies mainly shallow ground water, which is often contaminated and mixed with disposed water. The inter class difference is not much reflected in use of source of water. However, observation shows that the conditions and surrounding of well depends the SES of well owner. Well off families use drinking water of deep hand pump.

Table 5.3-Source of water by SES					
SES	Piped water	Ground water(deep)	Ground water (shallow)	Well water	Total
Low	1(4.76)	2(9.52)	6(28.57)	12(57.14)	21
Middle	0(0)	1(7.14)	4(28.57)	9(64.28)	14
High	1(8.33)	2(16.66)	4(33.34)	5(41.67)	12
Total	2(4.25)	5(10.6)	14(29.78)	26(55.31)	47

Type of Toilet Facility:

In the study village nearly all households have no proper toilet facility. They use bush, field and open spaces as toilet. These practices heightened the health hazard by polluting water, food and soil. There is

no class difference in toilet facilities. Only 2 respondent households have toilet facility but they are rarely used.

Table 5.4- Type of Toilet facility by SES			
SES	**Pit toilet**	**No facility/ bush/ field**	**Total**
Low	1(4.76)	20(95.24)	21
Middle	0 (0)	14 (100)	14
High	1(8.33)	11(92.67)	12
Total	2(4.25)	45(95.75)	47

Source of Light:

Electricity and kerosene oil are the two main sources of light in the village, (table 5.5). There is striking difference in use of source of electricity. Nearly all household of high SES have electricity while this is less than one-fourth in low SES family. A middle and low SES families use generally kerosene oil for lighting.

Table 5.5-Source of lighting by SES			
SES	**Electricity**	**Kerosene**	**Total**
Low	5(23.81)	16(76.19)	21
Middle	4(28.57)	10(71.43)	14
High	12(100)	0(0)	12
Total	21(44.69)	26(55.31)	47

Type of House by SES

Shelter is one of the most important pre requisite for survival of life. Adequate housing with provisions of basic services like potable water, sanitation, drainage and electricity with physical dwelling unit is equally important.

Table 5.6- Type of House by SES					
SES	**Houseless**	**Kuccha**	**Semi-Pukka**	**Pukka**	**Total**
Low	4(19.05)	10(47.62)	6(28.47)	1(4.76)	21
Middle	1(7.14)	4(28.57)	6(42.86)	3(21.43)	14
High	0(0)	0(0)	2(16.67)	10(83.33)	12
Total	5(10.6)	14(29.78)	14(29.78)	14(29.78)	47

Data on respondent households reflect that nearly one-tenth of households are living homeless or in the hut made of grass and leaves. Number of Kachha, semi-Pukka and Pukka owned households are equal. Well off families have Pukka or a minimum semi-Pukka house. Low SES people are not fortunate, they have Kachha, and semi-Pukka houses or they are totally homeless. Middle class households have mainly semi Pukka house.

Table 5.7-Number of total (kucha and Pukka) rooms in households by SES					
SES	**No rooms**	**One to two rooms**	**Three to five rooms**	**More than five rooms**	**Total**
Low	3(14.3)	6(28.6)	7(33.3)	5(23.8)	21
Middle	0(0)	2(9.5)	6(42.85)	6(42.85)	14
High	0(0)	0(0)	4(33.3)	8(66.67)	12
Total	3(6.38)	8(17)	17(36.1)	19(40.42)	47

Safe space available to the household is also measured through the number of rooms (both Kachha and Pukka) available to each household. In the entire household, majority (76.52%) of households have more than three rooms. But by SES, it shows two third of the well off families have

more than five rooms in their houses. While 43% poor households have less than two rooms mainly made up of Kachha rooms. Middle status families show equal number of rooms (three to four and more than five number) in each household.

Availability of separate kitchen room:

In the present study majority of households have no separate kitchen. Majority of well off households have separate rooms for kitchen. Whereas majority of low and middle households have no separate kitchen.

Table 5.8- Availability of separate kitchen room in households by SES

SES	Separate room for kitchen	No separate for kitchen	Open Air & Other	Total
Low	5(23.8)	13(61.90)	3(14.28)	21
Middle	5(23.8)	7(50)	2(9.5)	14
High	9(75.0)	3(25.0)	0(0)	12
Total	19(40.42)	23(48.9)	5(10.6)	47

Household have below 2-3 rooms use this kitchen for other purposes also.

Fuel for cooking in each household by SES:

Wood and dung cakes are the major fuels for cooking in each household. These are harmful and polluting fuels show significant health implications. The inter class variation is not significant. Use of cow dung affect the availability of green manure to the field and hence their

fertility in long term. Wood is accessible to those households, household belong to high SES, having their own tree garden or trees. Nearly 90 percent of households have livestock, but there number is more among high SES families. Women and girl children of low SES families collect cow dung from grazing land or other places. It is true in the case of woods too.

Table 5.9- Fuel for cooking in each household by SES					
SES	**Wood**	**Dung cakes**	**Wood and dung cakes**	**Kerosene and Other**	**Total**
Low	3(14.3)	2(9.5)	15(71.4)	1(4.7)	21
Middle	1(7.14)	0(0)	12(85.71)	1(7.14)	14
High	1(8.33)	2(16.67)	8(66.66)	1(8.33)	12
Total	5(10.6)	4(8.5)	35(74.46)	3(6.38)	47

Household articles by SES:

Possession of number of articles in household is an important indicator of wealth and socio-economic status. Mattress, cot, clock, TV, garden etc. are found in every household belonging to High SES category. While lower and middle class people are deprived of these things. Use of radio, T.V. and clock shows information of time, entertainment and knowledge in the social cultural life. Lack of water pumps, well and plough shows the dependency of low SES households on other people for agriculture and irrigation.

TABLE 5.10- OWNERSHIP OF HOUSEHOLD THINGS BY SES					
THINGS	**SES**	**LOW**	**MIDDLE**	**HIGH**	**Total**
MATRESS	YES	8(38.1)	8(57.14)	12(100)	28(59.57)
	NO	13(61.9)	6(42.86)	0(0)	19(40.43)
COT/BED	YES	16(76.200	12(85.71)	12(100)	40(85.11)
	NO	5(23.80)	2(14.29)	0(0)	7(14.89)
	YES	8(38.1)	9(64.29)	12(100)	29(61.70)
CLOCK	NO	13(61.9)	5(35.71)	0(0)	18(38.30)
ELECTRIC FAN	YES	7(33.3)	4(28.57)	12(100)	23(48.94)
	NO	14(66.67)	10(71.43)	0(0)	24(51.06)
BICYCLE	YES	16(76.2)	11(78.57)	11(91.67)	38(80.85)
	NO	5(23.8)	3(21.43)	1(8.33)	9(19.15)
RADIO	YES	9(42.85)	6(42.86)	9(75.00)	24(51.06)
	NO	12(57.15)	8(57.14)	3(25.00)	23(48.94)
SEWING MACHINE	YES	4(19.05)	1(7.14)	2(16.67)	7(14.89)
	NO	17(81.95)	13(92.86)	10(83.33)	40(85.11)
TELEVISION	YES	1(4.77)	1(7.14)	12(100)	14(29.79)
	NO	20(95.23)	13(92.86)	0(0)	33(70.21)
MOPED/MOTORC YCLE/SCOOTER	YES	2(9.52)	0(0)	7(58.33)	9(19.15)
	NO	19(90.48)	14(100)	5(41.67)	38(80.85)
PLOUGH	YES	7(33.3)	8(57.14)	9(75.0)	24(51.06)
	NO	14(66.67)	1(7.14)	1(8.33)	16(34.04)
WATER PUMP	YES	0(0)	2(14.29)	5(41.67)	7(14.89)
	NO	21(100)	12(85.71)	7(58.33)	40(85.11)
BULLOCK CART/TROLLEY	YES	1(4.77)	1(7.14)	5(41.67)	7(14.89)
	NO	20(95.23)	13(92.86)	7(58.33)	40(85.11)
THRESHER	YES	2(9.52)	2(14.29)	7(58.33)	11(23.40)
	NO	19(90.48)	12(85.71)	5(41.67)	36(76.60)
TRACTOR	YES	0(0)	1(7.14)	6(50.00)	7(14.89)
	NO	21(100)	13(92.86)	6(50.00)	40(85.11)
WELL/HANDPIPE	YES	9(42.85)	8(57.14)	11(91.67)	28(59.57)
	NO	12(57.15)	6(42.86)	1(8.33)	19(40.43)
GARDEN/GROUP OF TREES	YES	6(28.57)	10(71.43)	11(91.67)	27(57.45)
	NO	15(71.43)	4(28.57)	1(8.33)	20(42.55)
TOTAL		21	14	12	47

Demographic Characteristics of the Households

The Caste Structure of surveyed population:

As tables shows that 47 families have total population of 474. In which half of the persons belongs to 'Aheer' caste. On the division of

population in three groups 171, 124 and 179 people belong to low, middle and high class families respectively. The average family size for low, middle and high class family is 8.14, 8.85 and 14.91 respectively. So, well off families are normally big families in which peoples of more than three generations live together. As discussed earlier, all the high caste families come into high SES and low caste families comes into low SES categories. All Nai population comes into middle class families. Bhat and Aheer population comes in all three SES categories. The average family size of survey population is 10.09.

Table 5.11-Socio-economic status and population by caste by SES					
SES	**Low**	**Middle**	**High**	**Total Population**	**Average family size**
Brahmin	0	0	22	22 (4.64)	12
Bhat	7	10	20	37 (7.80)	9.25
Kshatriya	0	6	15	21 (4.43)	7
Aheer	21	94	122	237 (50.0)	9.8
Musahar	12	0	0	12 (2.53)	12
Kahar	26	0	0	26 (5.48)	13
Chamar	54	0	0	54(11.39)	13.5
Pasi	51	0	0	51 (10.75)	8.5
Nai	0	14	0	14(2.95)	14
Total	172	124	179	474(100)	10.9

SES wise Sex Ratio:

In the village there is gender gap in favour of men. There are 219 female against 255 males. The projection of female population on 1000 male shows the ratio of 858. As table (5.12) reveals that in low SES families sex ratio is more in favour of women. Higher the SES, lower the

sex ratio and vice-versa. Male-female gap is much more in high SES families. Where on 104 male only 75 females are found. That is 721 female on 1000 male. This shows the higher preference of boy child.

Table 5.12- Gender division by SES				
SES	**Male**	**Female**	**Total**	**Females per 1000 males**
Low	86	85	171	988
Middle	65	59	124	907
High	104	75	179	721
Total	255	219	474	858

Age:

Age and Sex are the basic characteristics of any group. In the surveyed population 42.6 percent fall in 0 to 14 years of age group while 51.67 percent population falls in 15 to 59 years of age group. Only 3.67 percent population belongs to age group of 60 and above. SES wise difference is evident. High class has maximum percentage of aged and lower SES have highest percentage of children. Adult (hence working) population is ore in high SES population. -

Table 5.13- Distribution of individual age pattern by SES				
SES	**0-14 year**	**15-59 year**	**60 and above**	**Total**
Low	78(45.61)	86(50.29)	7(4.1)	171
Middle	6(45.16)	60(48.39)	8(6.45)	124
High	68(38.5)	99(55.31)	12(6.70)	179
Total	202	245(51.67)	27(5.67)	474

Educational Status of Population by their SES:

As table 5.14 indicates that 27.8 percent of survey population is illiterate. Nearly half of the population is literates and falls between 1 to high school level. Only 8.64 percent population was educated from secondary level to college level.

Table 5.14- Education among individual by SES

SES	Illiterate	Primary level	Middle & high school	Secondary and above	Not applicable
Low	60(35.1)	47(27.48)	32(18.71)	3(1.75)	27(16.96)
Middle	32(25.81)	35(28.23)	35 (28.23)	7(5.64)	15(12.09)
High	40(22.35)	48(26.82)	48 (26.82)	31 (17.32)	28(15.64)
Total	132(27.8)	115 (24.26)	115 (24.26)	41 (8.64)	12 (15.18)

Data indicates that level of educational achievement is directly related to SES of people. The percentage of illiterate is more in low SES population than middle and high SES population. The percentage of educational status of people increases with their increase in SES. Low SES families have not a single graduates. Percentage of higher educated is highest in high SES families. Undoubtedly the illiteracy in the case of women is higher than men in all the SES groups. The lower SES women are very literate.

Occupation:

Table 5.15, shows that nearly one-fourth of total population is engaged in farming with allied activities like labour job, domestic work, and small-scale business. Nearly one-fourth of total population is engaged in farming. Females of lower SES categories do labour work.

While majority of females do both farming in the field and domestics work in the house. Only newly married females of all SES categories and females of high SES categories work inside the house. 8% of male population is working outside the village as migrant worker or very few of them works daily labourer in the village or adjacent area. Similarly persons in government job / permanent private work are few in numbers, that is 3.33 %. Student, both male and female also helps in households and family occupation. They also work as labourers during the vacations.

Table 5.15- Occupation of Population by SES

SES	Low	Middle	High	Total
Farming	3(1.75)	1(0.81)	1(0.56)	5(1.05)
Farming with labour job	19(11.11)	4(3.23)	0(0)	23(4.85)
Farming with domestic work	27(15.79)	27(21.77)	26(15.20)	80(16.81)
Domestic work	10(5.85)	8(6.45)	24 (13.41)	42 (8.86)
Labour job/daily worker	6(3.51)	3(2.42)	0(0)	9(1.89)
Migrant worker/job	4(2.34)	13 (10.48)	11(6.15)	38(8.01)
Govt. and private employee	4(2.34)	0(0)	12(6.70)	16(3.37)
Farming with business	3(1.75)	3(2.42)	10(5.59)	16(3.37)
Student	49 (28.65)	44 (35.48)	65 (36.3)	158 (33.3)
Not applicable	32 (18.71)	21 (16.93)	29(16.20)	82 (17.29)
Others	4(2.34)	0 (0)	1(0.56)	5 (1.05)
Total	171	124	179	474

Health and Use of Health Care Services

The present study has recorded all the illnesses that occurred in samples during the one month of the interview. For malaria and jaundice data was covered over 6 months. The study was carried out in December. This flexibility in the reference point of illness is necessary to cover the seasonal variation of diseases. In the study area May to November months are reported as a period when diseases mostly occur.

The reporting of illness is based on the perception of person and it is assumed that people are aware of their health conditions; able to express the symptoms of their health problems. During interviewing, persons and their family members jointly reported the health problem of the members of the households. People generally remember illness and their symptoms on the basis of treatment. It helps reporting of illness and identification of disease. The person, who did not take any treatment or did not seek help, is unable to report about symptoms and type of illness. Illiteracy and less knowledge and lack of vocabulary of health problems and symptom were expressed in female samples. They some time try to hide, or just discuss superficially their disease. So it becomes difficult to get information about their symptoms and labeled them.

Morbidity: Pattern of Illness

Before asking the illness and health problems and other question, an effort was made to build proper rapport with to all respondents. To the maximum extent this interviews were conducted in the presence of concerned family member, so that they are able to express about their illness.

Table 5.16 - Health Problem of Individual and their SES

SES	Low	Middle	High	Total
Eye Related Problems	9 (4.24)	4(2.53)	11(6.87)	24 (4.52)
Tuberculosis	2 (0.94)	2(1.26)	1(0.62)	5(0.94)
Malaria	42 (19.81)	38 (24.05)	23 (14.37)	103 (19.43)
Jaundice	5 (2.35)	1 (0.63)	1 (0.62)	7(1.32)
Physical Impairment	5 (2.35)	1(0.63)	1(0.62)	7(1.32)
Asthma/Respiratory problems	14 (6.60)	12 (7.59)	(7.5)	38 (7.16)

Cardiac vascular problems	2 (0.94)	1(0.63)	2(1.25)	5(0.94)
Head ache injuries	23 (10.84)	10 (6.32)	16 (10)	49 (9.24)
Teeth & mouth related problems	13(6.13)	16 (10.12)	6(3.75)	35 (6.60)
Skin related problems	7 (3.30)	8(5.06)	6 (3.75)	21 (3.96)
Accident/Injuries	2 (0.94)	2 (1.26)	1 (0.62)	5 (0.94)
Abdominal symptoms	35 (16.50)	18(11.39)	28 (17.5)	81 (15.28)
Genito-urinary problems	7(3.30)	4(2.53)	8 (5)	19 (3.58)
Musculo-skeletal problems	17(8.01)	17 (10.75)	21 (13.12)	55 (10.37)
Psychological problems	3 (1.41)	2 (1.26)	4 (2.5)	9 (1.69)
Feel sick and weak	17(8.01)	10 (6.32)	12 (7.5)	39 (7.35)
Ear/nose/throat (ENT) problems	6(2.83)	6 (3.79)	0	12 (2.26)
Others	3 (1.41)	5(3.16)	6 (3.75)	14(2.64)
Total	212	158	160	530

The perception of major and minor illness is normally based on their personal or family experiences or friends and relatives. As table (5.16) present all illness reported by respondents. Malaria and other fever is the single largest reported illness, which is nearly one-fifth of the total illness. People labelled shivering fever as malaria normally. Apart from this abdominal pain and gastro-entitis were reported as main illness. Musculo-skeletal problems, headache and injuries, currently feeling weak and sick, asthma and respiratory problems and tooth and mouth disease, are other main reported health problems.

The pattern of illness is more or less the same across various strata as presented in Table (5.16). But some differences in the type of illness among different variables do exist. However data were not analysed on this basis. This is based only on experience of interviewing and encoding. Among females genito-urinary, abdominal pain and symptoms and musculo-skeletal problems are more common than males. In aged people musculo-skeletal problems, physical impairment and psychological

problems, asthma are more reported than young persons. Similarly in children, ENT, teeth and mouth related problems, are more common than others.

Burden of Illness

The difference in the reported morbidity rate between the samples of different SES is exposed when we look at the number of health problem reported (Table5.17). Total 37.34 percent of population reported no illness during the reference span of one month in general, (and six months for malaria, jaundice and other chronic diseases). Nearly 45 percent of high SES people show no health problems at all, whereas only 27.42 of middle SES and 36.25 of low SES categories people show the situation of no health problem. It means maximum percentage of persons from middle SES group show illness, least percentages are from High SES group.

Table: 5.17 Showing 'Burden of Illness' by socio-economic status.

Burden of Illness	Low	Middle	High	Total
Only one health problem	39	38	60	137
Two health problem	37	28	24	89
Three health problems	33	24	14	71
Total population reporting illness	109	90	98	297
Total population reporting no health problem	62	34	81	177
Total population	171	124	179	474
% of total population reporting no illness	36.25%	27.42%	45.25%	
Burden of illness per people (Total illness / total population reporting illness)	1.94	1.84	1.63	

When we further explore these data we find that per person burden of disease is more on the people from low SES groups than middle groups. However, high SES people are less burdened of disease. The burden of disease in per person is 1.63, 1.84 and 1.94 in persons of High, Middle and Low SES group respectively.

It shows that middle SES people report their health problem more but they have less burden of disease while, in comparison to people, low SES people report less illness, but they are suffering from more number of diseases.

Utilisation of Health Services

'When member of your household get sick, where do you generally go for treatment?' We asked. Members of each household who sought treatment for their disease are discussed at three levels: public, private or traditional means of treatment. It is reported that people in the village generally people take treatment simultaneously traditional as well as modern; private as well as public health system. Regarding this data disposed that the utilisation of health care services is quite different in different SES households which is given below,

Utilisation of Public Health Service:

The health seeking behaviour in utilisation of public health services is low, majority (57.4 %) of people never use public health services at all. Whatever they use is the mainly the PHC and very few (4.25) use

government hospitals. Noticeably, the nearest health care unit, village sub-center is never used in the case of illness.

Table 5.18: Use of Public Health Services by SES

SES	Govt. Hospital	PHC	No use of Public Health Services	Total
Low	1(4.76)	11(52.38)	9 (42.86)	21
Middle	0(0)	6(42.85)	8(57.14)	14
High	1(8.33)	1(8.33)	10(83.33)	12
Total	2 (4.25%)	18(38.2%)	27(57.4%)	47(100%)

Inter class variations persist in the use of Public health sector, as revealed by Table 5.18. Low and middle SES people use public health services more. Majority (83.3%) of High SES people never use public health services, only 8.33 percent use PHC in the case of health problems. In the all means of treatment of health care, 57.4 percent, 6.38 percent and 12.76 percent of households does not use public health care, private health care, and traditional treatment methods respectively.

Use of Private Medical Services:

Medical services seem to be the common means of treatment in the case of illness for most of the section of the society. Only 6.38 household did not use any private medical facility. But, there is more variation in the use of type of private health care service. Private paramedic alone (27.65) and private paramedic with the doctors is the major (48.9%) modes of treatment in the private medical services. In

comparison to other mode of treatment, only few (17%) seek the specialist services of private doctors alone.

Table 5.19 - Use of Private Medical Services by SES					
SES	**Private Doctor**	**Private Paramedic**	**Pvt. Doctor & Pvt. Paramedic**	**Not use Private Medical Services**	**Total**
Low	3(14.86)	10(47.62)	6(28.57)	2(9.52)	21
Middle	3(21.43)	3(21.43)	7(50.0)	1(7.14)	14
High	2(16.69)	0(0)	10(83.33)	0(0)	12
Total	8(17)	13(27.65)	23(48.9)	3(6.38)	47

The table 5.19 shows that there is a clear-cut relation between modes of treatment of private medical services with the socio-economic status of households. All the high SES families seek private medical care but not solely depend upon private paramedic health services whereas nearly half of (47.6) low SES households use the health services of private paramedic alone. Private paramedics and private doctors simultaneously provide medical facilities for the 83.33% of high SES families.

Use of Traditional Treatment and Care

Use of traditional treatment is the common means of seeking care in rural community. But there are different systems of treatment. Traditional healing alone (27.65) and traditional healing with home treatment (34%) are two popular forms of traditional health care.

Table 5.20- Use of Traditional Treatment by SES							
SES	**Vaidya/ Hakim/Homeopath/Yoga**	**Traditional healer**	**Self medication**	**Home treatment**	**Traditional healer and home treatment**	**No traditional treatment**	**Total**
Low	1(4.76)	5(23.81)	3(14.23)	1(4.76)	8(38.10)	3(14.28)	21
Middle	0(0)	6(42.86)	0(0)	2(14.29)	4(28.58)	2(14.29)	14
High	4(33.34)	2(16.67)	0(0)	1(8.33)	4(33.34)	1(8.33)	12
Total	5(10.6)	13(27.65)	3(6.38)	4(8.5)	16(34)	6(12.76)	47

There is a visible class variation in terms of utilizations of traditional treatment. Self-medication is reported as the major form in poor families, where traditional healing and home treatment is more common. Other system of medicine like Vaidya, Hakkim, and Homeopath are the highest (33.34 %) form of traditional treatment. In the middle class family traditional healing and home treatment are more common forms of traditional treatment than any other SES groups.

Maternal and Child Health and Preventive Care

There are 39 women in the sample population, in which 15 were from poor families, and 11 were from middle families. As table 5.21 shows nearly half (18) belonged to Aheer castes (BC categories). In the caste categories, 9 were from SC, 18 were from BC, 3 from OBC, and 8 from higher castes.

Table 5.21	
Division of MCH Population by SES	
Low = (38.46%)	15
Middle = (28.20%)	11
High = (33.33%)	13
Total =	39

This section deals with the inter class (SES wise) differences in knowledge, attitude and practices and behaviour of the women who were pregnant during the time of the survey and also of those women who gave birth within the last three years prior to the survey. It particularly deals with the antenatal care and vaccination of children. The utilisation of antenatal care depends to a large extent on the socio-economic and socio-cultural background of the respondent.

Prenatal Care:

The survey data (Table5.21) indicate that health worker visit at the house is not common in the study area, during pregnancy of women. As we discussed in Chapter III village profile however there are ANM, Midwives, Dai and other health workers. There is no significant interclass difference in health worker's visit during pregnancy.

Table 5.22 - Health worker visit during Pregnancy by SES			
SES	**Yes**	**No**	**Total**
Low	1 (6.66)	14 (93.33)	15
Middle	1 (9.09)	10(90.91)	11
High	1 (7.69)	12 (92.31)	13
Total	3(7.69)	36 (92.31)	39

In spite of no tradition of health worker visit to the household, table 5.23—show that nearly two-third (64.10%) women received antenatal check-up during pregnancy. Noticeably, there are socio-economic status wise difference, where women of well off families received much more (84.62 percent) antenatal care than women of poor families (46.66) and middle families.

Table 5.23- Pattern of Antenatal check up received during pregnancy by SES			
SES	Yes	NO	Total
Low	7 (46.66)	8 (53.34)	15
Middle	7(63.64)	4 (36.36)	11
High	11 (84.62)	2 (15.38)	13
Total	25 (64.10)	14 (35.89)	39

Place of Antenatal Check up:

Village, sub-center, govt. hospital and private paramedical clinics are the places where women go for the antenatal check-ups. As data (Table5.24) indicate that sub-center is the most common place for antenatal care. The use of sub-center for antenatal services is not common in all sections; women of higher socio-economic status families use more than women of poor families.

Table5.24- Place of antenatal check up by SES					
SES	**Sub center**	**Govt. Hospital**	**Private Paramedic**	**Not Applicable**	**Total**
Low	6 (40.0)	1(6.67)	0(0)	8 (53.33)	15
Middle	6 (54.55)	0(0)	1(9.09)	4(36.37)	11
High	11(84.62)	0(0)	0(0)	2(15.38)	13
Total	23 (58.97)	1(2.56)	1(2.56)	14 (35.30)	39

Reasons for Not Receiving Antenatal Care

The women, who had not registered for antenatal care, reported it was not necessary, not customary or they lack the knowledge of antenatal care. Many of the women (35.9%) did not receive antenatal check up during pregnancy.

Table 5.25 - Reasons of non-availability of antenatal check up by SES						
SES	**Not necessary**	**Not customary**	**Lack of Knowledge**	**No health worker visited**	**Not applicable**	**Total**
Low	2 (13.33)	4 (26.67)	2 (13.33)	0(0)	7(46.67)	15
Middle	0(0)	2 918.18)	1 (9.09)	1 (9.03)	7 (63.64)	11
High	1 (7.69)	1 (7.69)	0 (0)	0(0)	11(84.61)	13
Total	3 (7.7)	7 (18.0)	3 (7.7)	1 (2.56)	25 (64.1)	39

Half of the women did not take antenatal care because it was not customary practice in their family. Few women, all of them belongs to poor and middle SES families told that they were unaware of the availability of MCH facilities at village health center. Few women (13.3%) of Low SES group and few (7.7%) of high SES group consider antenatal check-up as unnecessary. This may be due to their ignorance to the relevance of MCH services and have doubt about its benefits. These women are illiterate, elder in age and were from lower castes. They told that, they delivered babies without any antenatal care earlier.

Majority of women who had registered for antenatal care were given the iron/folic acid, and Vitamin A tablets and tetanus injections during their pregnancy. This time they were instructed to take nutritious meal, use family planning methods, and keep away from heavy work. In most of the cases, as told by 'Village health center ANM, "the women do not follow the instructions and advice given to them. Many of the women did not take the iron tablets because of the bad smell and it caused vomiting and nausea to them". Few women also said because of domestic work and conditions they could not take rest and eat properly to improve their diet during pregnancy.

Health Problems Faced by women during pregnancy:

Generally women of rural areas experienced illness or some sort of disturbance, during pregnancy. Generally, these ailments are perceived as natural or inevitable part of pregnancy experience. The reporting of these problems also depend upon their prior experience to pregnancy and childbirth. In the present study nearly three-fourth of women face some health related problems during pregnancy.

Table : 5.26 Health Problem faced by women /during Pregnancy by SES :				
Illness	Poor	Middle	Welloff	Total
Night blindness	6	2	0	8
Blurred vision	6	4	4	14
Convulsion	4	2	3	9
Swellings of legs, Body or face	4	3	5	12
Excessive fatigue	6	4	4	14
Anaemia	9	5	5	19
Genito-urinary Problems	2	0	1	3
Others	1	1	5	7
Total illness Reported	38	21	27	86
Total population	15	11	13	39
Total population Reporting no illness	2	4	3	9
% Of population not reporting illness	13.33	27.27	38.46	23.08
Burden of illness per Women (total illness/Total Reporting illness)	2.92	3.0	2.7	2.86

The data show that majority of women experience more than two or three illness. The average burden of illness during pregnancy on women is 2.86. According to the data, anemia, excessive fatigue and blurred vision, and swelling of legs, face and body are major reported sickness experiences. However, convulsion, night blindness, genito-urinary problem, irregularity in menstruation, weakness and body pain specially in stomach and backside, drowsiness, vomiting are other health ailments generally found during pregnancy.

Inter-class differences are also indicated by evidence but the differences are not much. It shows that more or less, women of all SES category experience health related problem during pregnancy. Again

middle class women show highest burden of illness (3.0). Anaemia, night blindness, excessive fatigue etc. are intensive among women of poor sections. A variety of small ailments are more reported by women of well off families.

Table 5.27- No. of Maternal health problems by SES					
SES	**No health problem**	**One health problem**	**Two health problems**	**Three health problems**	**Burden of illness**
Low	2 (13.33)	1 (6.7)	3 (20)	9(60)	2.84
Middle	4 (36.36)	1	2 (9.09)	6 (54.54)	2.857
High	3(23.07)	1 (7.69)	2(15.38)	9 (69.2)	2.46
Total	9 (23.08)	2(5.13)	6(15.38)	24 (61.54)	2.72

According to data women of study area prefer home delivery than any other institutional deliveries. Nearly 90% show home deliveries. Class differences are in the case of institutional delivery of poor off women this may be due to their serious health problem during pregnancy /delivery. As table 5.29 reflects only few women seeks help of a lady doctor and most of them are from poor families. Nearly other halves take help of family members and relatives and other takes help of nurse, Dai or paramedic at home level delivery. But there is a sharp difference of assistance in delivery. Poor are inclined to take help of relatives than trained personnel at home, while women of better families seek more help of trained personnel like nurse, Dai of paramedic during delivery at home.

Table 5.28- Birth Place of last child of each mother by SES					
SES	**Home**	**Govt. Hospital**	**Maternity home**	**Private clinic**	**Total**
Low	12 (80)	1(6.7)	1 (6.7)	1 (6.7)	15
Middle	11(100)	0(0)	0(0)	0(0)	11
High	12 (92.3)	0(0)	1 (7.69)	0(0)	13
Total	35 (89.74)	1 (2.56)	2 (5.12)	1(2.56)	39

Table 5.29 - Assistance in delivery of last child by SES.						
SES	**Lady doctor**	**ANM/Nurse/ midwives**	**Dai**	**Compounder/Para medic**	**Relatives**	**Total**
Low	2 (13.33)	1 (6.7)	2(13.33)	2(13.33)	8(53.33)	15
Middle	0(0)	4 (36.36)	0(0)	1(9.09)	6(54.54)	11
High	1 (7.69)	4 (30.76)	3 (23.07)	1(7.69)	4(30.76)	13
Total	3 (7.69)	9 (23.08)	5 (12.82)	4(10.26)	18(46.15)	39

Utilisation of health care for infants, particularly the utilisation of universal immunisation program (UIP) also shows strong class gradient in the favour of children of better off families. As table (5.30) shows that 100 percent of the children below age of three year were immunised against polio than diphtheria, whooping cough, and tetanus (DPT) 42.10 percent against BCG and last 31.58 against measles.

Table 5.30- Pattern of vaccination child received by SES									
Vaccines	**BCG**		**DPT**		**Polio**		**Measles**		**Total**
SES	Yes	No	Yes	No	Yes	No	Yes	No	
Low	4	10	6	8	14	0	3	11	14
Middle	5	6	8	3	11	0	3	8	11
High	7	6	6	7	13	0	6	7	13
Total	16(42.10)	22(58.9)	20(52.63)	18(47.37)	38(100)	0(0)	12 (31.51)	26(68.4)	38

Inter-class differences are more in the vaccination of BCG and measles, where children of poor families show significantly low vaccination than well off families. Under utilisation of immunisation

programme is clearly reflected in Table 5.31. Nearly two-fifth of children received only one vaccine and less than one-third children received all four vaccines. Socio-economic status wise, immunisation data show that children of well off families have more than two times chances of vaccination than of poor families.

Table 5.31- Number of vaccination received by each child by SES

SES	One vaccine received	Two vaccines received	Three vaccines received	All four vaccines received	Total
Low	7(50)	1(7.14)	3(21.42)	3(21.42)	14
Middle	3(27.3)	3(27.3)	2(18.2)	3(27.3)	11
High	6(46.6)	1(7.7)	0(0)	6(46.2)	13
Total	16(41.03)	5(12.82)	5(12.82)	12(30.77)	38

During infancy and childhood years very young children suffer from wide range of ailments. Majority (72.75%) of the survey children suffered from some kind of ailments or others during the fifteen days of survey. As table 5.32 shows that 29.72% suffer from cough/cold, 24.32% from fever, 24.32% rapid breathing, only 13.5% from diarrhoea. A great numbers of children (37.84%) suffer from diseases like muscular convulsion, pain, vomiting, dryness, weakness, skin related problems, infections, less weight and other unidentified problem. Class wise variations show that cough/cold problem and fever are more prevalent in poor children; whereas diarrhoea is in children of middle SES family. Poor children faced more than one problem, comparatively more than children of well off and middle SES families.

Table 5.32 - Health Problems faced by children (below 3 years)during last two weeks										
	Cough/cold		Fever		Rapid breathing		Diarrhoea		Others	
SES	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*	*Yes*	*No*
Low	6	8	5	9	4	10	0	14	4	10
Middle	3	8	2	9	1	10	4	7	5	6
High	2	10	2	10	4	8	1	11	5	7
Total	11 (29.73)	26 (70.27)	9 (24.32)	28 (75.68)	9 (24.32)	28 (75.68)	5 (13.51)	32 (86.49)	14 (37.84)	23 (62.16)

Discussion

Findings of the study show inequalities in perceived illness, burden of diseases, use of different type of health services and preventative prenatal practices by mothers. Less number of people in lower socio-economic class report illness than middle class. But the poor have highest burden of diseases and severe chronic illness than high and middle socio-economic classes. People from different SES prefer to use different type of health services. However, there were not much social class variation reported in the use of private and traditional means of treatment. Lower SES people use, private paramedical in comparison to highest people who take advantage of specialists and quality of services of private doctors. Women in the higher social class used MCH preventative practices much more.

The socio-economic and demographic characteristic of population, health culture, ecological condition of that area were used to understand

the above finding in the context of availability of both private and public health services to a agrarian rural community.

Perceived Morbidity

As summarized above the result shows that people show variation in illness prevalence according to their socio-economic group. The definition of illness differs community to community and people to people. One *Musahar* (lowest SES) boy of 25 year told that 'When body will not permit to work then I perceive himself as sick'. Another lady of lowest SES told that "when we are not able to eat properly, stop the taking food then we perceive people is ill.' She further said that "no one is healthy. This world is full of sickness that's why it affects to my family and me. It's creation of God. I had never took any treatment for my husband who has epilepsy from a long time".

However, one 54-year-old lady of high SES told that "illness occurs due to weakness of the body and lack of proper food and treatment. No one knows what will happen to anyone but we can improve our health". A 56-year Adult High SES people in government job told that "he feel himself ill when he experienced tiredness or fatigues or when our doctor tell that you have some disease".

These definitions show that people of lower classes never perceive themselves ill till they work. Probably due to this reason they report less

illness. But they have always some chronic problems and they are trying to avoid it. If they accept this condition they have to stop there work which affect their wage earning. Similarly if they perceive themselves ill they have to go for treatment. For which they have to pay for consultation fees, drugs, diagnostic testing, traveling, food etc. Acceptance of disease also affects their social life. One case of leprosy in a Harijan patient of lower SES group shows this situation. He concealed his disease and work continuously till the disease become severe. Latter, his relatives and family member also started neglecting him. The marriage of his young son also postponed and his daughter-in-law left to her elder son due to social perception of this disease. In the case of women, especially adolescent girls reporting of actual and serious disease makes trouble for their marriage. If a girl who has been fallen frequently ill she is not preffered. Due to these episodes they avoid reporting their illness. Lower SES people try to hide their disease with other peoples till it becomes life threatening. They take treatment of healer during night when no one knows. They say ' nothing is abnormal to it'. Due to delay in perception of disease their health risk increased and they go more fore hospitalization in serious condition.

People's inherent socioeconomic conditions are main drive to perceive him/her self-sick and try to seek health care. As the data shows, normally all low SES people have less land, and they are working as

wage laborers or other form activities. They have more dependent population and they cannot produce food grains adequate for whole family consumption. They do not have money to spend on their all-ill episodes. This conflicting condition of 'need of care and ability to pay for it' creates a state of cognitive imbalance and by perceiving him not ill they maintain this balance. In a lower SES family generally few member always feel sick. Family resources spent too much even to cure a single member. In the case of many illnesses, family resources have been shifted to cure one member, who will be more important and productive and whose chance of getting cure will be more. Hence scarcity of resources is cause of their less utilization of health services. In this condition, illness episodes are less reported. People suppressed their illness. Girls, women, mother, and parents conceal their ill health for the sake of their counterparts. If they feel themselves as sick then they have to go for treatment and spend more.

As soon as, family started to earn more, the episodes of illness being recognized more. Their frequency of visit for health care and level of consultation also increase. Above explanation would be clearer when we see the case of middle SES families. Middle SES families are complex class made up of families comes from both lower and higher class. Their socioeconomic condition is better than lower one. As data shows that these families reported maximum number of illness and use a

wide range of health care services. Another possible explanation for the more reporting of illness by middle class people is that people of this group have better understanding of their illness. Due to their high literacy, awareness, political mobilization and participation they know the benefits of early treatment and how to use efficiently health care services. At a certain extent, their economic condition also allows them to go for better treatment and immediate relief even they have to pay for it in private health sector.

Lower SES families mainly come from lower caste. They have less cultivatable land. This is insufficient for their whole year food consumption. So they work whole year as wage labor in agricultural or other activities. One Harijan househead told that:

"We could not produce food grain for the consumption of whole family. This is sufficient only for 6 to 8 months. What we earn totally spend on food. Then at the time of sickness how can we take treatment. We always borrow money for treatment. Brahmin ladies give me money on the debt on the interest of 10 percent per month. My debt is never going to end. This year I mortgaged our all-cultivable land, which was less than one *Bigha*, in exchange of 3000/rupees for the treatment of my wife. In spite of her sickness, she is working in the paddy field under 2-3 feet water, to collect paddy crops useful for few month".

Similarly poor families have more number of children, i.e., less working people and more dependent population. That's why their children started to work in family and outside the family at very early stage. We saw that girls of 6-7 years age are making food in the family when their mothers were ill. In this condition these health risk heightens and they deprived of schooling and other necessary social skills.

Ecological surroundings play important role in occurrence of disease. Data reveals that water born, diseases like malaria, gastro-entities, skin disease are common among poor. Lower class people do not have safe drinking water. A harijan lady told that:

" We have to use the water from well. The water is dirty and is not suitable for drinking, but we have to use it. The facility of latrine is also not available. The water is logged all around *Basti* for more than 6 months, due to which lot of mosquitoes and flies are present here. We have no *Pukka* road to go outside the village."

Their houses are made of leaves and mud. They have no electricity as well as separate kitchen. Very little safe space is available for them. Majority of low SES people have less than two rooms, in which their all-family members live. Women of this group suffer more. They have least available private space. In front of their houses there is very less ground in comparison to high SES peoples. Their poor socio-economic condition make them fatalistic. They accept this situation as

helplessness. So, even if there is some favorable time and chance they are unable to take benefit from it.

The ill health of children also depends upon the health of the mother. All the children suffer from more than one diseases. These children lack proper clothes, their houses are wet and full of moist and their mothers are working in the waterlogged field. This entire situation makes them more prone to cough and cold.

Utilization of Health Services

Above discussion highlight the occurrence of illness, there perception and process of seeking help. Socio-economic conditions of people are major determinant of their choice of health care and progression of treatment. As reported that multiple care is common in the study area. People seek the care of more of the one health care system. They seek help of spiritual healer, allopathic doctor and non-trained paramedical, home treatment, and other system of traditional treatment. One old person of backward caste middle SES told, "My daughter-in-law has some internal problem. Initially we did not take the help of any medical practitioner. We sought the help of *Ojha*. He had done some *jhaar-foonk*, but there was no relief. Then we went to a doctor."

Nearest public health sub-center provides mainly preventive services such as family planning and immunization. PHC provide curative services, but does not provide drugs and their treatment

perceived as ineffective. So people prefer private health services. For minor illness and injuries people of all SES prefer to go nearest paramedics or *Jhola chhap* doctor. But in the case of sever sickness, surgery or injury lower caste people go to paramedical services whereas in such situation high SES people go to trained doctor or clinics frequently.

One young lady of high SES family told "I do not take medicine from anywhere, when I have some problem. I prefer to consult good private practitioner. Not only this I even do not consult the government doctor. They do not charge money but they often do not pay proper attention and commit negligence. They are not trustworthy. Often the diagnosis is not appropriate. The medicine they prescribe may cause reaction. Thus it is better to consult a good private medical practioner."

Cost of treatment in private health is mostly unbearable for low and middle class people. As health narrative describes low SES people borrowed money for treatment. One 42-year-old male of *Harijan* caste told about their recent major stomach operation that:

"Within one week, due to hard manual work and late lunch I reach from simple illness to Operation Theater, finally I got admitted in a nursing home. I have to pay more than 14000 rupees for this treatment. At the time of sickness I have no money or savings. I took money from relatives, neighbours. I sold my watch and radio, I sold by both oxen. I

pawned my all land and even all land of my brother to borrow the money. Even now there are debt of more than 10,000. It affected my work, family life and progress severely."

Due to these type of situation people of both middle and low SES prefer traditional treatment, spiritual healing and self-medication. These are also culturally more suitable and customary for them. According to these people it helps to relieve their symptom of pain or illness for most of the times. When disease becomes 'over flow' (acute), in this situation person's physical activity restricted adversely, then they go for treatment to local paramedic or doctor. Once they diagnosed, generally people do not approach the health providers because of economic hurdles. After some time, when they experienced any previous type of illness then they take early-prescribed drugs from medical stores without any consultation. People of lower SES show more faith in the spiritual healing. Some time they also spent more money on these practices than modern medical treatment. But they also seek help of doctors in the failure of above methods.

Preventive Practices

There are large inequalities in the use of preventive practices. In this study preventive practice is concern with prenatal care during pregnancy. The data shows that antenatal care received by two-third women in spite of no tradition of health worker visit. ANM and other

local health worker visited only those families who have their contact or personal relation. Basically these are influential people of the village. Women of lower SES groups have vital need of prenatal care but very few receive it. These services are available too only those who go to the sub-center. Some time women also pay 3 to 5 rupees for per injection. Due to the illiteracy and ignorance of perceived benefit and lack of motivation to use these services, poor women become lagged in the care of prenatal care. Majority of women do not receive any antenatal care. They do not know much about these practices and no effort was made at local level to break the 'fear of care'. This shows that low use of preventive practices by women is connected with the socioeconomic status of households with their cultural constrains. These women and men are not informed about any health camp, vaccination or immunization programs. Due to lack of time, distance and hesitation to go out they often becomes deprived of these facilities. Further due to poor quality of prenatal care they not find much different of benefits between received or not received antenatal care women.

Place of delivery is mostly 'home' for all families. However, low SES women show high degree of hospitalization at the time of delivery. This preference is not because of safe delivery but this is due to high health risk and complication during delivery that compels them to go to hospitals. This is also verified that they take less assistance of trained

personal in delivery in comparison to women of high SES families. Due to less availability of trained Dai of nurse in the study area they prefer to go only those family who take them by a vehicle and pay more than 500 to 1000 rupees per child delivery. In this condition they (low SES families) cannot think about the assistance of a trained nurse or doctor at the time of delivery. PHC and Sub-center have no arrangement of delivery and they open only at daytime only. In life threatening situation people seek care of a lady doctor or available trained doctor. These lady health personnel visit only to those homes who entertain them and give respect and comfort. Same thing happen in the case of vaccination. In case of polio health personal visit each home while in the case of other vaccines this would not be happened.

Our findings of this study and its discussion shows that economic, social, cultural and ecological conditions are key factors in the perception of health problems and use of different health care services. Person socio-economic conditions and their poor social and ecological surroundings constraints their health seeking behaviour and their health action.

Chapter VI

CONCLUDING OBSERVATIONS

The study of socio-economic condition and health in the Basnehta village of Eastern UP is based on interviews on perception of village health problem at community level with the village representatives, health care providers and villagers. The overall conclusion shows that wide socio-economic wide disparities exist in socio-demographic indicators, health conditions and pattern of use of health care services.

Generally, rural people are facing more morbid situation due to change in ecological condition, poor housing and insecurity of income. There are marked social inequalities at socio-economic and political arena of village life. The poor people are marginalized in the all above field.

Due to poor socio-economic background and lack of previous tradition of participation in health activities the village representatives do not see their role in public health. There is lack of knowledge about the specific health problems of different population. Both people and providers see health problem and needs in their own way. The representatives see their health problem in wider socio-economic and ecological conditions.

The lower socio-economic and caste people are staying in bad physical environmental condition and less developed area. That's why representatives of these area give more importance to development of their locality in term of basic amenities of roads, electricity, housing, toilet, water drainage and employment than health, education and other activities.

There is a discrepancy of attitudes about people's health problems between people and providers. People perceive lack of adequate health care facilities as the reason for poor health status, while health personnel take opposite side who believe that due to ignorance, village people are unable to get the available health facilities. Consequently, there is a total lack of inter-sectoral coordination at village level for better use of health services.

All Schedule Caste (SC) population comes in lower socio-economic status (SES) whereas no higher caste comes in lower socio-economic group. Backward castes come in all three socio-economic groups with more number in middle socio-economic group.

There is significant variation in ownership of total land and actual cultivable land. Majority of high, middle and low SES people come in respective high, middle and low category of cultivable land. SES category also determined the type of house, families owned.

Peoples of well off families or high SES report least illness, and have least burden of diseases than other SES groups. Maximum number of middle SES people reported illness, however they have less burden of disease than lower SES people. In comparison to middle SES people, less number of lower numbers of SES or poor families reported illness but they bear maximum burden of disease than all SES group.

People of low SES families suffer from more chronic illnesses, but they do not perceive themselves as ill and do not take any treatment till they are unable to work. This is because of social and economic pressures. Therefore, there is less reporting of illness among lower class. Thus low SES people have least reported felt need of health despite of highest burden of disease. They also show highest unmet health needs than middle and higher socio-economic status people.

There is not much inter-class variation in the types of illness affecting the people. The pattern is more or less similar with 'malaria/fever' being leading cause followed by abdominal symptoms, muscular- skeletal aches and pains, head ache and injury, respiratory problem and teeth and mouth related disease. But some differences in the type of illness among different groups do exist. Chronic problems like genito–urinary, muscular-skeletal and symptoms of abdominal pain are more common in females. In aged people muscular-skeletal problems, physical impairment, psychological problems are more reported.

Similarly among children ear, nose and throat (ENT), teeth and mouth related problems, respiratory and gastro-entities are more common.

On the basis of socio-economic status clear-cut variation exists in the use of different available health services. Public health services are least used health services whereas private health services are commonly more used than public help services. Poor families seek help of PHCs and local non-trained practitioner and paramedic more. However, well off families seek services of private paramedic and doctors more. In traditional means of treatment significant number of poor people prefer self-medication and seek help of spiritual healers. While, well off families take help of other system like Aurvedic, Homeopathic, Unani and Yoga for health care significantly. Clearly, the level of seeking private health care depend upon the economic status of the family.

Public health services are mainly used for preventive and some time for curative health care, whereas private health care provides mainly curative care. Local non-trained private medical practitioners show least social distance than any other health personnel. They act as linkage between village people and higher level of health care providers.

For minor illness or injuries people of all SES prefer to go to local non-trained practitioners, while in the case of severe illnesses higher SES people prefer to seek help of more qualified doctors or nursing homes. People from low SES go to the private paramedicals. Only in the case of

life threatening events they prefer to visit qualified doctors or hospitals. At this time they spend much more on treatment.

Preventive care shows much SES wise difference than curative care. Village health sub-center is the common place for ante-natal care. There is no tradition of health worker visit during pregnancy across the all classes and SES.

There is wide inter-class difference in receiving antenatal care, assistance in delivery, and immunization of children and health problems of children and women during and after pregnancy. Women of well off families receive much more prenatal care than women of low SES.

Generally, women of all socio-economic groups show some sort of illness and health problem during pregnancy but the poor women suffer more than others. They experience more complication in pregnancy and consequently show more hospitalization. Women of poor families depend more upon family members or relatives for assistance in delivery. While women of well off family take more help of trained Dai, Nurse, or lady doctor for delivery.

Children of well off families have more than two times chances of vaccination than of poor families. Children's health is related to socio-economic condition of the parents, mother's occupation and their health. Poor children suffer many diseases at a time in comparison to children of middle and high SES families.

Thus, present study highlighted the effects of socio-economic status on the perception of illness, early treatment, use of various types of public, private and traditional health care and preventive practices. Since, the public health care institutions lack proper facilities for the treatment of diseases and cost of treatment in the private health care institution are very high. Therefore poor people resort to self–medication and approach unqualified private practitioners who provide cheaper medical care services compared to other trained medical practitioners. So, the health seeking behaviour of the rural people constraint by their socio-economic conditions and accessibility of health services. In this way, this study further emphasizes the need of wider socio-economic transformation and equitable distribution of health resources among all population, according to their need.

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APPENDICES

Section A

NO.....

Interview Schedule for Village Representatives

1. Name_____

2. Age_____ 3. Sex M/F_____

4. Caste_____ 5. Education_____

6. No. of Children_____7. Occupation_____8. Post/ Des_____

Questions: In your opinion :

9. What are the three important problems in this village?

_____

10. What are the three most prevalent health problems in this village?

_____

11. What are the most prevalent health problems faced by women in this village?

_____

12. What are the most prevalent health problems faced by children in this village?

_____

13. In your village which are the most suffered group?

_____

14. if you are asked to prepare a plan for village , what would be the two most important actions you would recommend?

_____

Section B

No.....

1. Name_____

2. Age_____ 3. Sex M/F_____

4. Caste_____ 5. Education_____

6. Training/ Work Experience_____

7. Post_____

8. Work place: Sub Centre/ PHC/CHC/Private Clinic/Nursing Homes/Home/ Drug Store/ Others(

specify)_____

Questions:

9. Distance of your work place from Basnehta(in Kilometres)_____

10. What are the three most important health problems in this village/ area?

_____

11. What are the three most important causes for death in this village/ area?

1.

_____

12. What are the three most prevalent diseases in this village/area?

_____

13. What are the most prevalent health problems faced by children in this village/area?

_____

14. What are the most prevalent health problems faced by women in this village/area?

_____

15. What are the most prevalent health problems faced by Old age in this village/area?

_____

16. People from which section comes to you more for health problems(please tick)

		Very Much	Much	Few	Very Less
Caste	SC/ST,				
	OBC,				
	Others				
Class	Lower				
	Middle				
	Upper				
Gender	Male				
	Female				
Age	Children(below-11)				
	Adolescent(12-19)				
	Adult(20-50)				
	Aged (50+)				
Education	Illiterate				
	Literate				
	1-8 Grade				
	8-12 Grade				
	12 +				

Section c

Maternal and Child Health Schedule

(This schedule is concerned with the women last pregnancy time and last birth within three years)

H.H No..... Sl. No.

Q.1: When you were pregnant did any health worker visited you at home?

Yes/ No if Yes—> 2

Q.2: Specify who came to you?

Q.3: When you were pregnant did you go for antenatal care?

Yes/ No if Yes—>4, if No—> 5

Q.4: Whom did you see?

(Record all responses in order)

Q.5: Why did you not receive any antenatal care?

1. Not necessary
2. Not customary
3. Cost too much
4. Too for/ no transport
5. No time to go
6. Lack of knowledge
7. Family did not allow
8. No health worker visited

Q.6: When you were pregnant (last child) did you experience any form of the following problems?

Night blindness(Rattondhi)?	Yes	No
Blurred Vision?	Yes	No
Convulsions?	Yes	No
Swellings of the legs, body, or face?	Yes	No
Excessive Fatigue?	Yes	No
Anaemia?	Yes	No

If others(specify)

Q.7: The place of your last delivery:

Home/Government Hospital/PHC/SubCentre/ Maternity Home/ private Clinic/ Other

Q.8: Who assisted you in your last delivery?

Doctor/Lady Doctor/ ANM-Nurse/Mid Wives/ Compounder / Dai/ Relatives/others

Q.9: Did (last child) ever receive any vaccinations?

Yes/No: if Yes—>10

Q.10: Which of the following vaccination(name) received:

(i)	BCG(Against Tuberculosis)	Yes/No
(ii)	DPT(against Diphtheria, Whooping cough & Tetanus)	Yes/No
(iii)	Polio	Yes/No
(iv)	Measles	Yes/No

Q.11: Have you been suffered with following problem in last two weeks:

Cough	Yes/No
Fever	Yes/No
Rapid breathing	Yes/No
Diarrhoea	Yes/No

Any other_____

Section – D

Household Schedule : H.H. No. - .....

HH Name : ..... Caste : ..... Religion : .....

No.	Resi-dents Name	Relat-ionship to House hold head	Sex (M/F)	Age (In years and if less than two year in month)	Education				Occupation	Illness & Health Problem s
					Can (name) Read & Write ? YES / NO	If never attended school (What is the main reason) *	If ever attended school		What kind of work does (name) do most of times ? & If working then for cash average per month income.	(Does any one listed suffer from any kind of illness ? If yes, specify the illness / health problems). ***
							Highest grade completed	If age is less than 18 years and not going in school than reason for not going in school. **		
1	2	3	4	5	6	7	8	9	10 & 11	12
1.										
2.										
3.										
4.										
5.										
6.										
7.										
8.										
9.										
10.										
11.										
12.										
13.										

14.										
15.										
16.										
17.										
18.										

*** Codes**

1. School Too Far Away
2. Transport not available
3. Education not considered necessary
4. Required for household work
5. Required for work on form / family business
6. Required for outside work for payment in cash or kind
7. Cost too much
8. No proper school facility for girls.
9. Required for care of siblings
10. Not interested in studies.

**** Codes (Continued from *)**

11. Repated Failures
12. Got Married
13. Other

***** Codes**

1. Blindness (PARTIAL/PERMANENT)
2. Tuberculosis
3. Malaria (LAST 6 MONTHS)
4. Jaundise (LAST 12 MONTS)
5. Physical Impairment
6. Asthama
7. Cardiac – Trouble
8. Head Ache / Injury
9. Teeth / Mouth related disease.
10. Others (Specify)

13.	When members of your household get sick, where do they generally go for treatment ?	PUBLIC MEDICAL SECTOR Govt. /Municipal Hospital ..... 11 Govt. Dispensary .... 12 CHC/Rural Hospital / PHC ..... 13 Sub-Centre .....14 Govt. Paramedic ..... 15 PRIVATE MEDICAL SECTOR Pvt. Hospital / Clinic ..... 31 Pvt. Doctor ..... 32 Pvt. Paramedic ..... 33 Pharmacy / Drugstore ..... 34 TRADITIONAL TREATMETNT Vaidya/Hakim/Homeopath ..... 35 Traditional Healer ..... 36 Pharmacy/Drugstore ..... 37 Home Treatment ..... 38 Other .....39 (Specify)
14.	What is the main source of drinking water for members of your household ?	PIPED WATER ..... 1 GROUND WATER (Shallow / Deep) ..... 2 WELL WATER ..... 3 OTHER 4
15.	How long does it take to go there get water, and come back in one trip ?	Minutes .....
16.	What kind of toilet facility does your household have ?	FLUSH TOILET ..... 1 PIT TOILET / LATRINE ..... 2 NO FACILITY / BUSH / FIELD ..... 3 Other ..... 4 (Specify)
17.	What is the main source of lighting for your household ?	Electricity ..... 1 Kerosene ..... 2 Gas ..... 3 Oil ..... 4 Other ..... 5 (Specify)

18.	How many rooms are there in your household ?	Rooms .....
19.	Do you have a separate room which is used as a kitchen ?	Yes ..... 1 No 2
20.	What type of fuel does your household mainly use for cooking ?	Wood ..... 1 Crop Residues ..... 2 Dung Cakes ..... 3 Coal / Coke / Lingnite ..... 4 Kerosene ..... 5 Electricity ..... 6 Liquid Petroleum Gas ..... 7 Bio-Gas ..... 8 Other ..... 96 (Specify)
21.	Does this household own any agricultural land ? IF YES, NO→22	Yes ..... 1 No 2
22.	_____ (Size and Unit) How much agricultural land does this household own.	.....
23.	_____ (Size and Unit) Out of this land, how much is irrigated / cuttivable.	Acres / Bigha ..... None .....
24.	Does this household own any livestock ? IF YES, THAN TOTAL Nos.	Yes ..... 1 No 2
25.	Does the household own any of the following : A mattress ? A pressure cooker ? A chair / Table? A cot or bed ? A Gas / Bio-gas ? A clock or watch ?	Yes No Mattress ..... 1 2 Pressure cooker ..... 1 2 Chair ..... 1 2 Cot/Bed ..... 1 2 Table ..... 1 2 Clock / Watch 1 2

	An electric fan ?	Electric Fan 1	2
	A bicycle ?	Bicycle 1	2
	A radio or transistor ?	Radio / Transistor 1	2
	A sewing machine ?	Sewing Machine 1	2
	A telephone ?	Telephone 1	2
	A refrigerator ?	Refreigerator 1	2
	T. V. ?	Television (B&W) 1	2
	A moped/scooter, or motorcycle ?	Television (Colour) 1	2
	A plugh ?	Moped/Scooter/Motorcycle 1	2
	A water pump ?	Plough 1	2
	A bullock cart / Troly	Water Pump 1	2
	A thresher ?	Bullock Cart/Trolly 1	2
	A tractor ?	Thresher 1	2
	A well / handpipe	Tractor 1	2
	A Garden / Group of trees	Well/Handpipe 1 Garden/Trees 1	2 2
26.	Type of House Roof	Pucca 1	
	Walls	Semi-Pucca 2	
	Record Observation. Floor	Kachha 3	

MORTALITY

27- Did any usual resident of this household die since past one year ?

Yes / No. If Yes→ go 28.

28- How many person died : Total Death : .....

What as / were the name (s) of the persons (s) who died (Name)	Was (Name) a Male or Female (M/F)	How old was he/she died ? (Record days if less than one month, months if less than two years or years)	What did (name) die of ?	Reason for death	Whose treatment he/she was taken.
(29)	(30)	(31)	(32)	(33)	(34)
1.					
2.					
3.					
4.					