Chapter II

FRAMEWORK OF STUDY

In last chapter concept and theory of society and health is discussed. This chapter deals with framework of study. Chapter is divided into two parts. First part deals with background of study and review of literature. Second part deals with objective, assumption, sample and method of data collection.

BACKGROUND OF STUDY

I am familiar with Patni community due to my belongingness to the community. I am born and brought up in the Barak valley and developed my primary socialisation within the community. Since my childhood I have been listening from my forefathers and aged persons about migration of Patni people to present locality Barak valley and its adjoining areas and states from a backward region Jaldup of Bangladesh (Lakshi Mahan Das 1996). I used to relate their views with my subsequent observation of Patni community. In my continuous career I intended to know more and more about Patni of Barak valley. That generated my curiosity to study Patni and its health dimension in particular.

A few literature are available on Patni, but whatever literature I studied to gather knowledge narrate their miserable socio-economic condition of past and contemporary life, which I discuss in subsequent chapters. During my initial professional carrier I become attached with problem of health and health care service, which accordingly propelled me to develop my interest in sociology of health and illness.

I have come across with various studies on health and society which highlight role of social structure on health. Particularly studies on health status of deprived or excluded communities attracted me to study health of Patni community.

Here I must mention contribution of Department of sociology, Assam University, Silchar to start a new course 'Sociology of Health and Illness' in the department. Such an important discipline with ample of prospects would not be known to me without this contribution. When first doctoral dissertation on Sociology of Health is completed under successful guidance of a faculty of the department, I and many other scholars got inspired to enter into this field. In the department we got opportunity to learn ABC of this new discipline. Without such basic knowledge a research would not have been possible to conduct in a new field. In fact my knowledge and

teaching of the subject at post graduate programme of study make me confident as I grow more interest to study health of Patni community.

I further developed and consolidated my ideas about different pitfalls of health of Patni community, when I studied more materials reflected below. Studies made by scholars on social determinants of health are of immense importance to correlate link between society and health of Patni community in Cachar district. Moreover, studies on access to health care in India, culture and health in Indian society and status of nutrition are important too.

Review of Literature

Study on Social Determinant of Health

Rao, Sujata K (1998) in her monograph '*Health Care Services in Tribal Areas of Andhra Pradesh: A Public Policy Perspective'* highlights health status of tribes in tribal sub-plan area of Andhra Pradesh. To her, poverty is prime cause of ill health, persistent morbidity and early death in tribal areas. Maternal mortality and infant mortality rate among tribes of is double of maternal and infant mortality rate in the state. She says among some tribes like *Savara, Gadava* and *Jatapu* crude death rate and under-five mortality rate is higher than state average. Even incidence of

tuberculosis and malaria is more frequent in tribal areas too. Tribals are suffering from lack of right food, iron, protein and micro-nutrients for which incidence of nutritional deficiency disease, anaemia, diarrhoea, night blindness and goitre are widespread among them. To her, these reasons are combined with lack of access to basic health care services which are responsible for adverse differential with developed parts of the state[1].

Marmot Michael (1999) in *'Social Determinants of Health'* reiterates upon gross inequality in health among different countries. By analysing trend of mortality rate of countries viz. Europe, America, Asia and Africa he views that social factors are at root of health inequalities. He further says that social determinants are relevant to communicable and non-communicable disease alike. Health status, according to him, should be concern of policy makers in every sector not solely those involve in health policy alone[2].

Ghanshyam Shah (2001) in his study *'The Plague, The Poor and Health Services'* highlights social background of victims of plague occurred in Surat city of Gujarat. In course of study he found that more than seventy

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[1]K. Sujata Rao, Health Care Services in Tribal Areas of Andhra Pradesh, A Public Policy Perspective, Economic and Political Weekly, February 28, 1998, Pp 481-486
[2]Michael Marmot and Richard G. Wilkinson, Social Determinants of Health, Ed, Oxford University Press, New York, 1999, Pp 1-14

percent of victims of plague were immigrants of Maharashtra and Saurashtra who were working class, engaged in factory and casual work. Housing condition of suspected patients were poor. Most patients used to live in *zopadpattis* namely small houses without ventilation made of mud or jute wall and a ceiling of bamboo held by plastic sheet, steel sheet or country tile. Flood and fire were routine calamities for residents. Their main source of drinking water was public tap or a bore well hand pump. Most of respondents in *zupadpattis* used river bank to respond for nature's call, many used road side and garbage tip as toilet. Initially plague occurred in *zupadpattis* and later on spread in entire city. But number of death due to plague was more in working class residing in *Zupadpattis.* To him, though number of death was not very high and epidemic was controlled within a week, gravity of problem still remains because plague in Surat was an outcome of condition that epitomises state of public health system and nature of urban growth in India[3].

Borooah K. Vani (2004) in '*Inequality in Health Outcomes in India: The Role of Caste and Religion*' highlights social background, morbidity and health care in India. By analysing reports of NSSO 2004 on morbidity and

[3]Imrana Qadeer, Kasturi Sen and K. R. Nayar, Public Health and The Poverty of Reform: The South Asian Predicaments, Ed, Sage Publications, New Delhi, 2001, Pp 459-475

health care (M & CH) survey he finds that *Adivasis, Dalits* and OBC and non OBC Muslims have more mortality rate as well as poor health condition than forward Hindus. As compared to relatively forward states in backward regions or states rate is higher. He also highlights relationship between household condition, age at death and self addressed health status in India and religious and caste gradients are responsible for both cases. Moreover, he finds level of education of a person plays a significant role in receiving health care[4].

Kshatriya Gautama K. and Kapoor A. K. (2005) in *'Demographic Structure and Health Care Practices of Dhodia Tribal Population of Valsad District of Gujarat'* examine role of demographic structure, health care practices and health care providers in determining health status of Dhodia of Gujarat. Their study reveals that majority of Dhodia are literate, sources of earning of majority of them are government job, private job and farming and very few people are day labourer. Their standard of living is relatively good because very few people are having absolute poverty. In terms of health indicators like mortality, morbidity, nutrition and access to health care services Dhobia are in many cases more advance than national

[4]Sukhadeo Thorat and Katherine S. Newman, Blocked by Caste Economic Discrimination in Modern India, (Ed), Oxford University Press, New Delhi, 2010, Pp 179-207

standard. Though they still hold their tradition but modern system of medicine is preferred by majority of Dhobia[5].

K. R. Nayar (2007) in his monograph '*Social Exclusion, Caste and Health: A Review'* based on social determinant framework mentions poverty and social exclusion are important socio-economic variables which often taken for granted while considering ill health effect. Marginalisation of certain group or classes occurs in all societies particularly in third world countries. In India, caste can be considered as a proxy for socio-economic status. Scheduled Caste, Scheduled Tribes and poor Other Backward Caste (OBC) are disadvantageous groups living in adverse condition. By analysing secondary data based on National Family Health Survey in India he points out marginalised section such as Scheduled Caste, Scheduled Tribes and poor Other Backward Castes suffer from social gap in terms of health status and health services[6].

Soreng Victor (2007) in '*Health of Indigenous People/Tribe'* talks about health of tribes in India. To him, health status of tribal population shows

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[5]Ajit Kumar Dalal and Subha Ray, Social Dimensions of Health, Ed, Rawat Publications, Jaipur, 2009, Pp 107-131

[6]K.R. Nayar, 'Social Exclusion, Caste and Health: A Review based on social determinants framework, Indian Journal of Medical Research, Vol. 126, October 2007, Pp 355-363

negative feature in morbidity, mortality, poverty, illiteracy, malnutrition, lack of personal hygiene, unsanitary conditions, absence of health education, poor mother and child health services and poor coverage of national health programmes. Above reasons are responsible for poor health status of tribes in India. Some specific diseases such as sickle cell anaemia and G-6-PD deficiency are found in tribal hinterlands. Government of India has implemented specific health care programmes for tribal communities. But there are many tribal areas in India where tribal people still practice their traditional system of medicine[7].

Antony G.M .and Laxmaiah A. (2008) in 'Human Development, poverty, health and nutrition situation in India' mention that as per reports of UNDP on Human Development Index, India's value has increased during 1991 to 2001, but its rank has not improved much. Human Poverty index is still high due to high percentage of undernourished children. Rank of Human Poverty Index has come down from 59 in 1997 to 54 to 2004. They also mention that states with high incidence of human poverty in India are Bihar, Orissa, Madhya Pradesh and Rajasthan. They also mention that life expectancy at birth of men and women, toddler mortality rate, maternal

[7]Victor Soreng, Health of Indigenous People/Tribes, Vikash Vani Journal, Vol. 1 No. 4 October-December, 2007 Pp 71-76

mortality rate and birth rate are significantly different between States with high HDI than States with low HDI[8].

Behera B. K. (2009) in *'Gender, Health Status and Primitive Tribes'* highlights role of economy, education and culture in determining women's health status among Juang tribe in Keonjhar District of Orissa. To him, poverty, hunger, landlessness and illiteracy are major causes of ill health of Juang women[9].

Study on access to health care

Kakkar D. N. (1981) in *'Differential utilization of Health Care Services in Rural Rajasthan'* finds social inequality plays important role in utilisation of health services in Rajasthan. To him, there is little doubt regarding members of lower classes and Scheduled Castes remaining deficient not only in terms of possessing adequate knowledge about disease etiology but

[8]G.M.Antony and A. Laxmiah, Human Development, Poverty, Health and Nutrition Situation in India, Indian Journal of Medical Research, Vol. 128, August 2008, Pp 198-205

[9]Bijay Kumar Behera, Gender, Health Status and Primitive Tribes, B and B Publishers, Bhubaneswar, 2009, Pp 11-12

also about seeking therapeutic help in time and they are in disadvantageous position as compared to their counterpart higher castes[10].

Nayar K. R. (1998) in *'Politics of Decentralisation: Lesson from Kerala'* highlights health condition in context of decentralisation of health care in Kerala. To him decentralisation of health care delivery system in Kerala has improved health status of people in number of ways. Need based programs have made an epidemiological shift in health status of Kerala but there are gaps in identifying needs and conflict between authority and political leaders in implementing need based programs may make the program ineffective in future[11].

Rechel Boika and others (2009) in *'Access to Health Care for Roma Children in Central and Eastern Europe-Findings from a qualitative study in Bulgaria'* find complexity of health problem faced by Roma. To them, access to health care cannot be discussed in isolation, because people experience other problems like poverty, restricted access to education and social exclusion. Poor economic situation of Roma affects their ability to

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[10]D.N.Kakkar and others, Differential Utilisation of Health Services: A Study in Rajasthan, paper presented at Seminar on Dimensions of Rural-Development and change in North-Western Region with Particular preference to Hariyana, held at Haryana Agricultural University, Hissar on 17-19 Sept. 1981

[11]Imrana Qudeer, Kasturi Sen and K.R. Nayar, Public Health and The Poverty of Reform: The South Asian Predicament, (Ed), Sage Publication, New Delhi, 2001, Pp363-378

access to health care services. They cannot afford cost of travel, official co-payment for investigation and drugs. Jobless Roma parent cannot provide food, clothing and necessary medicines for their children. Access to emergency health services is a major problem for Roma due to long distance from emergency care centers, poor road condition and discriminatory attitude of medical professionals. Level of education among Roma population is low that creates difficulty. Language makes a communication barrier between doctors and Roma patients. Discriminatory attitude of health care providers interface with process of seeking and receiving health services. Some doctors do not want to enroll Roma patients on their register, as Roma are perceived having more health problems. Cultural factors also restrict Roma to seek proper medication in time and thus infant mortality among Roma is higher[12].

Bello R. A. (2005) in *'Determinants of Demand for Traditional Method of Health Care in Osan State: Nigeria'* finds traditional method of care obviously becomes a rational alternative to modern medicine to people of Osan State in Nigeria. Traditional health care in Africa includes a wide variety of practices carried out by herbalists, birth attendants, bonesetters

[12]Boika Rechel and others, Access to Health Care for Roma Children in Central and Eastern Europe-Findings from a qualitative study in Bulgaria, www.equityhealthj.com/content/8/1/24, accessed on 05.10.2010

and diviners within cultural setting of every ethnic group. There are basic sacred and secular beliefs which run through traditional health care and provide strong background for utilization of modern health care. Both systems of medicines co-exist equally and people use both systems inter-changeably as per demand of situation. His finding shows household size, severity of illness, religion, attendance by doctors, education and location are found to be more important to seek traditional health care[13].

Gangadharan K. (2007) in *'Morbidity and Health Care in Kerala: A distributional profile and implication'* finds that health status in Kerala is better than other Indian states still ails in health front exists in Kerala. Though Kerala shows better result in health indicators but at same time morbidity is high in both rural and urban Kerala. Increasing population, increase in use of fossil fuel, tobacco use, vehicle transport, increasing sedentary habit and aging are basic reason for increased respiratory infectious disease. Among chronic illness, cardio-vascular disease, cancer, hypertension, diabetes etc. are emerging as severe health problem of the

[13]R.A. Bello, Determinants of Demand for Traditional Method of Health Care Service In Osun State: Nigeria, Indian Journal of Social Development, Vol. 5 No. 2, December 2005, Pp 203-217

state. It becomes difficult task on part of government to provide health care to ever increasing in Kerala[14].

Majumder, Amlan (2006) makes an interdisciplinary study on health seeking pattern in North Bengal in terms of utilisation of health care. To him, pattern of utilisation of health care is affected by different socio-economic, demographic and other relevant factors in rural and urban areas of Cooch Behar, and Jalpaiguri district of North Bengal[15].

Kumar, Unnithan in *'Households, kinship and access to reproductive health care among rural Muslim women in Jaipur'* examines reproductive health care in context of women's perceptions and experiences of illness in general and in terms of material, ideological and political dynamics of households, kin and gender relations in particular. She shows how perception of illness and health seeking behaviour in a village in Rajasthan are interlinked with outreach of health service, hospital experiences, age of

[14]K. Gangadharan, Morbidity and Health Care in Kerala: A Distributional Profile and Implications, Indian Journal of Social Development, Vol. 7, No. 2, December, 2007, Pp 195-211

[15]Amlan Majumder, Utilisation of Health Care in North Bengal: A Study of Health Seeking Pattern in an Interdisciplinary Framework, Journal of Social Sciences, Vol. 13 (1), 2006, Pp 43-51

marriage, belief about allopathic, unani and spiritual medicines, household composition, economic, educational and working conditions[16].

Mishra, Manasee in *'Gendered Vulnerabilities: Women's Health and Access to Health care in India'* highlights vulnerability of women in India with respect to their health and access to health care. Women experience inferior health status and restricted access to health care in India. Women's health needs are numerous. Nutrition, morbidity, reproductive health, disability, mental health, occupational health is interrelated to gender differentiation. As women progress through life stages, unresolved health needs can have cumulative burdens on their health[17].

Neelima A and Reddy Sudarshan A (2009) in '*People's Perspectives on Health Care Services in Rural Andhra Pradesh*' highlight nature of access to health care system and utilisation of health care service in rural area of Andhra Pradesh. Their study reveal that majority of people in rural Andhra Pradesh have access to health care. They prefer allopathic medicine because of availability of doctor, medicine and facility of medical tests and quick response of medicine in curing disease. Though villagers have no

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[16]Unnithan Kumar Maya, Household, Kinship and Access to Reproductive Health Care Among Rural Muslim Women in Jaipur, Economic and Political Weekly, Vol. XXXIV No. 10-11, March 6 1999, Pp 621-630

[17]http://www.cehat.org/humanrights/mansee.pdf accessed on 10.05.2011

problem with allopathic medicine but in their own village there is no facility of getting treatment due to lack of government hospital. Whatever facility is available cannot serve their purpose because of unavailability of doctors, medical staffs and lack of medicines. People are mostly depended on registered medical practitioners (RMP) and private hospitals. Private hospitals are far away from their house and cost of treatment is not affordable to them[18].

Acharya, Sanghamitra S.(2010) in '*Access to Health Care and Patterns of Discrimination: A Study of Dalit Children in Selected Villages of Gujarat and Rajasthan*' finds caste as a unique determinant of discrimination in access and utilization of health care in villages of Gujarat and Rajasthan. He highlights discrimination made by health care providers like doctors, supporting staffs and village level health workers in providing health care to dalit children in villages of Gujarat and Rajasthan. She measures discrimination in different spheres of health care like home visit

[18]A Neelima and A Sudarshan Reddy, People's Perception on Health Care Services in Rural Andhra Pradesh, Social Change, June 2009, Vol. 39 No 2 Pp 257-269

by health workers, Practice of untouchability, providing health care information, dispensing medicines, diagnosis and medical tests[19].

Mukherjee Subrata and Levesque Jean-Frederic (2010) in their article '*Changing Inequalities in Utilisation of Patient Care in Rural India: Evidence from the NSS'* highlight utilization and level of inequality in health care in India from 1995-2004. To them, rate of inpatient care utilisation is substantially increasing in India and this increase is higher among poor than rich. Certain states of India like Bihar, Uttar Pradesh, Madhya Pradesh and Punjab show high level of poor rich gap in health care utilisation. Inequality in distribution of health care is more in the states which have little capacity to provide health care. Poor people have less access to health care[20].

Dasgupta Monica and Others (2010) in '*How India's Public Health Systems Might be strengthened? Lessons from Tamil Nadu'* highlight that central government's policies have inadvertently not given importance to environmental health and other preventive public health services in India

[19]Sanghmitra S. Acharya, Access to Health Care and Patterns of Discrimination: A Study of Dalit Children in Selected Villages of Gujarat and Rajasthan, Working Paper Series, Indian Institute of Dalit Studies and UNICEF, 2010, Pp 1-38

[20]Subrata Mukherjee and J.F.Levesque, Changing Inequalities in Utilisation of Inpatient Care in Rural India: Evidence From The NSS, Economic and Political Weekly, Vol. XLV No. 46, November 13, 2010, Pp 84-91

since 1950s. Because giving less importance to environmental health communicable diseases are spreading and causing more health problems. Decisions made by successive governments of India on public health and sanitation particularly amalgamation of public health with medical service has loosen importance of public health in India. However, Kerala has adopted a separate and independent strategy for public health and sanitation for which health problems related to unsanitary condition are less in Kerala[21].

Baru Rama, Acharya Arnab and Others (2010) in *'Inequalities in Access to Health Services in India: Caste, Class and Region'* highlight inequalities in access to health service particularly in preventive and curative health services. By analyzing data of National Family and Health Services, Central Bureau of Health Intelligence and other organizations they highlight that inequalities are found in availability of public health services in rural and urban areas and across states. Variations are found in terms of infrastructure, human resources, supplies, bed-population ratio and spatial distribution of health institutions. To them, inequalities are found in utilisation of preventive service such as childhood immunization and anti

[21]Monika Dasgupta and others, How Might India's Public Health System Be Strengthened? Lessons From Tamil Nadu, Economic and Political Weekly, Vol.XLV No.10, March 6, 2010 Pp 45-59

natal care and affordability of health services in context of region, caste and class[22].

Hussain, Zakir (2011) in '*Health of National Rural Health Mission*' critically evaluates progress of National Rural Health Mission in India. To him, despite of measures taken by government of India for providing health care to rural people through NRHM there are many deficiencies for which people are not getting proper care. NRHM has fallen far short of its target. There are deficiencies in physical infrastructure, shortage of equipment and medicine; deficiencies of manpower are still prevailing in many states of India. However, he views that within limited period this programme has succeeded in putting back issue of public health at top of government agenda. This programme has put pressure on state governments to divert resources to health sector, there by substantially strengthening public health system including its workforce[23].

Jakhar S. Jagbir and Siwach kumar Raj (2010) in '*Child Development through ICDS: An Analysis of Rural Health Issues in Haryana*' view that in

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[22]Rama Baru and others, Inequities in Access to Health Services in India: Caste, Class and Region, Economic and Political Weekly, Vol. XLV No. 38, September 18, 2010, Pp 49-57

[23]Jakir Husain, Health of National Rural Health Mission, Economic and Political Weekly, Vol. XLVI No. 4, January 22, 2011 Pp 53-60

Haryana integrated child development programme is implemented to improve child health throughout entire state. Workers engaged in grass root level in ICDS are performing their role properly in terms of providing food, health check-up, immunisation and referral service but due to shortage of medicines at PHC referral system is getting disturbed. Another problem is tendency of government to assign extra duties to AWW's to implement other developmental schemes make ICDS staffs overburdened and diverts their attention from their principal duty[24].

Study on culture and health in India

Marriot Mckim (1955) focuses upon western medicine in Kisshan Garhi village of northern India and finds that social and cultural problems are hindrance on path of introduction of western medicine in the village. He finds that villagers believe spiritual healers more than professional doctors because spiritual healer gains divine or spiritual power through deity which a professional doctor does not have. Thus his technical skill is less valuable to villagers[25].

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[24]Matthews C.M.E., Health and Culture in a South Indian Village, Sterling Publishers Pvt. Ltd, New Delhi, 1979, Pp 63-109

[25]Mckim Marriot, Western Medicine in a Village of Northern India, in B. D. Paul (ed), Health Culture and Community, Russell Sage Foundation, New York,1955, Pp 239-260

Carstairs, Morris G. (1955) in *'Medicine and Faith in Rural Rajasthan'* finds difference between opinion of medical professionals and villagers regarding causes of disease and illness. Difference of opinion between modern medical professionals and village folk regarding concept of disease and illness, technique of treatment and role of physician in treating a patient leads to misunderstanding between physicians and patients. She observes that sickness is much moral than physical crisis to people of rural Rajasthan. Because people perceive that illness is caused by human conducts. Therefore, relief of sickness requires rituals and reassurance. Because of difference of opinion as well cultural difference between doctors and patients it becomes difficult to introduce modern medicines to rural settings[26].

Matthews, C. M. E. (1979) study about health culture in a south Indian village finds that belief of villagers in that village regarding health is not simply a superstition but a part of system. People keep faith on indigenous system of medicine like Ayurveda, Siddha and Unani and have very little knowledge on allopathic medicines. Although some people use allopathic

[26]Madhu Nagla, Sociology of Medical Profession, Rawat Publication, Jaipur, 1997, Pp 101

medicine but they have strong faith on indigenous medicine and traditional healers[27].

Sahu, S. K. (1980) in ' *Health Culture of Oraons of Rourkella and its Hinterland in State of Orissa*' finds that Oraons living in remote villages no health institution and other Oraons living outside village particularly those who are living in steel plant of Rourkella have access to extensive network of health services. Oraons living outside villages are not rigidly holding their traditional belief on health and thus their health culture is different from that of Oraons living in villages. To him, different ecological, social, economic and occupational context determine nature of health culture of a community or society[28].

Nichter, Mark (1981) in '*Towards a Culturally Responsive Rural Health Care Delivery System in India'* suggests that practice of medicine is culturally responsive and medical professionals should be culturally trained so that they can communicate with patients within their conceptual framework. He also suggests maintaining good cooperation between practitioner of modern medicine and indigenous healer. Cooperation

[27]Ibid Pp 99
[28]S.K.Sahu, Health Culture of Oraons of Rourkella and its Hinterland, Unpublished Ph.D. Thesis, Punjab University, Chandigarh, 1980, Pp 15-119

between indigenous and modern medical practitioners depends upon sharing of knowledge and resources. Moreover, this cooperation will help them to understand basic cultural concepts of health and healing and thus mutual respect will ensure a good working environment and strengthen a network of rural referral system[29].

Kannuri, Nanda Kishore (1998) in '*Koya Perception of Health and Illness: An Ethnomedical Analysis*' highlights perception of Koya of Andhra Pradesh about health and illness. His study reveals that Koya perceive someone as ill if he or she is unable to perform regular duty. They do not consider some illness like skin ailments, dental problems and gynecological problems of women as illness because these diseases do not hamper their regular duty. To him, Koya classify illness into three categories viz. illness caused by humoral imbalance, injuries and animal bites. They believe that human body consists of five natural elements viz sky, fire, water, earth and air in a balance. This balance gets disturbed due to intake of certain food items. They also believe on supernatural causes of illness. They do not have modern concept of health and illness. Their

[29]Madhu Nagla, Sociology of Medical Profession, Rawat Publication, Jaipur, 1997, Pp 103

poverty, illiteracy and ignorance are responsible for such perception of health and illness[30].

Studies on nutrition and health in India

Narkhede Vinod et al (2012) in their study indicate high level of both chronic and acute malnutrition among Indian children particularly in urban slum area of Nagpur. They observed that highest level of morbidity among under five children is anemia. Protein energy mal nutrition was also prevalent among them. Moreover children were also suffering from vitamin deficiency and respiratory diseases. Mal nutrition induced diseases hampered growth of children in slum area of urban Nagpur[31].

Meherotra Monika, Arora Sontosh and Nagar Veenu (2011) in *'Nutritional Health Status of Primary School Children: A study in Bareilly District'* highlight mal nutrition of children studying in primary school in Bareilley district. They found children were suffering from protein and carbohydrade deficiency. Mal nutrition is severe in rural areas than urban area of the district[32].

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[30]Ajit Kumar Dalal and Subha Ray, Social Dimensions of Health, Ed, Rawat Publications, Jaipur, 2009, Pp 150-160

[31]Vinod Narkhede, Umesh Sinha and others, Morbidity profile in Under Five Children in Urban Slum Area of Nagpur, National Journal of Community Medicine, Vol.3, Issue 3, July-September 2012, Pp 442-446

[32]Monika Meherotra, Santosh Arora and Veenu Nagar, Nutritional Health Status of Primary School Children: A Study of Bareilly District, Indian Educational Review, Vol. 48, No.1, January 2011, Pp 18-29

Mitasree Mitra and others (2007) in their article 'Nutritional and Health Status of Gond and Kawar Tribal Pre-school Children of Chhattisgarh, India' highlight nutritional and health status of Gond and Kawar tribal pre-school children. Their study reveals that nutritional and health status of these tribal children is very poor. Nutrition is measured through weight for height, height for age and weight for age. They find that several micro and macro nutrients are not being taken by these children due to poor economic condition of their parents. Children are suffering from different grades of malnutrition and girl children are suffering from more malnutrition than boys. They also observe Illiteracy, lack of awareness and socio-cultural factors are responsible for malnutrition and ill health of these tribal children[33].

Significance of Study

Indeed health or health status of either a community or society is determined by multiplicity of factors. Though many of us may not subscribe to such an idea and react sharply on different dimensions; health study becomes imperative at present juncture of society since many people are caught and affected by diseases. Health of a community or society

[33]Mitashree Mitra and others, Nutritional and Health Status of Gond and Kawar Tribal Pre-school Children of Chhattisgarh India, Journal of Human Ecology, Vol. 21 (4), 2007, Pp 293-299

depends upon biological, environmental, geo-political, ecological, demographic and socio-cultural factors. Therefore, Health status varies across community and society. Patni community in Cachar district of Assam belongs to schedule caste category. Patni has long tradition of socio-economic, political and cultural backwardness (Risley 1891). Therefore, it is important to know health status of patni community of Cachar district who are residing in the remotest corner of India. In view of the above research question is **How Health Status of Patni Community is determined by society they live in?**

Major **objectives** of the study are as follows

i) To study indices of health status of Patni community in terms of mortality, morbidity, longevity, level of nutrition, body mass index (BMI) etc.

ii) To investigate how health status of Patni community is determined by their social status.

iii) To study access to health care of Patni community.

iv) To study culture and health of the Patni community.

Hypothesis of the study are as follows

(i) Health status of Patni community depends upon their socio-economic status.

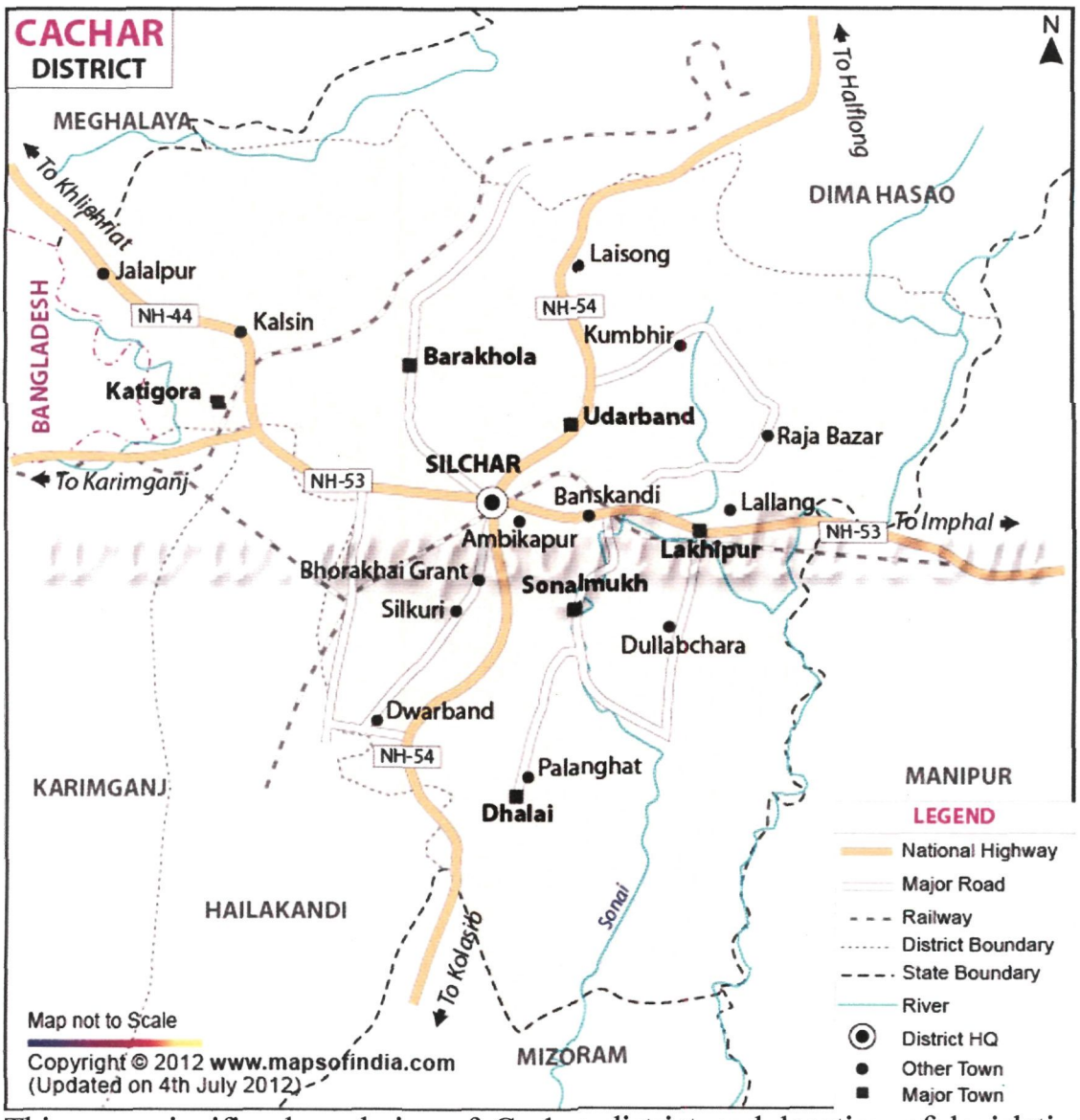
ii) Health status of Patni community depends upon access to health care system.

iii) Health of patni community is determined by their traditional belief and value.

Universe of Study

Study is undertaken in **Cachar District**. Cachar District is one of the oldest districts of Assam. District is created in 1830 after annexation of Cachari kingdom by British. It is located in the southernmost part of Assam on longitude of 92 degree 24second to 93 degree 15 second East and latitude of 24 degree 22 to 25 degree 8 second North. It is bounded on North by Barail and Jayantia hill ranges, on South by state of Mizoram and on East by two sister districts Karimganj and Hailakandi and neighbouring state of Bangladesh. Silchar is headquarter of Cachar district and the largest town in Barak valley. River Barak is the largest river of district which

contributes a lot to create fertile land of this valley. Total population of the District as per 2011 census report is 17,36,319 persons. Complete profile of population as per 2011 census is not available now. For purpose of study population profile of district is prepared on basis of 2001 census report which is given below. As per 2001 census report total population of Cachar district is 14,44,921 persons and 86.06% of total population live in rural areas. There are total 2,73,694 households in Cachar district out of which 2,34,326 rural and 39,368 urban households. Population density of district is 382 persons per square kilometer which exceeds state average of 340 persons per square kilometer. As per same census report Scheduled Caste constitutes 14.41 percent where as Scheduled Tribe constitutes only 1.29 percent of total population and around 41.39 percent of total rural population of district belong to religious minority of which Muslims are 97.77 percent.



This map signifies boundaries of Cachar district and location of legislative assembly constituencies viz Sonai, Dhalai, Katigora, Silchar, Barakhola from where Patni inhabited villages have been selected for conducting field work.

Table II.1

Population of Cachar District

Residence	Persons	Hindu	Muslim	Christian
Rural	1243534	728822	482685	29194
Urban	201387	157939	39366	2112
Total	**1444921**	**886761**	**522051**	**31306**

Source : Census of India, 2001

Above table II.1 shows that total population of Cachar district is 1444921. Out of which total urban population is 201387 and total rural population is 1243534. Hindu, Muslims and Christan people constitute majority of population of Cachar district.

Table II.2

Religious Distribution of Rural Population

Hindu	Muslim	Christi -an	Buddhi -st	Sikh	Jain	Other	Total
728822	482685	29194	653	468	158	1554	1243534
58.61%	38.82%	2.35%	0.05%	0.04%	0.01%	0.13%	100%

Source: Census of India, 2001

Above table II.2 shows rural population of Cachar district. It is observed from table that around 58.61% of total rural population is Hindu followed by 38.82% Muslims, 2.35% Christians and 0.23% others.

Table II.3

Decadal variation of Population

Place	1941-51	1951-61	1961-71	1971-91	1991-2001
Cachar	23.92	22.60	23.96	47.59	18.89
Assam	19.93	34.98	34.95	53.26	18.92

Source: Census of India, 2001

Table II.4

Caste wise Population Distribution of Cachar

Category	Number of People	Percentage
Scheduled Caste	208,235	14.4%
Scheduled Tribe	18,631	1.3%
General and OBC	1,218,055	84.3%
Total Population	**1,444,921**	**100%**

Source: Census of India, 2001

Table II. 3 shows decadal growth of population of Cachar district and it is observed that population of Cachar district grows on an average by 22.83% per decade. Decadal growth of Assam is little more than decadal growth of population of Cachar. Table II.4 shows caste wise distribution of population of Cachar district. It is observed that 84.3% of total population of district is constituted by General caste and Other Backward Caste category people followed by 14.4% Scheduled Caste and 1.3% Scheduled

Tribe population. However, individual population of general caste and Other Backward Class is not given in that report

Table II.5

Scheduled Caste Population in Cachar District

Sub-Caste	Number of people	Percentage
Patni	78,699	37.8%
Kaibarta	44,099	21.2%
Namasudra	39,823	19%
Others	45,614	22%
Total	**208,235**	**100%**

Source: District census handbook, Census of 1971, Cachar District

Table II.5 shows individual sub-caste wise distribution of scheduled caste population in Cachar district. It is found that out of 208,235 Scheduled Caste people of Cachar District Patni constitutes 37.8% followed by Kaibarta 21.2%, Namasudra 19% and 22% other Scheduled Caste people.

Table II.6

Patni population in Silchar Sub-division in 1971

Name of place	Total Population	Male	Female
Silchar subdivision	42,023	21,467	20,556
Katigora Police Station	11,015	5,712	5,303
Borkhola Police Station	2,294	1,147	1,147
Udarbond police station	242	129	113
Lakhipur police station	1,906	963	943
Silchar police station	13,676	6,995	6,681
Sonai police station	12,890	6,521	6,369

Source: Statistical Handbook, Assam, 2008

Since individual caste wise census was not conducted after 1971, therefore, profile of Patni in Cachar district is prepared by collecting data from field. Barak valley Patni Parishad, a social organization of Patni which looks after interest of patni in Barak valley, has provided data on population of Patni in Cachar district. An estimated population profile of Patni in Cachar district is prepared on basis of data provided by Barak Valley Patni Parishad. Population distribution of Patni as per 1971 census report in Silchar sub-division of undivided Cachar District is given in above table II.6. Patni population is found largest in Silchar police station followed by

Sonai, Katigora, Barakhola, Lakhipur and Udarbond police stations. It is found that total Patni population of the than Silchar sub-division was 42,023 persons. Under Silchar police station 13,676 Patni people were residing followed by 12,890 in Sonai police station, 11,115 in Katigora police station,2,294 in Barakhola police station, 1,906 in Lakhipur police station and only 242 people in Udarbond police station.

Table II.7

Estimated Patni population in Cachar District

Name of LA constituency	Patni population		Total
	Male	Female	
Silchar	5003	4905	9908
Dhalai	8640	7992	16632
Sonai	6407	6005	12412
Barakhola	6510	5955	12465
Katigora	10616	10089	20705
Lakhipur	2377	2210	4587
Udarband	1816	1690	3506
Total	**39346**	**37156**	**80215**

As per data collected from Barak Valley Patni Parishad, population distribution of Patni in Cachar District is shown in table II.7

From data collected from members of Barak Valley Patni Parishad and village Panchayat leaders of Patni dominated locality it is found that in Cachar district Patni are concentrated in more than 80 (eighty) villages and a good number of Patni are scattered in many other villages of the district. A small portion of Patni people are settled in Silchar town. Majority of Patni people are found in Dhalai, Sonai, Silchar, Katigora and Barakhola Legislative Assembly constituencies. As per data collected from Barak Valley Patni Parishad, Patni people are concentrated in following villages of Cachar District viz Devipur, Mahadevpur, Saptagram, Dhanipur, Ganganagar, Bhuvan Khal of Dhalai Assembly constituency. In Sonai assembly constituency Patni are concentrated in Tulagram, Kachudharam, and North Krishnapur.

In Katigora constituency Patni people are concentrated in Sadhirkal, Subodhnagar, Kandigram, Jabda, Seuti. In Silchar assembly constituency Patni people are concentrated in Rantibasti, Atalbasthi, Noaraj, and Silchar town. In Barakhola Assembly constituency Patnis are concentrated in Nich Jaynagar, Nayagram, Machughat, Salchapra. In Lakhipur Assembly constituency around ten to fifteen villages are there where Patnis are residing but their concentration in these villages is very less. Similarly in Udharband Legislative Assembly constituency Patnis are residing in few

villages. From table II.7 it is found that total estimated patni population of Cachar district is 80215 out of which there are 39346 males amd 37156 females.

Table II.8

Distribution of sample households

Name of Locality/Village	Number of sample Households
Ganganagar and Devipur	50
Tulagram and Kachudaram	50
Subodnagar, Seuti and Jabda	75
Nij Jaynagar and Machughat	50
Rangtibasti	25
Silchar Town	50
Total	**300**

The study has taken into account 300 sample households. Out of which 250 samples households have been taken from ten selected villages of cachar district and 50 sample households have been selected from silchar town. These ten villages are Ganganagar and Devipur of Dhalai L.A.constituency, Tulagram and Kachudaram of Sonai L.A.constituency, Subodnagar, Seuti and Jabda from Katigora L.A. constituency, Nij Jaynagar and Machughat from Barakhola L.A. constituency and Rangtibasti village and Silchar town from Silchar constituency.

Table II.9

Economic Profile of Sample Household

Monthly Income	Number of Respondents	Percentage
Up to Rs. 2000	177	59%
Rs. 2001-4000	42	14%
Rs. 4001-6000	18	6%
Rs. 6001-8000	15	5%
Rs. 8001-10000	18	6%
Above Rs. 10000	30	10%
Total	**300**	**100%**

Table II.9 shows that monthly income of 73% of respondent households is less than or equal to Rs 4000. Monthly income of 17% sample households ranges from Rs 6001 to 10,000 and only 10% of sample households' monthly income is above Rs 10,000.

Table II.10

Occupational profile of sample households

Occupational Category	Number of Households	Percentage
Day Labourer	150	50%
Small Farmer	60	20%
Mediocre Farmer	34	11.4%
Govt. Job Holders	26	8.6%
Private Job Holders	30	10%
Total	**300**	**100%**

It is observed from table that 50% of respondents are day labourers. Followed by 20% respondents as small farmers, 11.4% respondents are mediocre farmers. Around 8.6% respondents are engaged in government jobs, 10% respondents are engaged in private sector.

Table II.11

Educational profile of members of Households

Level of Education	No. of Persons	Percentage
Illiterate	195	10.60%
Upto Primary School	430	23.40%
Upto High School	458	24.90%
High School Passed	336	18.30%
Higher Secondary Passed	168	9.10%
Graduation not completed	101	5.40%
Graduation Completed	94	5.10%
Post Graduate	38	2.10%
Professional Degree	17	0.90%
Total	**1837**	**100%**

From above table it is observed that 10.60% people of respondent households are illiterate. Around 23.40% people attained education upto primary school followed by 24.90% high school, 18.30% H.S.L.C. passed. Around 9.10% people have passed H.S. School leaving certificate. Around 5.40% could not complete graduation but 5.10% people are graduate. Around 2.10% people are postgraduate and 0.90 % completed professional studies.

SAMPLING AND DATA COLLECTION

The study follows both exploratory and descriptive Research Design. Data is collected from primary and secondary sources. Secondary data about Patni population is collected from census report, books, journals, news papers and official reports of mission director NRHM Cachar District, Directorate of Economice and Statistics Cachar, records maintained by land revenue department government of Assam and voters list. Primary data is collected through **participant observation, interview guide and case study**. The study depends upon **ethnographic account**. Intensive fieldwork is done in selected Patni inhabited villages or localities in Cachar District. **Universe of sample** is Cachar district of Barak valley and **unit of sample** is villages where Patni exclusively live. Total sample size was taken initially more than three hundred. But subsequently due to ethnographic study and nature of fieldwork it was decided not to take more than three hundred sample size. Since Patni is a homogeneous community in terms of religion, language, occupation, income and education three hundred samples properly represent entire universe. However, in selecting samples randomly each and every household of selected villages or localities is given an equal opportunity of being selected. A list of household is prepared from voters list of different Legislative Assembly

constituencies of Cachar District from where sample households are randomly selected. Each selected locality or villages contain on an average 300 households. Out of three hundred households of each selected village 25 households have been randomly selected as sample. From ten selected localities of Cachar District 250 sample households have been selected. Another 50 sample households have been selected from Silchar town where around six hundred Patni households are existing. Since Patni are more concentrated in five legislative Assembly constituencies of Cachar District, therefore, from each of five constituencies two villages have been randomly selected for data collection. From Silchar legislative Assembly constituency 25 households have been selected from Rangtibasti village and another 50 households from silchar town. From Dhalai Legislative Assembly Constituency 50 sample households have been selected from two villages Ganganagar and Devipur. In Sonai Assembly Constituency 50 sample households have been selected from two villages Tulagram and Kochudaram. In Barakhola Assembly Constituency 50 sample households have been selected from Nij Jaynagar and Machughat villages. In Katigora Assembly Constituency 75 sample households have been selected from three villages Seuti, Jabda and Subodhnagar. Reason for selecting one more

village in this constituency is that it contributes more number of Patni villages than other constituencies.

Finally data collected from different sources are tabulated and presented in tables in thesis. I also **conducted Interview** of ANMs, ASHA workers and Anganwari workers of concerned villages. Folk healers to whom Patni people seek treatment are interviewed for purpose of study. Intensive fieldwork is done by maintaining field work dairy. Study is ethnographic in nature. Therefore, participant observation by maintaining a field work dairy is suitable method for collection of data from field. Electronic devices like camera, tape recorder etc. are also used during field work. Weight machines and a measuring tape are also used to measure weight and height of members of respondent households.

Table II.12

Field Work Summary

Name of LA constituency	Period of field work	Name of Villages/Town	No of days
Silchar	June-Dec 2010	Rengtibasti, Silchar town	88
Katigora	Jan- June 2011	Seuti, Jabda, Subodnagar	82
Barakhola	July-Dec 2011	Nij Jaynagar, Machughat	56
Sonai	Jan-Apr 2012	Tulagram, Kachudaram	58
Dhalai	May-Aug 2012	Ganganagar, Devipur	60
Total	**26 months**	**Ten villages and a town**	**344**

I started field work in the month of June 2010 in Rangtibasti village. Month of June is very crucial for me because I was completely free to concentrate on field work. I worked in field throughout entire month and I finished data collection of Rangtibasti village in the month of August 2010. In September 2010 I could not concentrate in field properly. I started to work in Silchar town in the month of October 2010. I concentrated fully in field and finished fifty percent field work of Silchar town within this month and rest I finished in November and December of 2010. In January 2011 I started to work in Seuti village of Katigora constituency and I finished it by end of February. Subsequently I finished field work in Subodnagar and Jabda of Katigora constituency by the end of June 2011. From July to

December 2011 I worked in villages Nij Jaynagar and Machughat under Borkhola Assembly constituency. I started field work in Sonai Assembly constituency in January 2012 and I finished by April 2012. I started in Dholai Assembly constituency in the month of May 2012 and I finished entire field work by 16th of August 2012. Total three hundred forty four days I worked in field from June 2010 to16th August 2012. Subsequently data are analysed and tabulated to prepare report of study.

FIELD WORK EXPERIENCE

In conducting intensive study in the field I faced difficulty initially but later on I become familiar to respondents in the field. I was mentally prepared to overcome all odd situations which I faced in field. Every day I used to contact my supervisor from field and he continuously guided me to tackle adverse situations. In fact data collection is never smooth and easy task. I faced multiple difficulties during field work in some villages. To visit one village, I went several times. I used to stay in some of villages for collection of data. I started field work from July 2010. In beginning of field work I felt little nervousness but gradually I managed it. My first respondent is 65 years old Dilip Narayan from Rangtibasti village. I felt ease in conducting field work in this village because some persons of this

locality are known to me. I convinced Mr. Dilip Narayan to spend some of his valuable time for me and briefly narrated him purpose of my visit. After listening my purpose he took a deep breath and asked me what I want to know from him about his family and his community. He provided me all data which I wanted to collect from him. In the first day of my field work I got help of a primary school teacher of this village. During the course of time I felt field work particularly in area of health and illness is really a difficult and troublesome task. People always tried to divert my attention to their personal problems which I had to handle carefully. Being eye witness of several pathetic events and for my empathetic response to those events I could not console and control my emotion which hampered smooth field work for short periods of time. Without describing some of these incidents and events during field work I feel my work will be incomplete. During my stay in a village there occurred an incidence of death of a mother around 34 years old. The patient had been suffering from leukemia (blood cancer) as per doctor's diagnosis. After fighting with disease for a longer period of time one day patient died. Dead body was brought in house from hospital. When massage of death was spread village I just came back from field work to the house where I used to stay. House owner informed me news of his neighbour's death and requested me to finish my launch because no

other person was present in house to serve me and he supposed to join in funeral to that house. Considering my loneliness in house I sought permission from house owner to accompany him in funeral. He laughed and then agreed to take me. When people were busy with ritual formalities to take the body to grave yard I noticed behind the house one lady was carrying a girl child of around four to five years old holding two pieces of biscuits in her hand. Lady was talking something to the girl and roaming here and there behind the house. I had been observing the matter very carefully. From enquiry I came to know that girl was deceased women's only daughter who was kept ignorant about her mother's death. During stay of her mother in hospital girl was asking and enquiring several times about her mother. I looked the girl closely. Her appearance showed she was perhaps deeply suspecting about entire happenings of that evening in her house. She was very much silent and deeply thoughtful and her face appeared pale. I felt very bad looking that girl. Next day morning again I went to their house and asked that lady about girl's reaction. The lady replied that at mid night all of a sudden the girl awaked and asked again and again about her mother but she was not crying. Next day morning also I found the girl silent and thoughtful. Being eye witness of the incident I got mentally disturbed and I decided that day to study maternal mortality

and aftermath in future. In field a researcher may find similar kind of incidents which are really pathetic if these are thought seriously. Several such incidents I faced but I had to console myself for sake of finishing my field work objectively.

Conclusion: Study is methodologically designed to make it more scientific. In every step of study scientific method is applied and used with a view to reach objectively at accurate findings.