Health, Households and Women's Lives
A Study of Illness and Childbearing Among Women in Nasik District, Maharashtra

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1. Introduction

It is the convention to narrate stories of everyday lives of women in health studies, but here their stories also serve as a reminder of the complex world they live in. This study attempts to convert vital information on their health into numbers, while simultaneously focussing on the complexity of their problems.

Shamabai, 40, is a Thakur tribal living in a remote village with three young daughters. Reaching the village means a four kilometre walk up a steep hill. No wonder, they call that hill 'Crying face'. Since there is no work for agricultural labourers in the village, they must travel to nearby villages to work in the four-month rice cultivation season. Shama's husband worked as a temporary worker in the railways. When he was critically ill, a year ago, helped by his colleagues, she took him all the way to Mumbai for treatment. For a brief while, Shamabai who had barely travelled ten kilometres from her home was catapulted into a complex and bizarre world of modern medicine and bureaucracy. Despite the treatment, her husband died. She still does not know what the ailment was. Now, she is back in her village that has no electricity, no water and no work. However, her brief stay in the city has changed her subtly. She speaks broken Marathi, she can imagine what city life is like and *she is now aware of how medical care can spare the people of her village pain and suffering.*

Godavari has greyed, having seen more of the world than most women would have, as wife of a former police patil. Freed from usual social restraints, in old age, she travelled across half the taluka with our research team. Her family lives in a small isolated outhouse in their fields. When she gets lonely, she hoists her grandson on her hip and walks the half kilometre to the main village with ease. A month after we first met her, she and her entire family were in a frenzy to pack in the rice crop before another unseasonal shower. She has turned dark in the sun and a little frail from the overwork and disturbed mealtimes. *She uses a little of the massage oil that she has brought for her husband for her own legs. She discounts the occasional aches and pains.*

Isabel lives in a shack on a pavement in Nashik. Her two elder daughters have been sent away to Mumbai to work as domestic maids. Isabel's husband does not always come home at night. When he does, he wants money and vents his frustration on his wife. After a long day at work, Isabel is often too tired to walk around the boundary wall and prefers to jump her way home. She had done it hundreds of times before her pregnancy but *this time she slipped and fell. She lost the child, but with Christmas approaching soon, she has no time to grieve or rest.*

Tarabai's life is by no means wasted. With one son doing very well in Nashik and the other two busy farming, she has no financial worries. Her house is the largest and best in the village. If only her husband's health would improve. She displays a sheaf of medical records she has collected in the last 14 years as he lay completely bed-ridden. He even has to be carried to the toilet. He seems to have lost the will to recover. *With her husband in such a state, no one seems to have noticed Tarabai sinking into a quiet depression of her own.*

Zubaida is an aanganwadi worker. She seemed lucky to live in a village so close to Igatpuri town to get LPG for cooking. It made her work at the crèche so much easier. One day, the pressure cooker burst in her face. As the only person in the village, who is paid a government 'salary' (meagre as it may be), entertaining all official visitors is solely

her responsibility. We too were directed to her. *Even this serious accident did not relieve her from this duty.* Too badly burnt to wear a blouse, she spoke to us from behind a curtain. In spite of the pain, she sat up and tried to talk to us, till a woman panchayat member relieved her.

Kanchan has a fairly comfortable life. She lives in an independent bungalow in one of Nashik's most prosperous areas. Apart from his small business in the town, her husband earns a good income from agriculture in their village. After seven years of marriage, she is getting desperate about having children. They went all the way to Baroda in search for a cure for her 'infertility'. *All the cures have been tried on her and have failed. And yet her husband has never thought of going through any treatment himself.*

Gauri, 17, is mentally retarded. Her left hand is paralysed and she moves with difficulty. *Only once, she was taken to the PHC, when she had malaria. She was taken by S.T bus, she fell down and nearly got run over.* She can barely talk. However, she has learnt to protect herself from the children who tease her by throwing stones at them. She spends her entire day picking reeds and flowers near her house. Her family has no land - not even a steady home. They migrate to any place where they can find work. There is only one man in the family, fifteen year old Dattu. He does all the chores that his sister would have otherwise done. During the agricultural season, he and his mother migrate for work to the more prosperous villages that grow grapes and ground nut. Gauri stays behind in the care of her old grand mother, who fends for them both by tending to someone else's cow. When the cow bears a calf, they earn a fairly decent sum. But the old woman must drag herself and Gauri to the market to sell it…

THESE STORIES are among the most dramatic but almost all women share fairly similar experiences. The stories provide pointers and direction to our analysis. For example, we were struck by the fluidity in the boundaries of women's family and work lives. We witnessed that women were not only dependent on the family's resources, but were also instrumental in generating them. There was no co-relation in the authority that women enjoyed and the care they took of themselves. Autonomy and responsibility seemed to make them more, rather than less, vulnerable to neglect themselves. The poverty of a household influenced women differently from others. Similarly, the poverty of entire villages and settlements made women's lives more difficult. We made an attempt to understand the multiple layers of the social life that women inhabit. The recognition that women live and struggle in this hierarchical, inequitable society forms the basis of this study.

The objectives of the study

Primarily the objective was to study the health problems of women in rural and urban areas of Nashik district; the kind of health care they get, if at all; how much

money is spent on this care; and to understand differences in all these on the basis of gender, age and other social factors.

Review of past household studies

WITH EVERY study, our understanding of the inter linkages between socio-economic, political and environmental factors with health is deepened. Studying ill health in a community by conducting household surveys of perceived morbidity has become an important part of health research in India. Notably, in the past decade, four attempts have been made to conduct country-wide studies by the National Sample Survey (1986-87, 1995-96) and National Council for Applied Economic Research (NCAER) (1990, 1993) to study morbidity, health care utilisation and expenditure through the use of household surveys. Apart from these, numerous small-scale studies have been conducted using the same methodology. The most significant among those include studies conducted in Jalgaon (FRCH, 1986-87), Madhya Pradesh (FRCH, 1990) and Kerala (KSSP, 1987).

The study conducted in Jalgaon, Maharashtra (Duggal and Amin, 1989) was a pioneering effort aimed at documenting household strategies of healthcare. The under-five population and the elderly population had the highest morbidity. The rural sample had a morbidity prevalence rate of 154.66 in comparison to the urban rate of 141.85. There was also an unexpected pattern of morbidity in relation to consumption expenditure class, in that the class that used more health care reported more morbidity. Infections, including fevers constituted the largest category of illness accounting for 32.6 of the total episodes. About ten per cent of the illnesses were not treated while as much as 77 per cent of the health facilities utilised were in the private sector. Health care cost was marginally higher in rural than in urban areas.

The 42nd round of the National Sample Survey (NSS, 1992) on morbidity and utilisation of medical services was conducted in 1986-87. Nationally, 81.5 per cent of the ailments in rural areas were treated while urban areas recorded a rate of 89 per cent. Private doctor as a source of treatment was preferred by 51.83 per cent nationally. A similar percent was recorded for Maharashtra. The average total expenditure per treatment was Rs. 84.93 (Rs 86.59 in Maharashtra)in rural areas and Rs. 91.30 (Rs 136.55 in Maharashtra) in urban areas.

The Kerala Sastra Sahitya Parishad (Kannan, 1991) conducted a household survey in rural Kerala to record mortality, morbidity and utilisation of health care. It recorded an unprecedented rate of morbidity and a particularly high prevalence of chronic illness. Morbidity was highest among children under five years and persons aged over 50 years. The prevalence of acute and chronic illnesses among women was marginally higher as compared to men. The KSSP study also found high utilisation of private health services and considerable use of self-care which accounted for 12 percent of health services utilised. The per capita cost of treatment was Rs. 16.56 with 50 per cent spent on medicines and fees accounting for 18 percent.

The NCAER conducted a household survey of medical care in 371 districts of the country covering 18,102 households (NCAER, 1992). The survey was conducted in May-July 1990. Overall rural morbidity was recorded as higher than urban morbidity. As this survey recorded only treated illnesses, there was a substantial difference in the

prevalence rates for male and female adults and children. In Maharashtra, the morbidity in urban areas was recorded as being lower than the national average. The rural morbidity prevalence rate was also lower in Maharashtra. Fevers were recorded as being the most prevalent illness in both rural and urban households. The cost per treated episode was recorded higher in the rural areas than in urban areas.

In the same year, a micro study was conducted by F.R.C.H in Sagar and Morena districts of Madhya Pradesh (George et al, 1994). The study recorded a monthly morbidity prevalence of 310.78 per thousand persons. The rate of prevalence differed for rural and urban households and for acute and chronic illness. The rural rates of prevalence were 156.53 per thousand and 132.32 per thousand for acute and chronic illnesses respectively while the rates were 179.07 and 121.06 respectively in urban areas. For women, morbidity was significantly higher after the age of 25 years and increased with age. As high as 69 per cent of treatment facilities were in the private sector with no significant rural-urban difference. The cost per illness episode was Rs. 134.23 with doctors' fees and medicines accounting for large portions of the costs. The expenditure on traditional practitioners was much higher in the case of females as compared to males. However, overall expenditure on males and females did not differ much.

In the summer of 1993, NCAER conducted another national household survey on health care utilisation and expenditure (Sundar R., 1995). The monthly prevalence of morbidity was 106.7 episodes per thousand for the rural areas and 103.0 per thousand persons for the urban areas with no significant difference in male and female morbidity. The study reported very high morbidity for the aged population though. In Maharashtra, the rate of illness among rural women was much lower than the all-India average. Similarly, urban women in Maharashtra showed a lower rate of morbidity. Nationally, the use of private practitioners was marginally higher in urban areas. Private facilities were used more in Maharashtra than the all-India average. The expenditure per non-hospitalised episode in the rural areas was recorded as Rs. 90.48, the equivalent figure in the urban sample being 113.93. The figures for Maharashtra were higher, being Rs. 90.71 and Rs. 136.93 per episode for rural and urban areas respectively. While the expenditure on health care in rural Maharashtra was similar to the all-India average, in urban Maharashtra, the expenditure was marginally higher.

The most recent large-scale household health survey was conducted by NSS in the 52^{nd} round in 1995-96. It recorded a monthly prevalence rate of 86 episodes per thousand for the rural areas (male-84, female-89) and a rate of 84 per thousand for the urban areas (male-81, female-89). Tuberculosis was found to be the most prevalent chronic illness. The survey reported that 83 per cent of those reporting illness were given treatment in the rural areas while the figure was 91 per cent for urban areas. There was no significant difference among males and females in this respect. The use of health care was more firmly based in the private sector, which accounted for 81 percent of all sources of non-hospitalised health care. Public hospitals accounted for only 11 percent of the total facilities used for non hospitalised care. In Maharashtra less than 32 per cent of both rural and urban hospitalised cases were recorded in the public sector. The average total expenditure per episode for non-hospitalised cases was Rs. 144 in rural areas and Rs. 175 in urban areas. The expenditure on females was lower, being Rs. 137 and Rs. 164 per episode in rural and urban areas respectively.

GENERALLY, we find that the household surveys show a marginally higher morbidity for females than males. Morbidity tends to be higher also among young children and the aged. The prevalence rates have risen gradually over the ten years between 1986 and 1996. The use of health care is higher among males than females in most of the studies, although there is only a slight difference. The use of private health care has been consistently high over the decade, especially in case of non-hospitalised care while non-use of health care is largely because illnesses are not considered serious enough for treatment, although financial problems and non-availability of medical facilities are also important reasons. The expenditure on health care incurred by households has shown a rise in the decade 1986-96, as can be expected due to rising inflation and the continued use of private health care. Significantly, **most of the studies have shown no remarkable gender difference in morbidity utilisation and expenditure on health care. This may be due to the fact that the above studies have not analysed information specifically in relation to women's health.**

The contribution of this study

LARGELY, those studies which recorded age-sex distribution of morbidity, showed that adult women reported higher morbidity than girls. However, no study had attempted to systematically document the nature of the additional illnesses suffered by women after they reached puberty. An important aspect of women's health is the strain put on their bodies by reproduction and the resultant short-term and life-long health problems. Apart from being responsible to meet the partner's sexual needs and reproduction, women must undertake all the tasks that are necessary for the sustaining their households. *How burdensome this role becomes depends on many factors such as the socio-economic condition of the village/settlement, larger social factors, resources available to the household, the expected number of children she must bear and raise, the number of dependants and the sexual and age-wise division of work within and outside the household.*

We attempted to use the household survey to explore the totality of women's health problems in relation to the varied aspects of their lives.

The utilisation of health care is related to many factors, such as the visibility of the health problems, the availability and access to health care facilities and the control and use of resources within households. Most household surveys have indicated only a marginal difference in the utilisation of health services by men and women. However, **the micro studies done on women's health (especially gynaecological morbidity) have noted that a large proportion of these problems remained unattended.** Importantly, when utilisation of services is low due to poverty and no access to health care, perception of morbidity itself is lowered. Also, women are conditioned into accepting certain health problems as part of life and are unlikely even to expect treatment for them. An important aspect of women's lives relates to childbearing. Childbearing is, in itself, an important health event and has a lasting impact on women's bodies and their perception of well being. The phase of maternity and the use of contraception are, often, the only times, when women come in contact with the medical system and experiences hospitalisation.

It is now widely accepted that much of the health expenditure in India is met directly by households from their own resources. Household per capita expenditure on health is about three to four times higher than the state per capita expenditure on health. In 1993,

the government revenue expenditure was Rs. 70.2 per capita (based on the Health Information of India, Ministry of Health and Family Welfare, Government of India).

However, the gender differentials in household spending on health have never been studied in detail. It is usually found in household surveys, that expenditure on hospitalisation for women during childbirth forms a significant proportion of the total health expenditure made on them. However, expenditure on treatment of non-maternity related health problems is clearly inadequate. **It is worthwhile to evaluate the level of discrimination faced by women with regard to expenditure on health care vis-à-vis the resources available to the household. A study of the maternity events provides insight into women's experience of health and the response of the household to one of the most important health needs of women.**

Also, there is dynamism in society, which is reflected in the shift in perception of ill health (increase in the morbidity prevalence rate), in the pattern of utilisation, (higher use of health care, more dependence on private sector) and in the increased health expenditure (due to increased utilisation, rising prices and greater use of private care). By using this modified methodology, we attempted to explore these relationships.

2. Study Design and Methodology

An important aspect of this study, as stated earlier, is the use of a modified methodology to elicit more information on the specific health problems of women. The design of this study used both quantitative and qualitative methods. A major component of the study was a household survey of morbidity, utilisation and expenditure. In addition to this, we also conducted in-depth interviews with individual women and key informants. This report presents only the findings of the survey of the households. However, the analysis also draws on the valuable insights and convictions that we developed during the qualitative inquiry.

The social distance between the researcher and participant has a great influence on such studies. In addition to that, conventional methodology is inherently biased against marginalised groups. For e.g., the use of standard language and scientific terms alienates a large number of people who have had little or no access to formal education (women, tribals). Nor are these groups accustomed to structuring their experiences in a manner that is intelligible to the urban educated researcher. No study can hope to transcend this distance completely. We believed that conventional methodologies do not do justice to the manner in which, especially women express themselves.

Though it is inevitable that researchers using their own sensibility interpret the responses of the participants, we attempted to structure the women's narratives as little as possible. It became necessary for us at every stage to grapple with the problems of translating unstructured narratives into standardised data. The challenge before us was to use a standard methodology like the health survey and, at the same time, subject it to a critique from the perspective of gender. The aim was not merely to generate information on the households' experience of health and health care, but also explore the extent to which such a methodology can address issues concerning women's health.

Sampling design

The size of the sample was fixed at 1200 households. This number seemed sufficiently large to enable collection of adequate data on illness as well as maternity events and contraception. The decision to select three fourths of the households from the rural sample and one fourth from the urban sample was arbitrary.

The decision to select Nashik district for the study was based on the fact that it is an average-developed district where the socio-economic and demographic profile is not very different from that of the rest of the state. We used the Centre for Monitoring Indian Economy (CMIE) development index as a reference for this selection. (Table 2.1). Within the selected district, we decided to select one taluka, which has a sizeable tribal as well as non-tribal population. Igatpuri taluka was, therefore, selected for the rural sample as it has a sizeable tribal population (48 per cent). Another reason for selecting the taluka was the presence of the organisation VACHAN which has done extensive work, albeit only in the north-eastern tribal belt. It was felt that selecting a taluka with a sizeable tribal population would allow us to better understand the disparities in health within rural society and also understand the specific social and cultural factors that affect health care seeking and perception of illness.

The urban sample was selected from Nashik City and suburbs, as the urban population in Igatpuri taluka was not very large. We also found that Igatpuri town, the only urban centre in Igatpuri taluka, has a very large migrant population and is, thus, not very typical of urban centres in Maharashtra. On the other hand, Nashik offered us more variation in socio-cultural profile and a wider range of health facilities in both the public and private sectors.

Selection of the sample

The selection of the villages was done using three criteria, size of the village, presence or absence of public health facilities and the proportion of tribal population. Although the villages are clustered on the map (Annexure 4), we took care to include villages with a range of different social, cultural and physical environments. We referred to the 1991 census to ascertain the size of the village, existing public health facilities and the proportion of tribal population. We decided to select every third house in villages having less than 300 households and every fourth house in the larger villages. We continued to select villages till the sample size of 800 households was reached. However, on visiting the villages, we found discrepancies in the census data.

Having recently concluded a survey for below poverty line households, most panchayats had their own list of households. We found that households had greatly increased in the five years following the collection of the census information. Another complicating factor was the presence of ‘new villages’. These were enumerated separately in the census reports. However, we included them in the survey as part of the panchayat villages from which these ‘new villages’ were being separated. On actual mapping, we found that the number of households were smaller than those quoted by the panchayats. We relied on our own enumeration for selection of the households. Voluntary action can substantially

influence the economy and also the health behaviour in a concentrated area. Hence, only two villages were selected from the project area of VACHAN.

It was decided to use socio-economic class as the criterion for selecting the urban households. The type of settlement was taken as the single indicator of socio-economic status. Hence, we decided to select 60 percent of the households from slum settlements, while the rest were distributed among apartments and bungalows. The slum clusters were also selected with the help of VACHAN, which had only recently initiated developmental work with women living in slum pockets in the suburban area of Nashik. In addition, a centrally located slum, Ganjmal Shramik Nagar was also selected with the help of UBSP (Urban Basic Services Programme), a programme of the Nashik Municipal Corporation and UNICEF. We found that the slum clusters were well demarcated and fairly small. Thus, we enumerated the entire slum settlements and selected every 2nd household in the smaller clusters and the 3rd household in the larger slum cluster.

For the non-slum households, it was decided to interview households living in flats in Radhaswami Nagar, a middle class area, peopled largely by professional and self-employed persons. Another cluster selected was Shivaji Nagar and its adjoining area; an elite locality consisting of privately owned independent houses. In these clusters, it was not possible to do enumeration. Thus, we contacted each and every household in the selected colonies/ housing societies and selected those who were willing to participate in the survey.

Collection of data

Actual fieldwork was conducted in three phases between September 1996 and December 1996. While we covered the rural households in the first two phases, the urban households were interviewed in the third phase.

We employed 16 investigators for data collection in the rural area and eight in Nashik city. They were all women between 18 and 30 years. Their educational qualification varied, ranging from high school to post graduation. However, the average investigator was matriculate with a year of college education. Seven of the 16 investigators were married women. Of them, six had one or more children. All of them were residing either in Nashik or Mumbai. All except one investigator had spent their childhood and youth in the city. For a majority of the investigators, this was their first experience in doing a survey. Very few, in fact, had done any kind of paid work earlier. The mother tongue of all the investigators was Marathi and they all possessed good ability to read and write that language. The majority of the investigators were Hindu, while a few were Neo-Buddhist.

Initially, there was a period of intensive training of the investigators, (explained below), which was followed by the actual survey. The survey of the rural households was conducted first. The fieldwork in the rural areas was completed in two phases of three and two week duration each. In the pre data collection phase, the researchers visited the selected villages, established contact with the local leaders and women in the community. We also conducted key informant interviews with women and men in the villages. This initial visit was also used to fix the time and date of the survey. Usually, there was a gap of three or four days between the first visit by the researchers and the

arrival of the research team. This time was sufficient for information to spread by word of mouth that such a survey was being planned. In almost all villages, we also held a public meeting for women in the balwadi, samaj mandir or temple to give information about the study, its objectives, the date and the process involved (mapping, sampling, and interview).

This process continued simultaneously with data collection. Thus, while the survey was going on in one village, the researchers would establish contact in the next village. Often, women from one village would have natal homes in the next sampled village. This network of relationships was very useful in reaching out directly to women and households without the mediation of the established leadership (panchayat, health workers, and police patil).

During the entire duration of the survey, we resided in Nashik and commuted to the villages. The villages varied in distance and were difficult to access. In some villages, which had no motorable road, we were required to travel on foot. Two such villages were located on hilltops, involving a climb of one to two hours. On the other hand, some villages were located on the main road at a very short distance from Nashik. However, we took care to cover all the wadis of the village and to follow the entire sampling procedure described above. Each and every respondent met the investigators at least twice -while mapping and during the interview.

As the survey was conducted in the period following the rice-sowing season, in most villages, women were relatively free. They were away from their houses only for a short period for weeding. Most women returned home from work by noon. When informed of the time and date of the survey, women, in fact, stayed at home specifically for the interview. Most interviews were conducted at home. However, in the second phase, where the selected villages had a high proportion of irrigated farming, it was not possible to meet women during the daytime. The work schedule of the women in these villages was different. They worked in the fields from early morning till late evening with a short lunch break at noon. In these villages, fieldwork was done in the early hours of the morning and late evenings and night.

The arrival of the entire research team always evoked a lot of interest in the villages. However, as we had already met the women in the village and informed them about the survey, there was less apprehension and suspicion. The research team would then divide into three or four groups and commence the work of mapping the households in one section/lane/wadi of the village. In some cases, impromptu meetings were again held for small groups of women who wanted to know about the study and the research team. The research investigators did mapping of the villages themselves. Care was taken to ascertain how many households resided in one physical structure (having same house, but different kitchens). Mapping was a process that enabled us to directly interact with each and every woman in the village. This was the time when a pamphlet describing the study, its objectives, information about the organisation and commitment to confidentiality and the rights of the respondents was handed over to the household and explained.

Based on our enumeration of the households, we decided the sample size for that particular village. Generally, a team of two investigators conducted the interview, one asking the questions and the other writing the responses. However, after some weeks, some investigators conducted the interviews alone. The respondent was any woman

above twelve years of age who was a member of that household. In the rural areas, it was not uncommon for this respondent to be quickly joined by other women from the household and occasionally men as well. The interviewers made note of all the individuals who participated in the interview. The questions in the probe list (explained later) which were directed to all women above 12 years of age were, ideally, to be asked in a place that offered privacy. The men were asked to move away from the group so that the women could answer this part of the interview in privacy. However, each woman could seldom be interviewed privately. Mostly, women answered these questions in a group. In cases where some women were not present at the interview, the main respondent answered for all the other women in the household.

On average, each interview took an hour and a half. This included the time spent by the investigators in introducing themselves and the study. The pamphlet described earlier was read out and given to the respondent. The name, age, educational qualification and marital status of each household member were elicited first. This was filled by asking the number of children for all ever-married women and pregnancy /delivery /abortion and contraception use for all currently married women. This was followed by questions on illness in the past one month suffered by all the household members. After recording the symptoms in brief for these episodes, additional illnesses were probed for all women above 12 years in the household. This was followed by recording detailed information on all the episodes reported by each person. Lastly, information on occupation, assets, income, infrastructure and residence were recorded.

Admittedly, all the actual interviews did not follow exactly in the manner outlined above. Quite often, respondents narrated histories of past illnesses, bereavements, family problems etc. Women spoke about losing husband or children, fights with relatives over property, the apathy of in laws or married children, the problems related to work and livelihood, about childbirth in the past, the experience of family planning, surgeries, accidents and serious illnesses. We had anticipated such incidents and our investigators had been trained to listen to these narratives patiently and also to discern what information was relevant for the interview (within reference month, pertaining only to household members) and what was to be recorded as remarks. Often, respondents asked us for advice and health tips. We were shown case papers and medical reports. Children with minor infections were brought forth for inspection. We handed out notes of referral or told them about available facilities. We also advised them as best as we could. Although this information was not strictly relevant for the study, occasionally, it allowed an investigator to follow up information, which was left out by the respondent while answering the interview schedule.

The conduct of field work in the urban area followed exactly the same process. The only difference being that public meetings were often substituted by house-to-house contact. In the apartments and bungalows, a specific date and time for the interview had to be fixed. In the slum households, we encountered many locked houses because it was the festival season and entire families had gone back to their villages for harvesting. This is the reason why all the 400 urban households, which were sampled could not be interviewed.

The interview schedule (Annexure 2)

The survey was conducted using an interview schedule to record all information on the socio economic profile of the household, morbidity, use of health care and expenditure on health care. In addition to this, information on maternity events and contraception for all women in the household was also recorded.

Some of the categories used were as follows:

The household: The household referred to all individuals who shared a common cooking fire. Information on all individuals who had lived in the household in the previous year was recorded.

Reference period: The reference period for recording all episodes of ill health in the households was one month prior to the date of the interview. These included problems starting prior to the reference period and continuing in the reference period, those starting and ending in/ continuing through in the reference period. For maternity events and contraception, the reference period was one year prior to the interview. The reference period was fixed as one month based on the experience of earlier research studies.

Duration of illness: The duration of illness was recorded as the total duration of the problem as well as the number of days for which the problems afflicted the person in the reference month.

Health care: Health care (upchaar) referred to all actions that were deliberately taken to influence the health problem that had been recorded. This included all aspects of self-care, self-medication, ritual and other practices and the use of all kinds of health care providers, both formal and informal. 'No treatment' consequently, means any situation where none of the above was taken recourse to.

Expenditure: This included all types of payment for goods and services, in cash and in kind, which were made in the reference period.

In this report, some terms, which have been used, need to be explained.

'Women', unless otherwise specified, refers to all female members residing in the household. 'Earners' refers to all individuals who are engaged in wage labour, salaried job, self employed or participate in home based production, including cultivation. 'Non workers' are those who are recorded as not participating even in household work. 'House-workers' are those engaged solely in unpaid household work required for the survival for the household, but not understood as economic production (cooking, cleaning, childcare, and collection of fuel and water). 'Ever married' single women include widows, deserted and divorced women.

'Socio-economic status/class' is not a very precise category. However, it is an occupation-based category used to measure the relative economic status of the household. 'Class' has always been a problematic category to define, especially, for rural households when calculated without an accurate measurement of land and output. However, we chose to use this category in order to understand the effect of income disparity on morbidity and health care utilisation.

'Morbidity' in this study refers to perceived illness, which is any feeling of pain, discomfort, abnormality, which can be perceived and articulated as physical or psychological symptoms by the respondent. It is illness that is not to be equated with disease, which can be identified and classified by the clinician.

Modifications in the methodology

Although not specified in the reports of the studies reviewed in the previous chapter, the favoured respondent is the head of the household. Morbidity is recorded in the form of episodes of acute illness and continuing chronic ailments. Generally, probing is not resorted to. However, as women were the focus of this study, we adopted specific measures to make the study more gender sensitive.

The exclusive use of women respondents and women interviewers. The entire field research team was comprised women. Surprisingly, we found that age and marital status of the investigator was not as significant factors as their self-confidence and the empathy that they developed with the respondent women. The ability to answer questions about the study, tact in questioning and sensitivity in dealing with disturbing information and unforeseen events (such as opposition from male members or aged persons to young women responding to the interview schedule, the presence of a seriously ill person in the household at the time of the interview, a recent death etc.), were key to the investigator's effectiveness. It was imperative for all investigators to be knowledgeable about health and health care, which was achieved through training. In their training, the most important components were imparting to them knowledge about the body and a perspective with which to approach women's problems.

1. ***Use of a probe list (a list of 14 questions probing specific symptoms) to elicit more information on women's health.*** After recording illnesses reported for all the members of the household by the respondent, a list of symptoms was used to probe for illness among women above 11 years of age. (Annexure 3) It contained elements of both general and reproductive health. The 'Pain during intercourse' and 'problems with using contraception' were the two symptoms to be probed only for among married and cohabiting women. The use of the probe list was not rigid. Investigators asked these questions in the order they preferred. There was also no check on whether all the questions in the probe list had been asked. Quite certainly, questions relating to intercourse and R.T.I s were not asked uniformly to all women due to lack of privacy.

2. ***Intensive training of investigators to make them sensitive to women's health problems and the difficulties that women have in articulating these.*** As stated earlier, we found that the most important part of training was imparting knowledge and perspective to the field team. The training programme emphasised three aspects. First, an introduction to the study, some basic inputs on the research methodology of the study, a complete understanding of the interview schedule, its contents and the method of administering it. Second the knowledge of physiological processes (such as menstruation, childbirth and menopause) and reproductive health problems and contraception, an introduction to a gender perspective to health issues. And the last, basic information of the geographical area, the economy of the villages, customs, language and the status of women in this society. Apart from the formal training programme, considerable training took place from interaction at work.

3. ***Establishing good rapport with the women in the community by holding community meetings and repeated contact with them before commencing the survey.*** The approach adopted in this study was not politically neutral. It was declared, at the outset, that the objective of the study was to highlight women's health problems because they get neglected due to various social and economic reasons. The fact that women are talking to women was stressed. Prior to the survey, we approached women in the villages and slums through participatory organisations such as mahila mandals and women's savings groups or through small meetings in lanes and settlements. A considerable amount of time was spent in ensuring that women understood the objectives of the study and the relevance of it. We also ensured that we had reached out to all sections of the village/settlements. Thus, in most large villages, where social boundaries were quite definite, we held separate meetings for the dalit settlements and the groups of migrant labourers. As our investigators had already contacted women in their homes, the motivation for women to come to a meeting was higher. We also found out if a section of village's women had stayed away from the meeting and then tried to probe whether there were any undercurrents in the politics of the village that we should be aware of. It was evident that in a meeting, women felt much more emboldened to ask questions and express doubts than when we approached them individually in their homes. It is certain that they felt security in numbers. The fact that the entire survey was being conducted publicly and we were willing to face women in a group also served to establish trust in us. Before each interview, our interviewers read out a pamphlet explaining the objectives of the study, the purpose for the collection of information and the rights of the respondents

Due to the methodology used, we were able to record a significantly higher burden of morbidity and information on non-treatment among women. All the modifications that were made must be viewed in totality. It is not possible for us to estimate the effect of any single factor on the reporting of women's morbidity. The idea was to create an environment that encouraged women to feel free speak about their health problems, even while a deliberate attempt was being made to elicit information about unreported illness through the probe list. This impressed on us the need to be sensitive to women's own perceptions about their health problems. Purely medical or even sociological categories of illness prove inadequate to record the complexity of illness perceived by women. Although this fact has been stressed in almost all the qualitative micro-studies on women's health, an attempt was made here to integrate these insights into a quantitative study.

Methodological issues

Studies on women's health have used a wide range of methodologies – behavioural studies, conventional surveys, family planning or child health studies. Few studies have focussed on the entire range of health issues concerning women and with the household women as respondents. In household health surveys, women's issues and concerns remained invisible. Women were neither the focus nor respondents of these studies. It was assumed that the knowledge gleaned from these inquiries was relevant equally to both men and women. However, as more attention is given to the continuing disparity between the sexes in the living standards and opportunities available for survival and

development, it is clear that the reality of women's lives differs substantially from that of men. Consequently, inequity in health care can hardly be ignored.

In practice, we find that women feel intimidated by the structure of the survey because a majority of women respondents cannot read what is being written about them. Also, we found that surveys were associated with government agencies, which exercise considerable control over people's lives (in terms of assigning 'below poverty line' status or recording land ownership etc.). Nonetheless, we felt that the survey design was the best suited methodology for this study, because there was a need to study variations in the health care situation of a considerably large number of households spread over a large geographical area.

1. One of the most significant issues that this study raises for us is the understanding of reporting of illness. Much of the analysis hinges on this crucial factor. We could find no precedent for the pattern of illness reporting that we found in our study. It forces us to enter into the long-standing debate about the reliability of reported morbidity. It is accepted that 'disease' and 'illness' are different phenomena. Inherent in our classification of health problems as either disease or illness, are certain judgements about severity and importance. Expectedly, the judgements made by experts and the community itself differ. From the perspective of the expert, those health problems which result more often in death or disability, and those which spread quickly among the population are more important. From the point of view of the community, it may be those problems, which severely diminish the quality of life, which are more important. Thus, while maternal mortality may not figure large in the total mortality statistics among women, the impact that a maternal death has on a community is tremendous. The first deaths to be spontaneously recalled in a community survey are maternal deaths.

2. Traditionally, the measurement of ill health and disease in India has been done using data on mortality. However, if we attempt to use data on morbidity, we find the experience of ill health is mediated by various players. The cultural means to experience and articulate bodily experience are pre determined for all of us. It is difficult to set down objective standards to measure and evaluate this experience. Thus, we are compelled to reflect and evolve some explanation for the profile of ill health that we encountered. There are certain universal problems related to the method of collecting data and the coding process. As these problems are not unique to our study, they need wider discussion.

   2.1 The use of a probe list to probe unreported illnesses among women above 12 years had a very dramatic overall effect on the morbidity rates. However, we do find that there is a distinct pattern. The objective of this study is to document all of women's health problems, not just those related to the reproductive system. And the focus of the study included all women, even adolescent girls and women past the reproductive age. The participant of the study was to be **any** woman who had sufficient information about the household. Nonetheless, we observed a bias on the part of the investigators to select currently married and cohabiting women within the age group of 25-55 years as respondents. The increase in morbidity is most significant for women in this age group. (Table 2.4) Thus, we find a significant co relation between the percentage of women who are main respondents and the probed morbidity rate of that age group. Although as the large majority of the respondents are in the reproductive and productive age,

they, for social and biological reasons, should also logically report higher morbidity.

One of the most important methodological issues is the definition of an episode of illness. We find that individuals have reported upto six episodes of illness as occurring in a single month. The problem is what basis must be used for describing an episode. For e.g., if time is taken as the deciding factor, then can two unrelated illnesses (pain during menstruation and an injury) running concurrently be regarded as one episode of illness. On the other hand, if we look for a causal link to define an episode, we must depend on the perception of the women to define the episode. For e.g. does **she** feel that her backache is related to the white discharge (or it could be related to the work that she does.) In actuality, a combination of both these comes into play. This seems to suggest that when we probe for specific complaints, the same illness may be reported as two or more different illnesses. The problem of defining an episode is compounded in our study due to the use of the probe list. A large number of complaints for women are noted on the basis of the list of symptoms. There is considerable subjectivity on the part of the respondent as well as the investigator in combining the complaints into episodes of illness.

At the stage of coding, we took care to incorporate as much detail as possible. Hence, for each episode (called 'aajar') we coded upto three symptoms, upto two perceived causes of illness, the duration of the entire illness and of the duration of suffering in the reference period and the link to any life event, if reported. On the basis of this information, we proceeded to rationalise the construction of episodes for each individual who reported multiple episodes. In spite of this, we find that due to the use of probing, women have reported multiple episodes in greater proportion than men have. (Table 2.5) In addition, we find that for men, 1.39 symptoms are recorded per episode. For women, this figure is 1.49 for unprobed episodes and 1.36 for probed episodes (Table 2.6). Multiple episodes in our study must not be seen to reflect automatically a high quantum of morbidity, but it must be seen as an indicator of the multifaceted nature of women's health problems. We were also constrained in our analysis by the fact that not much attention has been paid to the issue of episode construction in other studies.

3. A related methodological issue was ascertaining the duration of illness. Given the chronic and unrelenting nature of illness among women that we noted, the duration of illness that was reported was in approximate years, in many cases. Even in cases of complaints such as fever or diarrhoea, the duration was reported to be as long as two months. This may have been the result of multiple episodes of the same illness recurring in quick succession or merely an articulation of the prolonged suffering endured by the individual. However, although instructed in all cases, to record the exact date of the start and end of the illness, our investigators often did not probe enough to record the exact duration of the illness. Thus, the data on duration of illness is not very accurate. We have used duration of illness as a variable of analysis selectively. This was done merely to compare the general duration of different types of illnesses and the difference in the treatment of short and long-term illnesses.

4. Another methodological problem that resurfaces in all studies, especially with women respondents is the reporting of information on assets, income and land holding. When we also asked for information on income and assets, we suddenly transgressed the boundaries of our domain. When the study was declared to be on

health, the validity of asking such questions itself was questioned. In the tribal areas, knowledge about ownership of land, quantum of produce etc. among women as well as men was very limited. Besides information that women were able to provide on these aspects was very difficult to standardise. Their measures for land and produce were not those officially used. For example, *avne*, the most widely used term for describing the quantity of land is not a standard measure and cannot be converted into (e.g.) acres. As most rural households had joint incomes from agriculture and traditional crafts, it was impossible to determine the earning status of individual members. We took care to record all economic activity, especially, information on main and subsidiary occupations of each member, so that we did not miss out the unpaid work done by women in their homes and fields. Finally, we decided to rely on the data on occupation, which was most complete, for determining the socio-economic status of the household.

5. Similarly, the problem of recording components of cost in health expenditure. As women are not necessarily participants in the process of purchasing health care, their knowledge of details of health expenditure was poor. In most cases, they were able to report only the combined cost incurred on the use of that particular facility. This was particularly true of their reporting of expenditure when they were not present. However, women are more deeply involved in the management of household finances than acknowledged. Also, there is a strong reason to believe that an event such as health facility utilisation and concomitant expenditure would be discussed in the household. Thus, we find that a complete no response for expenditure is very rare. Given the nature of our health care services, we do find that a single provider (in most cases, a private practitioner) provides medical consultation, medicines as well as conducts other procedures such as suturing and administration of injections, saline.

The ethics of survey research

At the outset, there were many questions facing the research team. The decision of going into a community where we had no roots and no presence was made with many misgivings. Research done by professionals raises many specific ethical issues. This organisation pursues research as an end, not as a means to some other goal. When we declared that this survey was not a precursor to any health programme or scheme, it was but natural that some of the participants should lose interest in the study. However, we ourselves began to ponder on issues related to the act of research. The area that we had selected to study had been witness to innumerable surveys, government sponsored and others, in the past. As with these surveys, it was expected that we would “collect all this information, disappear and do nothing.” We reasoned about the need to generate knowledge and information about problems that remain unnoticed or ignored because they concern only marginalised groups. Talking about these problems and acknowledging them was like making a beginning in the long process of change.

Ethical issues in the study

1. Having involved women in the study, the problems of actually making space for them in debates on health became evident. Women spoke about themselves because we were able to articulate what they really experienced in their lives and houses. We,

however, were not obliged to speak about ourselves. All our efforts to maintain transparency about our organisation and our objectives, to seek informed consent, and to give information and help when it was sought were entirely voluntary. There is no system of accountability for such studies. Communities and individuals can exert no control over researchers apart from refusing to participate in the study. They may receive assurances about the sincerity and good intentions with which the information collected will be utilised. However, given the complex process by which knowledge is generated and disseminated, it is difficult even to ascertain where this information has gone and how it has been transformed.

2. Most conventional methodologies position themselves as gender neutral. There is ostensibly no bias towards any sex. The interview schedule, where information is pre-classified into columns and cards is the standard research tool used in health expenditure surveys. Anticipating some of the problems of restricting participants to selecting options pre determined by the researchers, most of the questions in this schedule were open ended. However, it is interesting to note how such a tool is received and transformed in the hands of women investigators and women participants. Our investigators had been instructed to record all additional information as remarks, including their own impressions and experience. The remarkable number and the degree of detail and variety of the 'remarks' convinces us that the survey methodology, in some way, negates women's experience and mode of expression. Many feminist researchers have emphasised that women use different narrative structures and ways of expressions than men. They abhor standard categories. When asked to narrate what happened when someone was ill or was having a child, women could not, or would not, structure their narrative according to the flow of questions in the interview schedule. The flow of their narratives was self determined including whatever they thought was relevant and interesting. Seldom did our respondents restrict themselves to one illness episode or event or to one member of the family at a time. The more involved they felt in the interview, the more complex and intertwined their narratives became. Initially, our investigators were frustrated with the task of reordering this unbroken flow of information according to the sequence of questions. Even after they had mastered this, they continued to write long detailed notes at the back of the questionnaire. Women consistently spoke about much more than what was being investigated, the investigators reciprocated by recording all this information, out of conviction that this information was as relevant as what had been recorded in the columns of the schedule. The dilemma for us has become to integrate this varied and dispersed information into our analysis.

3. Very little has been written about the emotional aspects of quantitative research. During our training, we emphasised the need to develop sensitivity and intimacy. Women responded not merely by answering our questions, but by telling us about their lives and all their problems. We found ourselves listening to life histories and even offering solace and advice. At the end of every day, when a meeting was held to take stock of the work accomplished and the problems encountered, the team members spent hours relating what various women had told them and what they had experienced themselves. The short intense relationships that were established during fieldwork were, in many ways, very distressing. We felt a sense of helplessness that arose from the realisation that not only could we offer very little help to the woman, but that the relationship itself was not long enough to be emotionally satisfying. All that could be achieved was that we learnt to reflect on what we had heard and seen.

The experience of the study made us more aware of the pressures that all women must face in their lives. Just as we aimed to study the effect that gender identities has on the lives of women whom we interviewed, we became more aware of that effect on researchers themselves. We have endeavoured to articulate the problems that we faced in the study in order to create a context in which to view the findings of this study as well as to initiate a discussion on the ethics and politics of research.

Table 2.1: District-wise relative index of development

	MAHARASHTRA STATE
DISTRICTS	**RELATIVE INDEX OF DEVELOPMENT**
Mumbai	704
Pune	157
Thane	128
Nagpur	109
Kolhapur	104
Wardha	99
Raigarh	88
Sangli	87
Solapur, Aurangabad, Jalgaon	85
Satara	83
Nashik	**81**
Ahmadnagar	79
Amravati	74
Bhandara	73
Dhule, Chandrapur	72
Sindhudurg	68
Parbahani	67
Akola, Jalna	65
Gadchiroli	64
Osmanabad	62
Buldhana	59
Beed	55
Nanded	53
Latur, Ratnagiri	51

Source - 'Economic Intelligence Service', Published by Centre for Monitoring Indian Economy Pvt. Ltd., November 1993.

The weightage pattern adopted to develop Relative Index of Development is as follows :

1. *Agricultural sector — 35% (per capita value of output of crops - 25% + per capita bank credit to agriculture - 10%)*
2. *Mining & manufacturing sector — 25%*
3. *Mining , manufacturing non-household & household workers per lakh of population-15%*
4. *Per capita bank credit to industry — 10%*
5. *Service sector — 40% (Per capita bank deposit - 15% + per capita bank credit to Services - 15% + literacy - 4% + urbanisation - 6%)*

Table 2.2: Comparison of the profile of the study sample on specific indicators with state and district block

	Census of India 1991				Our Study	
	Maharashtra		taluka	Igatpuri	Nashik	
	Rural	Urban	Rural	Urban aggl	Rural	Urban
S.C population	11.47	10.50	7.51	13.12	9.54	29.15
S.T population	13.24	2.99	48.44	6.76	47.80	19.30
Sex ratio	972	875	977	891	993	968
(0-6 Years) sex ratio	953	934	987	931	905	988
Literacy rate	55.52	79.21	42.8	81.61	52.23	70.52
Male literacy rate	69.75	86.41	59.91	87.78	67.13	81.49
Female literacy rate	40.96	70.87	25.34	73.28	37.53	59.00
Workforce partici. rate	46.06	33.11	50.88	31.15	50.54	38.28
Male W.P rate	53.2	50.6	52.66	48.73	53.04	50.26
Female W.P rate	46.1	11.4	49.08	11.40	48.01	25.91

Source: Census of India, Series 14, Part II – B (i); Government of India; 1991

Table 2.3: Comparison of Vital Statistics for the state, district and taluka

	Igatpuri*	Nashik*	Maharashtra^		
			Total	Rural	Urban
Crude Birth Rate	29.23	24.77	25.2	27.1	22.8
Infant Mortality Rate	115.4	50.50	50.0	63.0	32.0
Crude Death Rate	8.64	8.10	7.3	9.3	4.8

** District Health Officer; Nashik District; (Nashik and Igatpuri, figures are for the year 1994)*

^ Sample Registration Survey; registrar general of India; Ministry of Home Affairs; Govt. Of India; (Maharashtra figures are for the year 1993) Source: Database on Health: CEHAT.

Foot Notes*: CBR: Crude Birth Rate., (per 1000 population), IMR: Infant Mortality Rate (per 1000 live births) CDR: Crude Death Rate, (per 1000 population)*

Table 2.4: The percentage of women who were main respondents in each age group and the probed morbidity rate in that age group

Age group of women	Probed episodes per 1000 women	Main respondents (%age)	Number of women
12 – 17 years	179	8.7	413
18 – 25 years	535	40.7	619
26 – 35 years	908	74.45	509
36 – 45 years	870	68.28	331
46 – 55 years	892	66.02	259
56 years and above	791	40.6	234
No Response	500	33.3	78
Total	**408**	**48.5**	**2443**

Table 2.5 Number of episodes reported by each individual by sex

Number of episodes	Male		Female	
	No	**%**	**No**	**%**
0	2516	69.3	1769	49.4
1	1036	28.5	1101	30.7
2	74	2.0	415	11.6
3	4	.1	223	6.2
4	1	.0	57	1.6
5			14	.4
6			2	.1
	3631		**3581**	

Table 2.6 Number of symptoms reported for each episode by sex and use of probing

	Male		Female (without probe)		Female (with probing)	
No. of symptoms per episode	**No. of Episodes**	**%**	**No. of Episodes**	**%**	**No. of Episodes**	**%**
1 symptom	820	68.3	813	62.6	1141	70.8
2 symptoms	288	24.0	329	25.3	358	22.2
3 symptoms	92	7.7	156	12.0	112	7.0
Mean no. of symptoms	1.39	-	1.49		1.36	
Total episodes	**1200**	**100**	**1298**		**1611**	

3. Socio Economic Profile

To understand health care issues in a changing society, it is necessary to provide a perspective and backdrop against which the gathered information can be studied. Morbidity and health care seeking behaviour of a people is more fully understood against their social background. This chapter gives that overview with emphasis on the quality of life of a household and of the women living in it.

The political economy in which households are situated is complex and dynamic. So, the conventional concept of rural and urban, though necessary, is not entirely satisfactory. The interaction of these two has led to the formation of an entirely different kind of relationship. For e.g. migration (both seasonal and perennial) lent a new dimension to the concepts of economic status, occupation and poverty. This necessitates questioning many categories that are often used to understand such societies (e.g. rural / underdeveloped / traditional v\s urban / developed / modern).

The taluka and the city

In all, we interviewed members of 827 rural and 366 urban households. The rural sample was drawn entirely from rural Igatpuri taluka and the urban sample was drawn from Nashik city and suburbs. The villages and urban settlements from which they were drawn were diverse in terms of topography, culture, economy and politics.

Igatpuri taluka (rural) is spread over an area of 1006.97 sq. km. In 1991, there were 26,999 occupied residential households and a total population of 1,63,677 persons. There were 132 villages recorded in the taluka in the 1991 census. The bulk of the workforce was engaged in cultivation, while the second largest occupational category was of agricultural labourers. In actual numbers, women greatly exceeded men in this category - the numbers being 10617 and 6957 respectively.

Nashik (urban agglomeration) in which all the urban settlements were located, was spread over 321.94 sq. km. It had a population of 725,341 persons. There were 1,42,377 occupied. The majority of the main workers in this area were engaged in manufacturing, processing and services (27.9). 'Other services' like public utility services, government employees and professional services, trade or labour organisations recreational services etc accounted for a similar proportion of the main workers (27.5).

Migration was an important factor as Nashik district has 13.10 lakh migrants or 43.77 percent of the total population. Females predominate in intra-district migration while males predominate in inter district, inter state and inter national migration. The bulk of the intra-state migration in Nashik district was from rural to rural, while 17.72 percent were from rural to urban and 11.86 percent were from urban to urban. Of the total internal migrants (within Maharashtra) 29.57 percent were enumerated in the urban areas, while 70.43 were enumerated in the rural areas. Understandably, migrants from outside Maharashtra were concentrated in the urban areas (74.80 percent).

An attempt was made to make this sample as representative as possible. When compared with data on the taluka, city and the state, we find marked similarities as well as significant differences. (Table 2.2, 2.3)

As tribal / non tribal population of the village was one of the factors considered while sampling, when compared with Igatpuri taluka - rural (Census data 1991), there is a similar proportion of tribal population in the rural sample. The proportion of scheduled caste population in the sample is marginally higher. As in the urban areas, type of settlement was the criterion for sampling, there are differences in the profile of the sampled households and that of the entire city. The S.C and S.T population in our urban sample is more than twice as large, proportionally, than in the entire Nashik city (Urban aggl.) (Census, 1991). We assumed that these two groups represent the most deprived sections of urban society, and therefore, **this study has a proportionately greater representation from the lowest socio-economic class.**

An analysis of indicators of gender inequality reveals interesting trends. (Table 2.2) The sex ratio in both rural and urban areas is higher than that recorded in the census. This may be explained by the fact that all-male households were excluded from the study. However, the sex ratio among children below seven years reveals fewer girl children in the rural households of our study but a much more equitable child sex ratio in the urban households. The rate of literacy also reveals significant differences. The rural rates of literacy are closer to the statistics obtained for the entire state, but significantly higher than those for Igatpuri taluka. Conversely, the literacy rates for the urban sample are lower than both the state and Nashik urban agglomeration. This is further indication of the fact that the urban sample has a higher representation of households of the lower socio-economic class. The fact that the female workforce participation rate in our sample is more than twice as high as that of Nashik urban agglomeration also points towards this fact.

The settlements

An important factor to be considered in the analysis of women's conditions of life is the physical environment of their households. In rural areas where villages are dispersed, physical access is an important factor in the study of health care. Thus, we decided to categorise rural households in terms of the accessibility but defining physical access was a fairly complicated exercise. Various aspects had to be taken into consideration: the existence of a road, its condition, distance to the nearest bus stop and the frequency of public and private transport available. Accessibility was measured in relation to the nearest small town/ large village, which had an in-patient public health facility. The condition of the road also varied according to the season. Thus, easily accessible villages became less so after a shower and others could get completely cut off during the monsoon. Also, villages were not a single concentrated mass of houses but dispersed settlements; accessibility varied households situated in the main village and for those located on the slopes in the wadis. (Table 3.2)

The physical organisation of rural and urban settlements is not random, but has social and political underpinnings. There is a distinct pattern in the social composition of each type of settlements. (Table 3.1). Upper caste households are concentrated in the settlements with easy access as are the scheduled caste households. All the Muslim

and Christian households are in the easily accessible settlements. The Mahadev Koli households also similarly located. On the other hand, nearly one third of the Thakur and Katkari households are located in remote settlements and more than half are in settlements where access is difficult. There is a high co-relation between access and socio-economic status (explained later).

Most significant is the impact of physical access on perception of ill health and use of health care. Isolation from health facilities, educational institutions and markets reduces interaction with the 'mainstream' which is primarily responsible for increasing perception and articulation of health problems. The fact, that remote villages are usually poor add to the barriers to perception and reporting of illness. This fact - of low physical access compounded with low socio-economic status, also makes utilisation of health care difficult.

The aspect of physical isolation for women has special significance as it affects health care use not only in morbidity but also in childbirth. Ante-natal and post natal care is dispensed with due to the high monetary and time cost involved in accessing it. Reduction in mobility due to pregnancy and especially during childbirth can have very severe consequences for women's health care opportunities. Women in obstructed labour have to be carried in slings to the nearest road or health centre, a walk, which may take hours. During fieldwork in a remote village, we observed a woman being driven around the village in a bullock cart in the hope that the jerks would hasten labour. In a village with better access, this woman may have received some kind of medical attention.

In the urban sample, 66 per cent of the households lived in slums while 20 per cent lived in flats and 14 per cent in independent bungalows. In Nashik City, there was a clear demarcation of the clusters. The slums were a concentrated mass of dwellings having distinct boundaries and a great deal of homogenity both in the quality of structures and standard of living. On the other hand the households living in the bungalows though considerably above subsistence level were not all equally prosperous. There was a considerable variation in the size, condition and standard of the houses.

Of the urban sample, the scheduled caste, Muslim and Christian households were almost entirely located in the slums. The upper caste Hindu households were concentrated in buildings and bungalows. Although, in the urban areas, physical access to health services is not difficult, access may still be severely limited for slum households, where lack of education and finances impedes accessibility to health care severely.

The households in the study

There were 6.05 persons per household. The average family size in the rural and urban households varied. While it was 6.4 persons per household in the rural areas, it was 5.2 persons per household in the urban areas.

The rural households were very well established, with 87 per cent of them reporting that this was their original village (khurd gaon) or that they had been living here 'since long' (purvi paasun).

In contrast, 45 per cent of the urban households had been settled in Nashik for 15 years or less. This is also reflected in the responses received to the question about the households' 'own village.' **While 67 per cent of the urban households considered themselves migrants, 92 per cent of the rural households were living in the village of their origin or were old settlers.** Usually, migrant families had few fixed assets, a poor social network and a more unstable economic condition.

Assets

Possession of assets indicates the standard of living attained by a household. While 27 per cent of the households had a television set, 33 per cent had a radio and merely 6.4 per cent owned a refrigerator. A comparison of rural and urban households reveals that 24 per cent of the rural households and 53 per cent of the urban households possessed a radio. More than 90 per cent of both rural and urban households used steel, brass or copper utensils for eating. None of the urban households reported using aluminium utensils for this purpose, while only 2 per cent of the rural households did so.

Nearly 91 per cent of urban households and 39 per cent of rural households possessed no productive assets (machinery, another house, shop, godown, implements etc.). Of the remaining 61 per cent of rural households, for 56 per cent, non-mechanised farm tools were the most valuable assets. Thus, among both rural and urban households, a very small minority owned any productive assets (except land). Urban households also had very limited access to income from land. This is an indication of the precarious position of the poorer households in the urban areas. Although, ownership of land in itself does not indicate well being, it does provide employment to women and subsidises the cost of fuel and fodder. Usually, migrant families had few fixed assets, a poor social network and a more unstable economic condition.

Occupation

The main and subsidiary occupations for each member of the household were recorded. Also included were the geographical area of work (own village, other village, city), level of organisation at the place of work (formal, informal private sector, government unit, self-employed) and the type of work (cultivator, tailor, clerk, etc). The combination of these three described the occupation of the individual. The main occupation of each individual was then re-classified into occupational categories. These categories were further ranked to indicate the individual's relative position in the household and the community.

A particularly difficult problem of classification arose with the category of "cultivators". According to 1991 census 61.74 per cent of the rural male main workers and 58.75 per cent of the rural female main workers in Igatpuri taluka were recorded as cultivators. This study threw up figures of 57 per cent and 82 per cent respectively cultivating own land. However, this category covers a wide range of the rural population who enjoy significantly different levels of opportunities and standards of living. Thus, to

disaggregate this group, it was decided to combine occupations undertaken by those whose main occupation is cultivation. In addition, on the assumption that irrigated land would signify greater prosperity and continuous availability of work, households with irrigated land were also disaggregated. Thus, three classes of cultivators: (1) Cultivators who supplemented their income with agricultural labour or casual labour. (2) Cultivators of rain fed land who had no subsidiary occupation or who practised their traditional craft or engaged in trade. (3) Cultivators of irrigated land, who had no subsidiary occupation or who practised their traditional craft or engaged in trade.

The most deprived rural workers were those who engaged in agricultural labour or migrated seasonally to the city as contract labourers. This is imperative to meet the survival needs of the family. However, a small proportion of migrants from rural areas to the city who were engaged as skilled workers or service sector workers could be assumed to have migrated in search of better opportunities.

A little over half of all the individuals were, dependants having no paid employment. (Table 3.3) Only 1.5 per cent were in the privileged category of professionals, traders and managers. The largest group of workers was in the category of informal and casual unskilled workers – wage labour – while about 10 per cent supported themselves by supplementing income from land by casual labour. Expectedly, the majority of workers in the rural areas are in cultivation. The category of professionals and self-employed in the rural areas is extremely small though the proportion of casual labourers in the male workforce is considerable.

In the urban areas, workers who own no capital and are unorganised predominate the workforce. The majority of male and female workers are engaged in unskilled labour in the informal sector. In this category, too, we find that women workers exceed men workers in real numbers — 36.4 per cent male to 64.7 per cent female. This clearly indicates that unorganised manual workers forms the base of the urban workforce. Skilled and unskilled workers in the informal sector constitute 63.2 per cent of the male workers. Thus, we find evidence of the extent of deprivation among the urban households.

The women workers enjoy even less security. In the urban areas the majority of women workers are casual or informal sector unskilled workers. Only 1.4 per cent are self employed and professionals. One third of the women are house-workers. In the rural areas, women's participation in the economy is much more visible with the majority of them engaged in the cultivation of their own land. **On combining all categories of cultivators, more women are engaged in cultivation than males. 25 per cent of the women also worked for wages in agriculture. This complements the observation that the female workers in poor rural households were the first to seek wage work in addition to cultivating their own fields.**

Socio economic status

Since the response to our inquiry on land ownership was poor, it was decided to use occupational level as an indicator of socio-economic status. As the household is an integrated unit, the socio-economic status of the family is determined by achievements of all its members. In order to evolve a standard to measure the relative status of both urban and rural households, we have used the highest occupational level attained by any member of the family as an indicator. (Table 3.4)

Half the households are situated in the lowest two categories. About one third of the households are situated in the middle category, while a very small proportion of the households (13 per cent) are to be found in the highest category. Since land ownership is significant in ranking occupations, rural households are concentrated at the centre of the spectrum. In addition, 11 per cent of the households are found in the highest category. In comparison, we have classified 18 per cent of the urban households as belonging to this highest level. In the urban areas, we observe a greater degree of disparity, with more than one-third households belonging to the lowest level. Unlike rural households, the urban households in the second level are predominantly skilled workers in the unorganised sector who have no assets or land. Thus, the distribution of households in the rural and urban samples show marked variation.

Also, a large proportion of the urban households does not own productive resources (i.e. land, capital) and is engaged in the informal sector. In the rural areas, at least half the households have one worker engaged solely in cultivation of its own land. In spite of disaggregation, this class of cultivators shows a wide variation.

The highest class including those engaged in trade and highly qualified professionals is very minute in the rural areas. It is substantially larger in the urban areas, partly, on account of the professionals' housing colonies that we encountered. The periphery of Nashik City has become centre of rapid industrial expansion. As in any other city, these migrants have been accommodated not in the centre of the city but in newly built residential complexes in its suburban areas. Having selected such a suburban area for the sample of middle and upper income households, there was a large group of professionally qualified migrant service sector workers. An analysis of the distribution of the household across 'class' shows the high degree of polarisation in the urban areas in comparison with the rural scenario. As the categorisation of 'status' places great emphasis on ownership of the means of production (in this case, mainly land), more households are concentrated towards the centre of the spectrum.

Poverty

Poverty, in the present context, must be seen in two dimensions: scarcity of resources/income and the dependence on the market. Although the upper class in both the urban and rural samples is small, the majority of the rural households are relatively better placed although the landless in rural areas are distinctly the most deprived. Wage-workers, who form the bulk of the urban workforce, are dispersed across a wide range. 136 of the 366 urban households (37 per cent) were settled in slums and had either no earners or all their workers were employed as unskilled informal sector or casual workers.

Urban households are concentrated in the two lowest classes. In spite of greater availability of employment, urban households must use cash to purchase all the necessities required for survival. Although one accepts that the rural population no longer has any unlimited access to 'free goods', fuel, fodder and water are still not commodities to be purchased routinely from the market. However, for the poorer households in the urban slums, the purchase of these necessities constitutes an

important part of their cash expenditure. In the context of health care utilisation, both the need and availability of cash income are very significant factors. Thus, the predicament of poor urban households can be easily imagined.

The women in the study

Position in the family

There were 3581 women in the sample. On average, there were three women members in a household. While 34 per cent of the women were daughters of the household head, 29 per cent were wives. The other significant groups were daughters-in-law (13 per cent) and grand-daughters (11 per cent). Thus, almost all the women belonged to the immediate or extended family of the head of the household. (Table 3.5)

Marital status

An important aspect to consider in a study of women's health is marital status. Combined with age, it is a fair indicator of the pattern of life of women (Table 3.6). Nearly 45 per cent of all women were married and cohabiting. Another 1.8 per cent of the women lived in households with their co-wives. A substantial 9.3 per cent were once-married single women (only 1.4 per cent of the men were in this category). This is an indication of the grossly unequal opportunities for re-marriage offered to men and women. There were also marked differences in the marital status of women in the different age groups. There were no married women below the age of 12 years. However, 17 per cent of the girls between 12 and 17 years were already married. By the age of 25, more than four-fifths of the women were married (82.7 per cent). Marriage of 26 women (4.2 per cent) had ended due to widowhood or separation. Among the older women, there was a consistent increase in the proportion of widows with more than half the women above 55 years being widows.

Marriage was an imperative for all women; no woman above 35 years recorded as never-married. An analysis of the marital status indicates that marriage for most women takes place between 18 and 25 years, while widowhood is very common among the aged women. When we consider that the sex ratio in all age groups is adverse, the only explanation for the high proportion of widows is the vast gap in the ages of husbands and wives. The mean age for currently married women was 33 years and for men, it was 39 years. Thus, the mean age difference between spouses is 6 years.

Though 63 women – small in number — were living in the households with other wife/s of their husbands, the existence of such households indicates a high degree of gender inequality. An analysis of the marital status and childlessness for women above 25 years shows that while 14 per cent of the currently married women had no living children, 23 per cent of the separated and divorced women and 35 per cent of the 'one of two/three wives' were childless. **This indicates very clearly the strong co-relation between bigamy, the desertion of women and childlessness.**

Number of living children

Though there is little information on the reproductive history of women, we have recorded the number of living children for each married woman. (Table 3.8) It gives a fair estimate of the burden of childbearing that they have had to bear. **For all the women in the sample, it was an average of 2.81 children per woman.** However there was a steady decline in the number of children per woman in the younger age group. While women above 56 years had 3.85 living children each, it was 3.14 for women between 26 and 35 years. Older urban women had more children than their rural counterparts. In women above 45 years, there was a marginal increase in the average number of children per woman. However, the most significant factor is the steady reduction in the number of children in the younger age groups. Assuming there has been an improvement in child survival, it can be concluded that younger women are bearing relatively even fewer children than older women.

Composition of the households

Expectedly, there was a difference in urban and rural household composition. A nuclear family was defined as comprising spouse and children of the head of household. A joint family was defined as a family that had members who shared a relationship to the head other than wife and child.

The nuclear male-headed family predominated in the urban sample while the joint and nuclear male-headed family was almost equally common in the rural sample (Table 3.7). However, there was a distinct difference in the female-headed rural and urban households. While in the former, the joint family was more common, the nuclear family predominated the urban sample. 67. 8 percent of the rural women lived in joint households, while 46.7 percent of the urban women lived in joint households. While 12.2 percent of the women lived in female headed rural households, 11.3 percent of the urban women lived in female-headed households.

69.3 percent of the nuclear households had only one woman above 12 years of age. Conversely, 47.4 percent of the joint households had three or more women above 12 years. The number of adolescent and adult women in the household played an important role in determining the distribution of household work. The fewer the number of women, the greater was the burden of housework. Understandably, 78.4 of the women above 12 years in single woman households lived with families of upto 5 members. While the size of the family was an important factor in deciding the quantum of work, all households require a certain minimum of labour to function. Thus, single woman households, whether large or small, placed a great burden of housework on women. Also, women in single woman households are more likely to be earners.

The size of the family and the number of women in the household have been used as variables of analysis in this report in order to understand the intra-household distribution of work and opportunity for health care among women. While such analysis is incomplete without taking into account earning status and distribution of power in the household, it at least allowed us to integrate the internal and external world of the household in order to study women's health care situation more holistically.

Respondents

Due the modifications we made in the methodology, the discussion on respondents gains additional significance. The study assumed that women would not report certain categories of illness without probing. Hence, the use of the probe list. However, probing is unlikely to be equally effective with women when they are answering for themselves and for other women in the family. In addition to that, the profile of the respondents is important in order to understand the nature of the information received. The respondent represents the household in this study.

In the rural households, relatively more households had multiple respondents (Table 3.9). The presence of male respondents was also more frequent than in the urban. As large joint families were more common in the rural area, more than one woman participated in the interview. This seems to suggest that information, at least, on the health of other women in the households would be reported. In the urban households, typically, one adult woman in each household responded to the interview.

One of the respondents was identified as the main respondent. In only three cases in rural sample and four cases in the urban sample was this respondent male. In both cases, the main respondent was most likely to be the head or the spouse of the head of the household (Table 3.9). However, in the rural households, others, including the sisters/daughters-in-law formed a sizeable 21 per cent of the respondents.

An analysis of the age group in which these respondents were to be found indicates that the average age of the respondents was 36 years (Table 3.10). The average age of the rural main respondent was 36 years and the urban main respondent was 34 years. 39 per cent of the urban female members were respondents while 31 per cent of the rural female members were respondents. Among women of between 25 years and 55 years in both the rural and urban samples, the likelihood of that woman being the main respondent was extremely high. This becomes a significant fact in the context of the methodology used in our study. The use of the probe list, the objective of which was to record unperceived morbidity, was most likely to be successful when answered to by the woman herself.

The marital status of the main respondents indicates the strong bias towards women who are currently married and cohabiting (Table 3.9). Single ever-married women were proportionately represented among the respondents but never-married women were very poorly represented. Most of them were girl children and adolescents. However, the fact that very few girls between 12 and 17 years were respondents, although the probe list applied to them, may have a bearing on the reporting of additional morbidity in this age group.

Conclusions

There was a wide variation in the socio-economic status of households in both the rural and urban samples. A large proportion of the households, in both samples, had no assets or access to land. The poorest households were in a relatively greater proportion

in the urban sample which led to greater disparity in the sample. A large majority of the workers were unskilled and worked in the casual or informal sector. Women were almost invariably employed in this sector. **Women were less likely to be employed and have a lower occupational status than men.** This is seen in the fact that they were more likely to be employed as agricultural cultivators or cultivator-labourers than men in the rural sample and in the informal and casual sector in the urban sample.

Within households, women were dependants, with only 13 per cent of the households headed by women. They were mostly married between the ages of 18 and 25 years though a substantial number married before 18 years. Childlessness among women living with co-wives and deserted women was high, indicating the importance place on the bearing of children to ensure continued familial support. **The 25-45 year old ever-married women predominate among the respondents. Thus, it is their health problems which, are highlighted greatly in the study.**

Table 3.1 The location and community/caste of rural and urban households

Rural

	Easy access		Difficult access		Remote Access		Total
	No.	%	No.	%	No.	%	No.
Upper castes	97	66.0	37	25.2	13	8.8	147
Middle castes	49	28.5	116	67.4	7	4.1	172
Scheduled castes	51	57.3	37	41.6	1	1.1	89
Mahadev Kolis	112	69.1	42	25.9	8	4.9	162
Thakur / Katkari tribes	30	16.3	96	52.2	58	31.5	184
Other scheduled tribes	28	53.8	24	46.2	-	-	52
Muslims, Christians	21	100.0	-	-	-	-	21
Total	388	46.9	352	42.6	87	10.5	827

Urban

	Slum		Non slum		Total
	No.	%	No.	%	No.
Upper castes	14	17.9	64	82.1	78
Middle castes	26	44.1	33	55.9	59
Scheduled castes	81	83.5	16	16.5	97
Scheduled tribes	65	91.5	6	8.5	71
Muslim, Christian, Other	55	90.2	6	9.8	61
Total	241	65.8	125	34.2	366

Table 3.2 Distribution of rural households according to access

Village and description	Easy access	Difficult access	Remote
Wadi warhe, village located at a distance of less than 1 km from the Mumbai-Nashik highway. Connected to Igatpuri and Nashik by frequent state transport and corporation buses	102		
Dhamangaon, this village is located on the busy road connecting Bhagur and Ghoti. Frequent buses and private vehicles.	94		
Kaluste Gaothan on flat land with bus stop and private jeeps starting every half hour to Ghoti, the nearest large village, having rural Wadis on slopes and across streams, no bus stop and no motorable road	59	37	
Pimpri Sado, located at a distance of 7 kms from Igatpuri, connected to town by ST buses, rickshaws and other private vehicles. Wadis located at a distance from main village, no bus stop and no motorable road.		52	28
Take Harsha, located close to road to Vaitarna and on the route to Trimbak. Frequent buses and private vehicles ply on the road. Wadis located away from main village, some have no bus stop.	43	30	
Dahalewadi, located close to road to Vaitarna and on the route to Trimbak. Frequent buses and private vehicles ply on the road. Wadi located away from main village.	37	1	
Lahamge wadi, no bus stop in village. Located close to Wadi Warhe	1	17	
Kanadwadi bus stop three kilometres from village and the road is in bad condition and distance from Igatpuri 25 kms			9
Manwede Bus route bisected by river Darna and can be crossed only in summer. The rest of the year, vehicles required to take a long detour to Igatpuri		44	
Jamunde located on a hill slope requiring a one and half - hour climb. Very rocky motorable road, unusable except in summer months.			27
Fangul Gavhan, bus stop located in neighbouring village, however narrow motorable road present.		67	
Shirsete, bus stop present, however road intersected by stream and in bad condition.		60	
Kurungwadi, Located very high on hill slope requiring three hour climb. Extremely rocky road usuable only in summer. No bus stop. Road to nearest village intersected by river.			26
Bharvir Bk, resettled village with homesteads located far from the main road. The reservoir of the dam neccesitates vehicles to take a circuitous route. However, private jeeps to Bhagur ply regularly.			53
Bhandardarawadi, located on the same road as Bharvir Bk. Further ahead. However, the wadis located at considerable distance from the main village, no bus stop and very bad road.		15	25
Total	**388**	**352**	**87**

Table 3.3 Occupational status of all earners and all individuals in rural and urban households by sex

Occupation of Employed Persons	Rural				Urban			
	Male		Female		Male		Female	
	No.	%	No.	%	No.	%	No.	%
Professionals, Traders, Managers	31	2.2	1	0.1	66	13.5	13	5.1
Formal Sect' Skilled & Service Sector Wrkrs	49	3.5	6	0.5	74	15.1	21	8.2
Informal Sector Skilled & Service Sector Wrkrs	101	7.2	18	1.4	131	26.8	27	10.6
Informal & Casual Unskilled Workers	378	26.8	233	18.3	178	36.4	165	64.7
Sole Cultivators (Rain Fed)	406	28.8	457	36	8	1.6	8	3.1
Any Others	51	3.6	24	2.9	27	5.5	21	7.8
Sole Cultivators (Irrigated Land)	101	7.2	93	7.3	1	0.2		
Cultivator Labourers	295	20.9	438	34.5	4	0.8		
Total	**1412**	100	**1270**	100	**489**	100	**255**	100
Non earners	1247	46.8	1008	38.1	478	49.3	381	40.6
House-workers	3	0.1	365	13.8	2	0.2	302	32.2
Employed (earners)	1412	53.0	1270	48.1	489	50.5	255	27.2
	2662	100	**2643**	100	**969**	100	**938**	100

Table 3.4 Socio-economic status of the household in rural and urban areas

Highest Level Of Occupation Attained by any member of Household	Rural		Urban		Total	
	No.	%	No.	%	No.	%
Non workers, casual labourers and agricultural labourers	144	17.4	136	37.2	280	23.5
Informal sector Skilled labourers and artisans, cultivator-labourers	244	29.5	99	27.0	343	28.8
Formal sect. skilled and service sector workers, sole cultivators of rain fed land	347	42.0	65	17.8	412	34.5
Professionals, managers, sole cultivators of irrigated land	92	11.1	66	18.0	158	13.2
Total	827	100	366	100	1193	100

Table 3.5 Relationship of women to head of household

Relationship to head of household	Number	Percent
Self	155	4.3
Parent	143	4.0
Sibling	36	1.0
Spouse	1039	29.0
Child	1198	33.5
Grandchild	393	11.0
Parent in law	26	.7
Any other relative	82	2.3
Not related	1	.0
Daughter in law	461	12.9
Sibling in law	22	.6
Niece	15	.4
Grandparent	5	.1
Aunt	2	.1
Co wife	3	.1
Total	**3581**	**100.0**

Table 3.6. Marital status of women according to age group (in years)

res-	Upto4 Total	5 - 11	12 - 17	18 - 25	26 - 35	36 - 45	46 - 55	Above	No	56	ponse
Currently married & cohabiting	-	-	67 16.2	511 82.7	453 89.0	260 78.5	176 68.0	94 40.2	58 74.4	1619 45.2	
Never married	491 100.0	647 100.0	343 83.1	76 12.3	2 0.4	-	-	-	5 6.4	1564 43.7	
Widowed	-	-	-	13 2.1	19 3.7	39 11.8	68 26.3	136 58.1	12 15.4	287 8.0	
Separated/divo-rced/deserted	-	-	3 0.7	13 2.1	16 3.1	10 3.0	3 1.2	2 0.9	-	47 1.3	
One of two/ three wives	-	-	-	5 0.8	19 3.7	22 6.6	12 4.6	2 0.9	3 3.8	63 1.8	

Table 3.7. The type of family in the rural and urban sample

Type of family	Rural		Urban	
	Number	Percent	Number	Percent
Nuclear male headed	339	41.0	211	57.7
Nuclear female headed	30	3.6	22	6.0
Joint male headed	375	45.3	113	30.9
Joint female headed	83	10.0	20	5.5
Total	**827**	**100.0**	**366**	**100.0**

Table 3.8 Average number of living children per ever married woman in each age group

Age group	Total	Rural	Urban
12 – 17 years	.26	.28	.11
18 – 25 years	1.62	1.61	1.66
26 – 35 years	3.14	3.25	2.91
36 – 45 years	3.52	3.65	3.15
46 – 55 years	3.45	3.40	3.59
56 years & above	3.85	3.70	4.27
No response	2.96	2.86	5.33
Total	2.81	2.79	2.87

Table 3.9 Profile of the respondents

The gender of respondents in rural and urban households			
Gender of the respondents	**Rural**	**Urban**	**Total**
One woman (88.4)	711 (86.0)	344 (94.0)	1055
Woman and man (5.3)	55 (6.7)	8 (2.2)	63
More than one woman (6.3)	61 (7.4)	14 (3.8)	75
Total	**827**	**366**	**1193**
Main respondent's relationship to head of the household			
	Rural	**Urban**	**Total**
Self (9.6)	81 (9.8)	34 (9.3)	115
Spouse (70.6)	570 (69.0)	272 (74.3)	842
Others (19.8)	175 (21.2)	60 (16.4)	235
Total (100)	826 (100)	366 (100)	1192
Note: One rural respondent did not belong to the household sampled.			
Marital Status of main respondent			
	Rural	**Urban**	**Total**
Never married (1.9)	11 (1.3)	12 (3.3)	23

Currently married and cohabiting (85.5)	708 (85.7)	310 (84.9)	1018
Widowed, separated, deserted, divorced (12.6)	107 (13.0)	43 (11.8)	150
Total	826	366	1192

Note: Number of missing cases: 1

Table 3.10: The proportion of women who were main respondents in each age group in comparison to their proportion in the total sample population.

	Main respondents			Total women in age group		
Age group	**Rural**	**Urban**	**Total**	**Rural**	**Urban**	**Total**
Up to 4 years				364 (14.2)	127 (13.6)	491 (14.0)
5-11 years				486 (18.9)	161 (17.2)	647 (18.5)
12-17 years	26 (8.3)	10 (10.0)	36	313 (12.2)	100 (10.7)	413 (11.8)
18-25 years	167 (37.4)	85 (49.1)	252	446 (17.4)	173 (18.5)	619 (17.7)
26-35 years	248 (70.5)	131 (83.4)	379	352 (13.7)	157 (16.8)	509 (14.5)
36-45 years	166 (67.2)	60 (71.4)	226	247 (9.6)	84 (9.0)	331 (9.4)
46-55 years	121 (65.4)	50 (67.6)	171	185 (7.2)	74 (7.9)	259 (7.4)
56 years & above	70 (40.0)	25 (42.4)	95	175 (6.8)	59 (6.3)	264 (6.7)
Sub Total	798 (31.1)	361 (38.6)	1159	2568 (100.0)	935 (100.0)	3503 (100.0)
No response	28	5	33	75	3	
Total	826	366	1192	2643	938	

Note: % in column 2 and 3 indicates the percentage of women in that age/rural-urban group who were main respondents. % in column 5,6 and 7 are column percentages

Number of missing cases: 1

4. Morbidity

The socio-cultural dimensions of health

Morbidity is understood in this study as a social state, not merely a biological one. The perception of illness reflects not merely the health problems of individuals but also their understanding of their own bodies and their relationship to the living environment. It is not merely the changing disease patterns that lend dynamism to the concept of morbidity, but a host of other social factors as well. Thus, analysing the gathered data meant understanding it in the social context in which information was received.

The relationship between the existence of disease and its perception is complex. A study of reported morbidity is not the study of diseases, but a study of ill health. The correspondence between the actual classifiable disease which can be observed, the manner in which it is perceived as illness and the articulation of that experience can vary considerably. **For morbidity to be recorded, it has to be perceived and reported.** This may not happen due to various socio-cultural and political reasons. Social barriers of caste and class and differences in language and culture between interviewer and respondent may affect the reporting of morbidity.

For instance, the manner of the interviewer may become prejudiced, prompting the respondent to either withhold information or give a tailored response. In other cases, certain words may have a specific connotation for the respondent, which the interviewer is not able to understand. Or, there may be no specific words in that language to describe the experience of the respondent. Certain kinds of illness, such as sexually transmitted diseases or reproductive tract infections have cultural associations, which may prevent their being reported in a survey. Certain problems such as aches and pains are so widespread that they are not perceived as illness and are therefore not reported. There is also a possibility of a feeling of 'not being well' in the absence of disease, which also gets recorded as morbidity. Thus there is some element of subjectivity in the recording of perceived morbidity.

However, the importance of reported morbidity study lies in the fact it is an economical method to gauge the extent of ill health in a community. Also, perceived morbidity uncovers other social dimensions of health. It has direct implications for estimating the need and demand for health care and the extent of expenditure that is or would be incurred. Hence, while perceived morbidity is not a completely accurate measure of the 'burden of disease' in a community, it has significant importance in understanding the social processes underlying health and health care in a given community.

Background

Although data on mortality does not give much insight into the pattern of morbidity existing in the population, it provides us with some information on health problems. The survey of the causes of death for rural Nashik (DHO, Nashik district; 1995) shows that respiratory diseases are the chief cause of death for both males and females. 27.8 per cent of the total 772 deaths surveyed were due to respiratory diseases.

Blood and circulatory disorders were the second most important cause of death accounting for 18.4 per cent of the surveyed deaths. Accidental deaths and suicide accounted for 10.5 per cent of the total deaths. While the deaths of infants from birth complications and infections accounted for 11.5 per cent of the total deaths. Deaths due to gastrointestinal diseases accounted for 6.3 per cent of the total deaths. There are only marginal differences in the causes of deaths for males and females. We find that 1.2 per

cent of the female deaths are maternal deaths. Of the 772 deaths, 12.69 per cent of the deaths are of infants below one year of age, while 18.65 per cent of the deaths occurred among children below five years. 18.10 per cent of the female deaths were of women between 15 and 45 years.

In general, we find that respiratory illnesses and circulatory disorders are important causes of death in rural Nashik. Gastrointestinal diseases do not account for a very large proportion of deaths, while accidental deaths and suicide constitute a significant proportion of total deaths.

Extent of morbidity

In this study, we recorded a total [monthly] morbidity rate of 570 episodes per 1000 persons. (Table 4.1). Expectedly, due to the methodology used, **there is a vast difference between the morbidity rates for men and women. While for men it is 330, for women it is 812.** There is only a marginal difference between the total (both sexes combined) rural and urban rates, which are 569 and 571 respectively.

While men in the urban areas reported a lower rate of morbidity than their rural counterparts, the reverse is true for women. Men in the rural sample reported a morbidity rate of 346 per thousand; their urban counterparts had a rate of 285. For women the rates were 793 for rural and 866 for urban sample. A significant factor contributing to these dramatically high rates of morbidity is the reporting of multiple episodes, largely, by women. While 2 per cent of the men reported more than one episode during the recall period, a substantial 20 per cent of the women did so. While 11.6 per cent of the women reported two episodes of illness, 8.4 per cent of the women reported three or more episodes.

Probing was responsible largely for the reporting of multiple episodes among women. For instance, a woman may report an acute episode of malaria before probing. After probing, an episode of work related chronic back-pain could be added to it. **As actively probing for illness resulted in the massive rise in morbidity, it may be incorrect to gauge the quantum of illness from the morbidity rate alone. However, multiple episodes are certainly an indicator of the complexity of women's health problems.**

An analysis of the *number of persons ill* also gives evidence to the high morbidity prevalence in the sample. 406 out of every 1000 persons in the sample reported at least one episode of illness in the previous month. The rural-urban difference was considerable, with the figure for the rural area being 419 persons and the urban areas 369 persons. The gender difference was also significant with 307 men and 506 women out of 1000 reporting an illness. While 326 rural men reported an illness, 254 in the urban sample reported an illness. For rural and urban women, the numbers were only marginally different, being 512 and 487 respectively.

With regard to the type of morbidity (Table 4.2), fevers and respiratory problems constitute the largest categories of illness in the total population. Reproductive health problems, aches and pains follow them. However, as probing for illness was restricted to women, it would be incorrect to compare morbidity data for males and females. Probing was designed to elicit more information on specific types of illness; hence, a gender-specific analysis of type of morbidity would be more meaningful.

Male morbidity

The use of exclusively women interviewers and women respondents was an important part of the methodology of this study. However, there is a very strong possibility that this method affected the reporting of morbidity for men. The morbidity rate obtained for men was 330, while that for women (prior to probing) was 362, a difference of 9.6 per cent. This marginal difference in male and female morbidity has been observed in the previous studies. Also, in spite of interviewing only women respondents, the morbidity rate obtained for men in this study is considerably higher than that reported in any of the previous studies.

Morbidity is the highest among men above the age of 45 years (373) (Table 4.3) while among young men between 18 years and 45 years it is the lowest at 292 episodes per 1000. Morbidity among boys below 18 years is higher being 350 episodes per 1000. Thus, the characteristic J shaped curve is also to be found in this study for morbidity among men.

Among men, acute infections constituted a large proportion of the morbidity reported (Table 4.4). Of them, unclassified 'fevers' constitutes the largest component accounting for 37.5 per cent of all episodes. Respiratory illness was the second most important category with 27.3 per cent of all the episodes. G.I.T problems were relatively less significant accounting for 9.1 of the illness episodes. General aches and pains constituted 7.1 per cent of male health problems.

The most significant difference in the type of morbidity among rural as compared to urban males is the substitution of fevers by respiratory problems as the single largest category of illness. This clearly indicates the co-relation between morbidity and the environment. Igatpuri taluka has a high prevalence of malaria that is indicated by the overwhelming numbers of fever episodes reported there. The upsurge of respiratory problems of rapidly developing urban centres has been well documented. The pattern of morbidity recorded in the Nashik city's male population confirms that trend.

The fact that acute infections dominated reported male morbidity is confirmed by the fact that more than half of the episodes reported among men were of seven days duration or less (Table 4.4). While 77 per cent of the episodes in the rural areas lasted for less than a month, only 70 per cent of the urban episodes had a similar duration. 11 per cent of the rural episodes and 17 per cent of the urban episodes were reported to be associated with an illness having duration of one year or more. This suggests that urban men suffer from or, at least, report more chronic health problems.

This study also attempted to record the perceived cause of illness. The perception of illness is structured by many external factors. The stated cause of illness is a key to understanding not merely the nature of the illness, but also the social context in which the individual experiences illness. In 71.08 per cent of the episodes (853 out of 1200), a reason was stated for the illness. Upto two reasons were recorded for each episode of illness. The reasons stated for male morbidity are also in keeping with the type of

illness reported by them. More than 60 per cent of the reasons reported relate to environmental factors (food, water, weather etc.) and to the occurrence of an epidemic. Work and fatigue, as causes of illness constitute the other major category making up 11.4 per cent of the stated reasons. Remarkably only 3 per cent of the reasons relate to general debility (weakness, old age). Injury and trauma are the other significant reasons stated for illness (7.3 per cent)

The reporting of morbidity among men is done entirely by women. It is possible that the morbidity especially of young men who stay out of the house for the most part of the day are missed out. Women also reported morbidity for all children. **Women have reported higher morbidity for young boys below five years than for girls of the same age; morbidity rates being 431 and 372 respectively. This finding is explained by the fact that more attention is paid to boys in their childhood**. **Surprisingly, this gender difference is not to be found in the older age groups.** For children between 6 and 11 years, the morbidity is reported to be equally high among boys and girls, the morbidity rates being 350 and 349 respectively. The rise in women morbidity is consistent across all the age groups till old age. However, no comparable trend is observed among men. In general, we find that morbidity rate is high for young boys and it declines till the age group of 26-35 years. After that, the rate increases gradually. It is possible that due to the fact the all reporting of male morbidity is by proxy, the absence of consistent trend may be due to problems of reporting. Therefore it is necessary to interpret all the findings about male morbidity cautiously.

Morbidity among women

The quantum of morbidity recorded among women was unprecedented. 2909 episodes were recorded for 3581 women. (Table 4.5) Half the women (1812 women, 50.06 per cent) in the entire sample reported being ill in the month prior to the interview. Thus, 812 episodes of illness were reported per 1000 women in the same period**. The morbidity rate among women reported without probing was 362 episodes per 1000, this rose to 812 episodes per 1000 after probing.** Thus, the morbidity rate for women increased by 124 per cent. Likewise, we find that the number of women reporting an illness before probing was 339 per 1000, while, after probing, 506 women in every 1000 reported having an illness in the past month.

Expectedly, there was a wide variation in the quantum and pattern of morbidity among women. Complex networks of factors determine health status. In order to understand the social context in which women live, we have studied the *position of the woman's household* and her *position in the household*. Morbidity, as well as other aspects of health care must be related to both these factors.

Geography

The difference in the quantum of morbidity reported by rural and urban women was noteworthy (Table 4.5). While the morbidity prevalence rate for the rural women was 793 (2096 episodes for 2643 women), for the urban women, it was 866 (813 episodes for 938 women). However, the pattern was reversed for the number of women ill. Proportionately more rural women (512 per 1000) were ill during the recall period than urban women (487 per 1000). **This indicates that a higher proportion of urban**

women reported multiple episodes of illness than rural women. The reason the reporting of more multiple episodes among urban women could be that the urban women were most likely to be responding for themselves. Probing was relatively more effective among urban women. It has also been noted that the level of awareness about health is higher in the urban areas, leading to higher reporting of morbidity. It is also important to remember that the urban sample has a very high proportion of slum households surviving in poor and unhealthy surroundings, which may have resulted in finding high morbidity among women in urban households. The higher reporting of multiple episodes among urban women may in fact be a combination of all these different factors.

Duration of settlement

In general, the duration of settlement was correlated with morbidity. **While old/original settlers reported a morbidity of 789 episodes per 1000 women, migrant women had a morbidity rate of 866 episodes.** This difference is distinct in the rural areas, where the migrant women have a morbidity rate of 973 in comparison to the total rural morbidity rate of 793. The ill persons' rate for migrant women is also higher than that for settled women. As explored in the earlier chapter, the rural households, in general, were relatively well established. Hence, the difference between the migrants and the old settlers was quite striking.

Migrant families in rural areas were almost invariably the poorest in the village. These women were almost always land-less agricultural labourers. Thus, it is not surprising to find that they have reported higher levels of morbidity. In comparison, the migrant urban women had a varied socio-economic profile. They actually outnumber the original settlers. Also, they could belong to families of varied socio-economic class. Also, they do not differ so significantly in the quantum of morbidity reported. However, as may be seen in the following chapters, they are less likely to receive health care for their problems.

Socio-economic class

As explained in the section of methodology, it was not possible to record accurate information on income and assets. However, the highest occupational level in the household was used as an approximate measure of socio-economic status. **Among rural households, there is no consistent relationship between socio-economic status and morbidity**. Among the lower three classes, the morbidity rate declines with rise in socio-economic status. However, the highest class has reported higher morbidity than the preceding class. The noteworthy finding here is that the women of the lowest class have reported the highest morbidity. For the households of land-less labourers and unskilled workers, we find that the morbidity rate is 951, while 586 women out of every 1000 in this class have reported an illness.

Urban areas show a highly consistent inverse co-relation of the morbidity rate with socio-economic class. However, *the number of women reporting an illness* in every class is not very highly co-related. The difference in the morbidity rates of women of different socio-economic classes, in both rural and urban households is much greater than the difference in the number of women ill for each class. This is an indicator of the greater impact of probing for poor women. Among the poorest rural women, the increase in the morbidity rate after probing is 15 per cent more than that for all women. While for the

poorest urban women, the increase is 36 per cent. Thus, the use of probing reveals a greater burden of unreported morbidity among poor women. In general**, the dramatically high morbidity rate for women in the poorest households is a telling indicator of the effect of poverty on women's health.**

Caste/community

In rural households, where caste/community is still an accurate indicator of socio-economic status, the scheduled caste (880) and minority community (1009) women have higher rates of morbidity than upper caste (803). However, all these groups have a higher morbidity than tribal women (745). This finding is inconsistent with our finding that poorest women have highest morbidity. If we assume that the burden of illness must be highest among the poorest women, the morbidity rate among tribal women should have been among the highest. However, we find that the reverse is true. In fact, that the most deprived communities even among the tribal (Thakurs and Katkaris) have the lowest morbidity rates among all rural women.

However, the effectiveness of probing among tribal women was low. There is a marked difference in the socio-political conditions of tribal villages and non-tribal villages. Culturally, as well as economically, tribal villages are marginalised. Health facilities are absent, schools are non-functional and there is very peripheral contact with the market and media. The differences in culture and language as well as lack of opportunity to access health care may lead to low consciousness of health problems and, thus, low perception of morbidity. The fact that the process of probing did not remedy this imbalance cautions us about the limitations of this methodology.

Access

The classification of rural households according to 'access' shows that higher morbidity was reported by 'easy access' households (813) and the lowest morbidity by remote households (700).

It was observed in the previous chapter that the caste/community groups tended to concentrate into settlements (villages/wadis). The two tribes mentioned above were concentrated mainly in the remote village/wadis. There is a similar pattern of morbidity in the analysis with 'access' as with caste/community. Those in the 'remote' settlements have lower morbidity rates than the other women. Here, too, the morbidity rates vary significantly more than the rate of persons ill. This is further evidence to suggest that the entire range of illness among the women in the 'remote' settlements have not been captured by our study.

It is widely accepted that higher perceived morbidity does not necessarily translate into more ill health. It is important for women to be able to articulate health problems for a study of perceived morbidity. The multiplicity of illness reported is an indicator of the ability to articulate health information. If we accept that perception is deeply influenced by access to services, a pattern emerges. As will be seen in the following chapter, most of the illness in the 'remote' settlements was not treated. Apart from health services, access is also vital in determining the level of awareness about health problems through the media, contact with modern market systems, a complex social structure and

integration with 'mainstream life'. When we consider that the minority community households were situated entirely in the 'easy access' settlements and the Thakurs and Katkaris largely in the 'remote' settlements, the differences in morbidity reporting according to caste/community status appear logical.

A combination of cultural factors and social access are necessary to understand the pattern of morbidity. It has often been argued that perceived morbidity as a concept is biased against deprived and marginalised groups, as they are less able to articulate their health problems. Apparently, it appears so in this study, too. However, the information on health care utilisation makes clear the links between deprivation and morbidity. When we observe that women in these communities have the least access to health care even for the low level of morbidity reported, it can only mean that actual ill health among them must be much more widespread than is reflected in our study.

Comparing slum and non-slum households in the urban areas, we find a drastic difference in the morbidity reported by women. **The morbidity reported by women in non-slum households is significantly lower than the morbidity reported by women in slum households.** While physical access may not differ significantly, the social and economic condition of the two groups of women is vastly different. This reflects itself in the higher reporting of morbidity for women whose households are living in poverty, and whose work burden is tremendously high owing to the deterioration of the living environment as well and the need to engage in poorly paid wage work together with hard domestic labour.

Composition of household

If only the quantum of morbidity is considered, interesting trends emerge in relation to the composition of the household (Table 4.6). In both rural as urban households, there is a negative relationship between the size of the households and morbidity. The morbidity rate for women in families having five members or less is 991, while for women in families of more than 15 members have a morbidity rate of 450. With increase in family size, proxy reporting increases resulting in a lower reporting of morbidity for family members other than the respondent. Also, the number of women above 11 years in the household is co-related to the morbidity rate reported by women in those households. In households having only one woman, the female morbidity rate is 1016, while when there are 3 or more women, the morbidity rate is 672.

The co-relation between the burden of housework and illness is best understood when we consider the family size and number of women together. The comparison of single woman households is most reliable, since the women in all these households responded for themselves. When there is only one woman in a household of five or less members, the morbidity rate of such women 1500, while the ill person's rate is 765. However, when there is only one woman in a household of 6 to 10 members, the morbidity rate is 1727, while the ill person's rate is 828. Similarly, for a given household size, the morbidity rate for women above 12 years declines consistently with increase in the number of women. Thus, for households with five to ten members, when there is only one woman above twelve years, the ill persons rate for these women is 828, while it 701, when there are two women and 546 when there are 3 or more women.

Though no conclusive observation can be made from these findings, it would be interesting to explore further the link between household labour and women's health.
It is well known that male members of the household do not share responsibility for housework. Thus, the women must distribute the load of housework among themselves. The presence of more women is likely to lead to greater distribution of work and, thus, less physical exhaustion. However, even in such a situation there is unlikely to be equal distribution of work. The relationship of work to family structure must be explored more deeply for such an analysis. The relationship of work itself with ill health needs an exploration much deeper than was possible within the scope of this study.

Apart from the factors that influence the household, women are also affected by power structures and relationships within households. Thus, the individual profile of the woman also determines health status to a large extent.

Life stage

The most significant individual characteristic affecting women's health appears to be their life stage (Table 4.7). In contrast with men, among whom we find that morbidity is highest in childhood and old age with an intervening period of low morbidity, **among women morbidity continues to increase with age.** For all women above 18 years in rural and urban areas, more than 1000 episodes for every 1000 women were recorded. Also 65 to 70 per cent of the women in these age groups report illness. Most household studies, which have reported age-wise information on morbidity, have shown a similar trend. Adult morbidity exceeds child morbidity among women. Although there is a constant increase, we see a sharp rise in the morbidity rates after the age of 25 years, an age when childbearing is continuing or has even been completed. **There seems to be a definite co-relation between childbearing and morbidity.**

However, it is important to note that morbidity does not decline for women with any stage in life. Post-menopausal women have a larger number of health problems than women in the reproductive age group. This further indicates the incremental nature of women's health problems. It is widely argued that childhood illness and neglect contributes much to adult women's health problems. Similarly, high morbidity in youth is followed by high morbidity in old age. Culturally, as well as politically, older women's health problems have been ignored, as they are no longer producing children. However, it must be noted that not only are ageing women vulnerable to degenerative diseases, but they must also continue to endure the consequences of neglect and ill health during the reproductive years.

Marital status

The analysis shows a highly significant co-relation of morbidity with marital status of women as well. Never married women have the lowest rates of morbidity (379). Ever married women have much higher rates of morbidity. Currently married women have a morbidity rate of 1141 episodes per thousand women. The highest rates of morbidity are to be found among ever-married single women (1182).

While only 344 never married women out of a thousand reported an illness, 685 widowed, divorced, deserted and separated women out of 1000 reported illness. The difference in the average age and social situation of these two groups of women play a significant role in determining their health. It would be interesting to note whether certain social factors such as lack of support and rejection in itself can articulate itself as high morbidity.

Number of living children

The number of children borne by a woman has significance for morbidity (Table4.8). Though complete reproductive history of all women was not available, **there is a definite relationship between the number of living children and morbidity. The morbidity rate for married women with no children was 779 in contrast with a morbidity rate of 1364 for women with more than four children.**

458 women reported an illness in the former category, while 718 women reported an illness in the latter group. It is not surprising to find a relationship between morbidity and the reproductive history of women. For women between 18-45 years, those with no children have the lowest morbidity rate of 732, while those with one of two children had a morbidity rate of 936, those with more than three or four children had a morbidity rate of 1354, which rose to 1472, when the women had more than four children. Having more children not only implies a more prolonged and strenuous period of childbearing; it also means a much heavier burden of household and child-rearing work. Hence, it would be incorrect to attribute women's illness merely to higher parity while ignoring the gender inequality in the division of household labour.

Morbidity is the result of compounding of stress factors such as advancing age, childbearing, poverty, social isolation and life-style. These factors add nuances to the overall high reporting of morbidity by adult women. Not surprisingly, we find that morbidity is highest among women who have borne a heavier burden of child bearing as well as ever-married single women who have low social status.

Work

Household work is inevitably part of every woman's life. Besides, a majority of the adult women also engage in wage work or in household production. In the sample, 42.2 per cent of all women were engaged in an income earning activity. While in the rural 50.54 of the women were employed, in the urban areas, only 38.28 of the women had a similar status. However, 70 per cent of the 'working women' in the rural areas were engaged either entirely or partially in household farm production. Therefore, very few rural or urban women had an independent source of income. It must also be noted that the rest of the women workers were employed in low paying informal sector occupations. However, an occupation-specific analysis of morbidity is difficult due to the small number of women in every category.

The morbidity rates for housewives and earning women were 1093 and 1055 respectively – not a significant difference except that a clearer pattern emerges in urban area with earners having the highest morbidity rate of 1231. As most rural women workers are employed in household production, their status as workers is

obscured. Also, a significant part of agricultural operations take place in and around the house. Hence, it is unlikely that the work routines of 'housewives' and 'earners' in the rural areas will be perceptibly different. In the urban areas, where the workplace is distinct from the household, the morbidity rates or 'earners' show a perceptible increase. This clearly indicates not merely the effect of 'double burden' of work on women's health, but also the link between perception on illness and work status. Finally, morbidity for 'housewives' is also significantly high, indicating that domestic labour in itself places a heavy burden of ill health on women.

Education

There is no strong co-relation between education and morbidity. However, the morbidity rate declines with increasing education among urban women. The ill person's rate does not show a similar trend. There is no direct relationship between formal education and perception of illness. It has often been argued that higher education in itself would raise awareness about illness and, reporting of morbidity. However, that phenomenon is certainly not visible in this study. Among urban women, where the general consciousness about health is high, regardless of educational achievement, even the least educated women report the highest morbidity. As women's education is dependent on socio-economic status of the household, this finding indicates a relationship with class rather than education. **The fact that low or no education does not inhibit the reporting of morbidity, especially in the urban areas, in this study is an important finding. This indicates that articulation of health problems does not depend on educational status, but may be influenced by factors such as exposure to the media, to health facilities and political consciousness.**

In itself, the quantum of illness among any group of women is only an approximate indicator of their health problems. That adult women, in general, suffer high morbidity is conclusively proved by the above analysis. Although the reporting of illness is dependent on many subjective factors, we do find strong evidence to support a few observations. Marriage, motherhood, household responsibility, the need to earn and the absence of other women in the household are significant factors contributing to high morbidity. The cultural and socio-economic status of the household also affects women's morbidity, wherein the disadvantaged bear a heavier burden of ill health. The location of the community as measured in its access to services has deep impact on the perception of ill health. Women in remote settlements, who do not perceive illness are, in fact, very likely to be the most ill, but our methodology fails to take note of it.

Type of morbidity

A more detailed analysis of the type of morbidity as reflected in the total female episodes (Table 4.10) shows that of the reproductive problems, a large proportion were related to maternity and contraception (41.9 per cent) and menstrual irregularities (31.21 per cent). Reproductive tract infections accounted for less than one fifth of all the reproductive problems (18.1 per cent). It is very probable that infections have been under reported because of inhibitions and also that the symptoms of R.T.I s are occasionally not observed by women themselves. However, the burden of long-term problems resulting from childbearing and contraception are very significant. Contraception is cited as the reason for 5.36 per cent of all the episodes and 23 per cent of reproductive problems.

Likewise, pregnancy, childbearing and abortion are cited as a reason for illness in 4.5 per cent of the total episodes and 15 per cent of the reproductive problems.

This indicates that reproductive health must be viewed not merely in terms of treating acute infections and of pre/post natal care, but as importantly as the management of long term problems resulting out of the stress suffered during childbearing and contraception use. **It is noteworthy that post delivery / abortion / sterilisation care, which are important in preventing long-term morbidity remain the weakest links in the public maternal and child health programme.** While mortality due to maternity is still very high and well recognised, the health implications of morbidity related to maternity need to be regarded seriously. Similarly, while sterilisation as a family planning method is promoted, the morbidity related to that has been given scant attention. Women continue to associate morbidity with these particular events for a considerably long period after they have happened. This may not be an entirely subjective perception; the scientific basis must be explored. Also, it is necessary to probe whether these events become more traumatic for women due to external factors such as poor medical care, lack of adequate rest, lack of freedom to make individual choices and the general subjugation of their bodies.

Symptoms indicating weakness (either as general weakness, tiredness, anaemia, or weakness with pain of extremities with tingling, etc.) accounted for 176 episodes. Night-blindness, which results from vitamin deficiency, has been categorised as part of weakness. 84 episodes have night-blindness as their main symptom. Reporting of weakness as a general feeling of ill health is common among women. Equally common is the tendency among professionals to dismiss it as a 'vague, non specific' experience. However, the overwhelming numbers of such complaints received in our study made it evident that its inclusion in a study of morbidity is necessary. That these complaints may, indeed, have a physiological basis in conditions such, as anaemia must be considered. This study considers such a category of illness as having great significance for gender analysis. "Weakness' provides the link between under-nourishment and morbidity that we observe in women.

General aches and pains account for overwhelming 462 episodes (15.8 per cent of all episodes), with another 58 episodes having headache as the main symptom. The former is another category of illness that cannot be included in a systemic classification of disease. However, the organic basis of these complaints was difficult to identify. The gender specificity of these complaints is apparent and it signifies an articulation of a general feeling of ill health. Together reproductive health problems, 'weakness' and 'aches and pains' account for 46.74 per cent of all the episodes. They also form a complex of inter-linked health problems that are gender specific. Gender discrimination in distribution of food and care adversely affects women's general health state, which is further debilitated by childbearing and the practice of contraception. All these three categories of illness are among the most invisible and neglected problems of women. Admittedly, their contribution to eventual mortality may be obscured and difficult to document. However, it would be irrational to ignore how deeply they affect the quality of women's day-to-day lives.

The prevalence of general health problems among women is also high. Although the proportion of gastro-intestinal complaints is relatively small, we find that infections predominate in this category. We find that a large proportion of gastro-intestinal problems (53.2) are exclusively complaints of diarrhoea and/or vomiting. The remaining

complaints relate to feelings of discomfort, namely, stomachache. These may not necessarily be related to infections, though the possibility cannot be ruled out.

It has been widely observed that respiratory diseases have substituted water borne diseases as the single most important causes of morbidity and mortality. We find evidence of that in this study too. Coughs and colds are almost equally prevalent comprising approximately five per cent each of all the illness episodes. A sizeable number of episodes of breathlessness are reported as well giving evidence to the increase in non-infectious respiratory health problems.

A significant 7.8 per cent of women's illness episodes were related to complaints of eyes and ears. A significant proportion was conjunctivitis episodes, which we encountered, in epidemic form in the rural area. Injuries/burns constituted 1.5 per cent of women's illnesses. A similar proportion of the illnesses could be directly related to mental stress and 'possession'

An important advantage of our data recording and classification design is the small proportion of episodes that had to be included in 'others'. These constitute only 3.5 per cent of all the illness episodes. They include a wide category of infectious and non-infectious complaints. (Non reproductive involuntary urination, bladder/kidney stones, liver complaints, piles, cardiovascular problems, diabetes, paralysis, hernia, nodes and tumours, oral health problems and ulcers in the mouth.)

While it is not possible to analyse the pattern of morbidity with relation to all variables, we have attempted to explore the major variations (Table 4.11).

Type of illness and geography

In the rural-urban analysis, (Table 4.11) there are some significant differences in the type of morbidity. **In the rural areas, 171 episodes of 'fevers' were recorded for every 1000 women.** As fieldwork in the rural areas was conducted in the months after the monsoon, there was a high prevalence of malaria in all the villages. This accounts for the high reporting of fever episodes in the rural sample. **However, 'fevers' as a category of illness becomes less significant in the urban areas, where we find higher number of respiratory problems (136 episodes per 1000 women).** Reproductive problems also become significantly more prevalent. In the rural households, women could never be interviewed in privacy and individually. Therefore, it is not surprising that reproductive problems are recorded less frequently in the rural households. It is noteworthy that in spite of the low level of environmental hygiene that we observed, gastro-intestinal problems do not constitute an overwhelmingly large proportion of the illnesses, either in the rural or urban areas. Surprisingly, aches and pains are more prevalent among the urban women in spite of the fact that they are younger and undertake less manual work. Though the numbers of episodes become too small, we find that weakness, injury/boils/burns, mental stress and other problems are all more prevalent among urban women. **In general, we find that morbidity in the urban women is spread more evenly across the various categories and, thus, shows more variation.** This may be seen as a result of their being more articulate in describing their health problems in a manner suitable to the study. It is also worth noting that probing was more effective among the urban women. This, evidently, increased the variation in the type of morbidity reported by them.

Type of illness and socio-economic class

An analysis of type of morbidity with the socio-economic status of the household shows no specific relationship (Table 4.11). The distribution of illness by type in all the categories is similar. Reproductive illnesses, aches and pains, fevers and respiratory illnesses constitute the most important problems in each group. As to the prevalence of each type of illness across the groups, the lowest class has the highest prevalence of both reproductive illness as well as respiratory illnesses, which declines progressively. However, in the case of the other health problems, there is no consistent relationship. Overall, the prevalence of all types of illnesses, except fevers, is higher than average in the lowest class. Conversely, in the highest class, the prevalence of all types of illness, except 'fevers' and 'others', is lower than average. This indicates that deprivation does not increase vulnerability to specific health problems, but has a general effect of increasing ill health.

Type of illness and life stage

The most significant analysis of type of morbidity is, expectedly, yielded in relation with age (Table 4.11). There is universal increase in the reporting of all types of morbidity among adult women. Adjusting for probing does not alter this pattern. The only category where we observe a contrary movement is 'fevers', which are highest among girls below 18 years. Among the young girls and women, we find that fevers and respiratory illnesses account for the bulk of all morbidity. Sense organ problems constitute the other significant group.

Among adult women, there is a shift in the pattern of morbidity. It is important to note that general health problems do not become less prevalent. More than 100 episodes of fevers for 1000 women are recorded consistently for each age group. However, we find that the prevalence of the 'gender specific' health problems identified by us rises sharply. Among the adult women too, we find a very distinct illness profile for younger and older women. Reproductive problems, which are highly prevalent among the younger women, decline considerably for women above 45 years. However, they are substituted by a heavy load of weakness and aches and pains. Respiratory problems and problems of the sense organs also become very significant among these women. Thus there is a combination of degenerative and infectious diseases afflicting this group.

Since all these women belong to the same households, there is a pattern of morbidity developing through the life span of these women. It is logical for individuals to relate their ill health to the roles that preoccupy them most at that point. The social construction of illness also depends greatly on the role that women perform in society. As has already been noted, our classification of illness depends almost entirely on the respondent's perception. Hence, it is to be expected that the pattern of morbidity will reflect the social role that women perform and their predominant concerns. Women in the younger age group are more likely to be involved with pregnancy and childbirth. However, it must not be forgotten that the older women have undergone an equally, if not more arduous phase of reproduction. The incremental effect of childbearing and hard physical labour is seen in old age, but not perceived as being so. Childbearing is dissociated from illness by older women.

However, the difference in the pattern of morbidity among women of each age group must be understood in a continuum, as progressing through a life span. For example, backache is a common complaint for adult women. There are 29 complaints of backache for 100 women in the 18-45 years age group, while there are 25 complaints of backache for every 100 women above 45 years. This reveals that backache is equally prevalent in both groups of women. It is also to be expected that this problem commences in youth and continues into old age. However, among the younger women, a majority of these complaints are related to maternity and contraception. In old age, these problems remain but are attributed to causes such as ageing, over-work and weakness. Consequently, while there are 323 episodes of reproductive problems among women between 18-45 years, there are 318 episodes of aches and pains for every 1000 women in the eldest age group.

The profile of illness for each age group is distinct. While for girls below 18 years, respiratory problems and fevers predominate, the adult women have a high burden of reproductive problems and aches and pains, in addition to fevers. In addition to ill health caused by environmental factors, they must contend with the problems related to work, childbearing and deprivation. This outlines the need for viewing women's health problems from a wide perspective. Their problems are complex and interwoven. Thus, malaria is as significant a problem for sixty-year-old women as arthritis. And young women, no doubt, must be protected from R.T.I s, but they are also afflicted often enough from diarrhoea. The public health policy of offering only specific services to women and concentrating on problems 'specific' to a certain age/life stage (e.g. maternal health) and ignoring general complaints and common infections is a fallacy that women are paying a heavy price for.

Duration of illness

The duration of illness as indicated in the previous chapter was a problematic area. Usually, we find that there is a preponderance of short-term acute illnesses in any household survey. However, the duration for episodes recorded prior to probing themselves indicates the difference between male and female morbidity (Table 4.12). Only 52.4 percent of the episodes reported by women have duration of a week or less. This is in contrast to the duration of male illness, which was of short duration. The episodes reported after probing are generally of much longer duration, largely between one month and five years. It is evident, therefore, that probing resulted in the recording of a large number of chronic illnesses. Hence, in the episodes recorded without probing, 72.9 per cent have duration of four weeks or less while in the episodes recorded after probing, 55.2 per cent of the episodes have duration of more than one year.

Duration and type of illness

Also the duration of various types of illness vary greatly (Table 4.13). For example, 89 per cent of the fevers, 70 per cent of the respiratory problems, 79.1 per cent of the injury / burns / boils and 54.3 per cent of the gastro-intestinal complaints had a duration of four weeks or less. In contrast, more than 40 per cent of reproductive problems, aches and pains, weakness related illness, as well as mental health problems have duration of more than one year to 10 years. It is important to note here that the recording of duration of illness was based entirely on the response of the woman. We observed that a wide

range of illnesses would be perceived as originating in one traumatic event (e.g. a miscarriage, or even death of a loved one). It was impossible for us to probe deeper into the duration of the long-term illnesses because no treatment was sought for them. Neglect could also be a factor contributing to the prolonging of the illness. It is noteworthy that the types of illness observed to have long-term duration are rarely debilitating enough to prevent activity altogether. Hence, they are also most likely to be neglected. However, they are persistent low intensity problems that considerably lower the women's feeling of well-being.

There is a significant difference in the duration of illness in the rural and urban households. 44.3 per cent of the rural episodes have duration of four weeks or less, compared to 28.4 per cent in the urban households. Even after adjusting for probing, urban women have, on average, reported a longer duration of illness. Access to treatment and health care is an important factor in shortening the duration of illness. However, as we will observe in the following chapters, access to health care in the urban areas is also very poor. With changing perceptions of illness, the awareness of bodily discomfort becomes more acute. In spite of advances in medicine, certain illnesses remain untreatable. For e.g. chronic back or body pain due to long hours of manual work; their cause may be traced to gender division of labour, coupled with lack of rest and insufficient nutrition. Though women have attained awareness of pain, they are powerless to remedy it. The presence of such long duration illnesses is not so much a sign of the intractability of disease as much as a reminder of the fact that women's roles remain unchanged and tedious. The greater reporting of long term illnesses among urban women may be seen as a result of a greater awareness of health problems.

The reasons for illness and links to life events

In 74 per cent of the female episodes, a reason for illness was stated (Table 4.14). In 4.5 per cent of the episodes, two reasons were stated for illness. We find a high degree of correspondence between the pattern of morbidity and the stated reasons for illness. In contrast to the males, **non-environmental causes are frequently cited by women for their illness**. **This is in keeping with the finding of a large number of non-infectious and long-term illnesses among women.** The wide variation in the reasons stated for illness is also an indicator of the complexity of women's perception of their health. For example, childbirth, contraception, menstruation, intercourse etc. comprise 22.8 per cent of the reasons stated for illness. A substantial 15.7 per cent of the reasons revolved around the effect of work and fatigue on ill health. Only 29.9 per cent of the reasons were directly related to the physical environment, food or the presence of an epidemic. A category of illness such as mental stress/illness can be attributed to many different causes. While most of these episodes are caused by general feelings of anxiety and 'tension', some of the episodes are specifically linked to grief (5 episodes), violence (3 episodes), infertility (2 episodes) and even old age and fatigue (2 episodes).

How women perceive illness is closely related to their lives and their dominant concerns. The reasons for illness reported by women of different ages are markedly different (Table 4.14). This also corresponds to the difference in the type of illness reported by each age group. Not surprisingly, 66 per cent of the reasons for illness among girls below 18 years are related to environmental factors and epidemics. For women in the childbearing age, reproductive reasons constitute 33.6 per cent of the stated causes of illness. It is worth noting that the second most important reason is work-related stress. In

the oldest age group, we find that 43.8 per cent of the reasons are comprised of work, fatigue, weakness and ageing. As we had earlier observed in the case of back pain, the same symptom/complaint is attributed by women of different ages to different reasons. That ill health must be understood in sociological terms, not merely medical terms, is evident from this example.

Similarly, we find some degree of co relation between women's work and their perception of illness. 22.1 per cent of the earning women's reasons were related to work and fatigue in comparison with 10.65 per cent among house-workers. They also associated emotional trauma, injury and stress/addictions more frequently with morbidity than house-workers. Remarkably, we find that 'environmental reasons' and reproductive reasons are present in the same proportion among both these groups of women. While house-workers cite weakness/old age more frequently as a reason for illness than earning women. This analysis demonstrates that factors such as stress, fatigue and weakness are perceived differently by each group of women. And is evidently linked to the milieu in which they live and work.

Conclusions

There is a marked difference in the illness of men and women, as well as different groups of women. Each aspect of women's lives influence morbidity in a distinct manner.

Certain factors as lack of physical access and social isolation inhibits the reporting of morbidity. However, poverty does not have a similar effect. Thus, there is a distinct co-relation between low socio-economic status and high morbidity, but not with 'access' or 'caste/community'.

The life stage of the woman has a pervasive effect on morbidity, both in terms of quantum and type. Factors, not hitherto considered seriously in studying morbidity, such as the size of household and the number of women sharing housework, are important keys to understanding what contributes to ill health among women. A gender analysis of health cannot afford to ignore these intra-household dynamics that affect women directly and, perhaps, more acutely, than men.

The rural-urban difference in type of morbidity, though marked, is not entirely predictable. Any understanding of health transition would prove insufficient in this case unless it is complemented by a better understanding of how illness is actually perceived by individuals and groups.

A little less than half of women's illnesses have continued for longer than a year. Nonetheless, they bear an equally heavy burden of acute infections as men.
Their gendered roles, as mothers and house-workers, contribute an additional load of health problems apart from the general health problems. Women's understanding of their own illness is deeply shaped by their experiences as can be observed from the range of reasons stated for illness. That they differ in emphasis in each group of women must be noted when we attempt any analysis of women's attempts to alleviate their suffering.

Table 4.1 Morbidity and Ill person's rate by sex and geography

	Persons ill	Ill person's rate	Episodes	Morbidity rate	Index	Total persons
Total Male	**1115**	**307**	**1200**	**330**	58	**3631**
Rural Male	868	326	923	346	61	2662
Urban Male	247	254	277	285	50	969
Total Female	**1812**	**506**	**2909**	**812**	142	**3581**
Rural Female	1355	512	2096	793	139	2643
Urban Female	457	487	813	866	152	938
Total	**2927**	**406**	**4109**	**570**	**100**	**7212**

Table 4.2 Type of morbidity in rural and urban households

Type of morbidity	Rural		Urban		Total	
Reproductive	386	12.8	196	18.0	582	14.2
GIT	227	7.5	74	6.8	301	7.3
Weakness	185	6.1	92	8.4	277	6.7
Aches/pain	412	13.6	193	17.7	605	14.7
Fevers	855	28.3	88	8.1	943	22.9
Respiratory	436	14.4	252	23.1	688	16.7
Sense organs	366	12.1	91	8.3	457	11.1
Injury/boil/burn	37	1.2	30	2.8	67	1.6
Mental stress	29	1.0	21	1.9	50	1.2
Others	86	2.8	53	4.9	139	3.4
Total	**3019**	**100**	**1090**	**100**	**4109**	**100**

Table 4.3 Morbidity rates among males by age group

Age group	Morbi-dity rate	Index	Number of males
0-17 years	350	106	1685
18-45 years	292	88	1370
46 years & above	373	113	479
No response	309	94	97
Total	**330**	**100**	**3631**

Table 4.4 Type of morbidity among Males

Type of Morbidity	Rural	Urban	Total

	Episodes	Percent	Episodes	Percent	Episodes	Percent
Reproductive	2	.2	—	—	2	.2
GIT	91	9.9	22	7.9	113	9.4
Weakness	12	1.3	5	1.8	17	1.4
Aches/pain	58	6.3	27	9.7	85	7.1
Fevers	403	43.7	47	17.0	450	37.5
Respiratory	204	22.1	124	44.8	328	27.3
Sense organs	111	12.0	31	11.2	142	11.8
Injury/boil/burn	12	1.3	12	4.3	24	2.0
Mental stress	2	.2			2	.2
Others	28	3.0	9	3.2	37	3.1
Total	**923**	**100**	**277**	**100**	**1200**	**100**

Duration of episodes among rural and urban males

Duration of episode	**Rural**		**Urban**		**Total**	
0-7 days	502	54.4	135	48.7	637	53.1
8-14 days	153	16.6	37	13.4	190	15.8
15-21 days	54	5.9	18	6.5	72	6.0
22-28 days	2	.2	3	1.1	5	.4
29-365 days	94	10.2	34	12.3	128	10.7
1 to 5 years	61	6.6	32	11.6	93	7.8
>5 to 10 years	23	2.5	9	3.2	32	2.7
>10 years	15	1.6	6	2.2	21	1.8
No Response	19	2.1	3	1.1	22	1.8
Total	**923**	**100.0**	**277**	**100.0**	**1200**	**100.0**

Reason of illness among rural and urban males

Reason for illness	**Rural**		**Urban**		**Total**	
Reproductive reasons	2	.3			2	.2
Stress, Addiction	7	1.1	7	3.0	14	1.6
Weakness, Old age	18	2.8	9	3.8	27	3.0
Work, Fatigue	79	12.1	22	9.4	101	11.4
Epidemic	218	33.4	12	5.1	230	25.9
Food, Water, Weather	208	31.9	114	48.5	322	36.3
Other Illness, Iatrogenic	37	5.7	23	9.8	60	6.8
Trauma, Injury	42	6.4	23	9.8	65	7.3
Others	42	6.4	25	10.6	67	7.5
Total responses	653	100	235	100	888	100
Total episodes	**636**		**217**		**853**	

Note: Multiple reasons for illness were stated.

Table 4.5 Ill person's rate and morbidity rate among women

	Women ill	Ill persons	Episodes	Episodes	Index	Number of
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**

Rural	1355	512	2096	793	98	2643
Urban	457	487	813	866	107	938
Duration of settlement						
Original/old settler	**1371**	**508**	**2131**	**789**	**97**	**2699**
Rural	1269	511	1944	783	96	2480
Urban	102	465	187	853	105	219
All year migrants,	**364**	**501**	**629**	**866**	**107**	**726**
Rural	66	584	110	973	120	113
Urban	298	486	519	846	104	613
Others	**77**	**493**	**149**	**955**	**118**	**156**
Rural	20	400	42	840	103	50
Urban	57	537	107	1009	124	106
Socio economic class						
Non worker, unskilled	**401**	**564**	**689**	**970**	**119**	**710**
Rural	207	586	336	951	117	353
Urban	194	543	353	988	122	357
Formal sector unskilled	**519**	**519**	**818**	**818**	**101**	**1000**
Rural	397	542	587	801	99	732
Urban	122	455	231	861	106	268
Formal sector skilled	**632**	**467**	**1000**	**739**	**91**	**1352**
Rural	556	461	873	725	89	1204
Urban	76	513	127	858	106	148
Professionals, trade	**260**	**501**	**402**	**774**	**95**	**519**
Rural	195	550	300	847	104	354
Urban	65	393	102	618	76	165
Caste/community status						
Upper Hindu castes	**335**	**481**	**559**	**803**	**99**	**696**
Rural	266	504	444	842	104	527
Urban	69	408	115	680	84	169
Other Hindu Castes	**373**	**540**	**586**	**848**	**104**	**691**
Rural	302	544	449	809	100	555
Urban	71	522	137	1007	124	136
Scheduled castes	**276**	**516**	**470**	**880**	**108**	**534**
Rural	142	561	239	944	116	253
Urban	134	476	231	822	101	281
Scheduled tribes	**704**	**488**	**1075**	**745**	**92**	**1443**

Rural	603	483	902	722	89	1249
Urban	101	521	173	892	110	194
Muslims, Christian	**124**	**571**	**219**	**1009**	**124**	**217**
Rural	42	711	62	1050	129	59
Urban	82	519	157	993	122	158
Rural women by Access*						
Easy Access	617	516	971	813	103	1194
Difficult Access	603	517	926	794	100	1165
Remote	135	475	199	700	88	284
Urban women by social access¨						
Non slum	115	424	181	668	77	271
Slum	341	512	631	947	109	666

**The referent for index is rural female morbidity rate (793)*
¨The referent for index is urban female morbidity rate (866)

Table 4.6 Ill person's rate and morbidity rates among women

	Women ill	Ill persons	Episodes	Episodes	Index	Number of
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Family size						
1-5 members	**620**	**576**	**1067**	**991**	**122**	**1076**
Rural	401	611	676	1030	127	656
Urban	219	521	391	931	115	420
6-10 members	**960**	**501**	**1509**	**787**	**97**	**1916**
Rural	744	511	1125	773	95	1455
Urban	216	468	384	833	103	461
11-15 members	**189**	**422**	**269**	**601**	**74**	**447**
Rural	167	428	231	592	73	390
Urban	22	386	38	666	82	57
More than 15 members	**43**	**302**	**64**	**450**	**55**	**142**
Rural	43	302	64	450	55	142
Number of women in household						
One woman	**521**	**594**	**891**	**1016**	**125**	**877**
Rural	336	607	549	992	122	553
Urban	185	571	342	1055	130	324
Two women	**585**	**517**	**960**	**848**	**104**	**1131**
Rural	426	531	682	851	105	801

Urban	159	481	278	842	104	330
3 or more women	**706**	**448**	**1058**	**672**	**83**	**1573**
Rural	593	460	865	671	83	1289
Urban	113	397	193	679	84	284
Morbidity and Ill person's rate for women above 12 years in households with only one woman						
1-5 members		765		1500	185	362
6-10 members		828		1727	213	99
11-15 members		1000		2000	246	1

Table 4.7 Ill person's rates and morbidity rates for women

	Women reporting illness	Ill persons per 1000	Total episodes	Morbidity rate per 1000	Index	Total Women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
Age group						
Upto 4 years	**175**	**356**	**183**	**372**	**46**	**491**
Rural	130	357	134	368	45	364
Urban	45	354	49	385	47	127
5 - 11 years	**214**	**330**	**226**	**349**	**43**	**647**
Rural	170	349	176	362	45	486
Urban	44	273	50	310	38	161
12 - 17 years	**156**	**377**	**198**	**479**	**59**	**413**
Rural	122	389	152	485	60	313
Urban	34	340	46	460	57	100
18 - 25 years	**307**	**496**	**507**	**819**	**101**	**619**
Rural	222	497	345	773	95	446
Urban	85	491	162	936	115	173
26 - 35 years	**346**	**679**	**655**	**1286**	**158**	**509**
Rural	245	696	441	1252	154	352
Urban	101	643	214	1363	168	157
36 - 45 years	**231**	**697**	**442**	**1335**	**164**	**331**
Rural	172	696	320	1295	159	247
Urban	59	702	122	1452	179	84
46 - 55 years	**178**	**687**	**339**	**1308**	**161**	**259**
Rural	130	702	250	1351	166	185
Urban	48	648	89	1202	148	74

56 years and above	**168**	**717**	**299**	**1277**	**157**	**234**
Rural	128	731	220	1257	155	175
Urban	40	678	79	1339	165	59
No response	**37**	**474**	**60**	**769**	**95**	**78**
Rural	36	480	58	773	95	75
			Marital status			
Never married	**538**	**344**	**594**	**379**	**47**	**1564**
Rural	406	358	436	384	47	1134
Urban	132	307	158	367	45	430
Currently married and cohabiting	**1045**	**621**	**1920**	**1141**	**141**	**1682**
Rural	782	619	1385	1096	135	1263
Urban	263	627	535	1276	157	419
Widowed, separated, e.t.c	**229**	**685**	**395**	**1182**	**146**	**334**
Rural	167	678	275	1117	138	246
Urban	62	704	120	1363	168	88

Table 4.8 Ill person's rates and morbidity rates for women

	Women reporting illness	Ill persons per 1000	Total episodes	Morbidity rate per 1000	Index	Total Women
Total	**1812**	**506**	**2909**	**812**	**100**	**3581**
			Number of living children			
No children	**127**	**458**	**216**	**779**	**96**	**277**
Rural	107	455	177	753	93	235
Urban	20	476	39	928	114	42
1-2 children	**376**	**573**	**645**	**983**	**121**	**656**
Rural	260	567	420	917	113	458
Urban	116	585	225	1136	140	198
3-4 children	**490**	**707**	**923**	**1331**	**164**	**693**
Rural	371	717	680	1315	162	517
Urban	119	676	243	1380	170	176
More than 4 children	**276**	**718**	**524**	**1364**	**168**	**384**
Rural	207	706	378	1290	159	293
Urban	69	758	146	1604	198	91
Not married	**538**	**344**	**594**	**379**	**47**	**1564**

Rural	406	358	436	384	47	1134
Urban	132	307	158	367	45	430
No response	**5**	**714**	**7**	**1000**	**123**	**7**
			Earning status			
Non earners	**496**	**357**	**571**	**411**	**51**	**1389**
Rural	371	368	413	409	50	1008
Urban	125	328	158	414	51	381
House-workers	**398**	**596**	**729**	**1093**	**135**	**667**
Rural	221	605	388	1063	131	365
Urban	177	586	341	1129	139	302
Earners	**918**	**602**	**1609**	**1055**	**130**	**1525**
Rural	763	600	1295	1019	125	1270
Urban	155	607	314	1231	152	255
			Education			
Illiterate	**967**	**653**	**1766**	**1193**	**147**	**1480**
Rural	774	643	1357	1127	139	1204
Urban	193	699	409	1482	183	276
Primary	**94**	**696**	**171**	**1267**	**156**	**135**
Rural	63	708	113	1270	156	89
Urban	31	674	58	1261	155	46
Secondary	**137**	**557**	**256**	**1041**	**128**	**246**
Rural	82	526	143	917	113	156
Urban	55	611	113	1256	155	90
Higher secondary	**43**	**478**	**66**	**733**	**90**	**90**
Rural	12	462	17	654	81	26
Urban	31	484	49	766	94	64
College, tech, prof'nl	**23**	**307**	**37**	**493**	**61**	**75**
Rural	1	333	3	1000	123	3
Urban	22	306	34	472	58	72

Table 4.9 Type of morbidity among women before and after probing

Type of morbidity	Before probing		Total	
	Episodes	Percent	Episodes	Percent
Reproductive	50	3.9	580	19.9
Aches/pain	125	9.6	520	17.9
Fevers	489	37.7	493	16.9
Respiratory	301	23.2	360	12.4
Sense organs	128	9.9	315	10.8
Weakness	30	2.3	260	8.9
GIT	103	7.9	188	6.5
Others	52	4.0	102	3.5
Mental stress	7	.5	48	1.7

Injury/boil/burn	13	1.0	43	1.5
Total	1298	100.0	2909	100.0

Table 4.10 Detailed type of morbidity among women

Type of morbidity episodes	Episodes	% of sub total	% of all
Menstrual problems	181	31.2	6.2
R.T.I	105	18.1	3.6
Maternity and Contraceptive related prob.	243	41.9	8.4
Other Reproductive problems	51	8.8	1.8
Sub-total	**580**	**100**	**19.0**
Weakness	176	67.7	6.1
Night blindness	84	32.3	2.9
Sub-total	**260**	**100**	**9**
Aches, pains	462	88.9	15.9
Head ache	58	11.2	2.0
Sub-total	**520**	**100**	**17.9**
Stomach ache	88	46.8	3.0
Diarrhea, Vomiting	100	53.2	3.4
Sub-total	**188**	**100**	**6.4**
Fevers	493	100	17.0
Sub-total	**493**	**100**	**17.0**
Colds	152	42.2	5.2
Cough, TB	148	41.1	5.1
Breathlessness	60	16.7	2.1
Sub-total	**360**	**100**	**12.4**
Eyes, ears problems	228	72.4	7.8
Boils, skin, hair problems	87	27.6	3.0

Sub-total	**315**	**100**	**10.8**
Injury, burns, bites	43	100	**1.5**
Mental illness, stress	48	100	**1.7**
Others	102	100	**3.5**
Total	**2909**		**100**

Table 4.11 Type of morbidity among women with specific variables

Rural and urban households

	Rural			**Urban**			**Total**		
Type of morbidity	*Episodes*	*percent*	*Episodes per 1000*	*Episodes*	*Percent*	*Episodes per 1000*	*Episodes*	*Percent*	*Episodes per 1000*
Reproductive	384	18.3	145	196	24.1	209	580	19.9	162
GIT	136	6.5	51	52	6.4	55	188	6.5	52
Weakness	173	8.3	65	87	10.7	93	260	8.9	73
Aches/pain	354	16.9	134	166	20.4	177	520	17.9	145
Fevers	452	21.6	171	41	5.0	44	493	16.9	138
Respiratory	232	11.1	88	128	15.7	136	360	12.4	101
Sense organs	255	12.2	96	60	7.4	64	315	10.8	88
Injury/boil/burn	25	1.2	9	18	2.2	19	43	1.5	12
Mental stress	27	1.3	10	21	2.6	22	48	1.7	13
Others	58	2.8	22	44	5.4	47	102	3.5	28
Total	**2096**	**100**	**793**	**813**	**100**	**867**	**2909**	**100**	**812**

Age groups

Age group response	**0 - 17 years**		**18-45 years**		**Above 45 years**		**No**	
Type of morbidity	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*
Reproductive	41	26	471	323	59	120	9	115
GIT	45	29	96	66	46	93	1	13
Weakness	7	5	159	109	83	168	11	141
Aches/pain	36	23	306	210	157	318	21	269
Fevers	227	146	189	130	71	144	6	77
Respiratory	157	101	119	82	81	164	3	38
Sense organs	69	44	142	97	98	199	6	77
Injury/boil/burn	7	5	28	19	8	16		0

Mental stress	1	1	36	25	9	18	2	26
Others	17	11	58	40	26	53	1	13
Total	**607**	**391**	**1604**	**1099**	**638**	**1294**	**60**	**769**

	Socio-economic class of household							
	Non-Worker, Professionals, Unskilled		**Formal Sector /Unskilled**		**Formal Sector Skilled**		**Trade**	
Type of morbidity	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*	*Episodes*	*Episodes per 1000*
Reproductive	152	162	161	214	189	161	78	140
GIT	42	52	56	59	72	56	18	53
Weakness	69	73	71	97	86	71	34	64
Aches/pain	120	145	145	169	180	145	75	133
Fevers	93	138	146	131	179	146	75	132
Respiratory	87	101	110	123	107	110	56	79
Sense organs	70	88	82	99	125	82	38	92
Injury/boil/burn	15	12	10	21	10	10	8	7
Mental stress	17	13	16	24	12	16	3	9
Others	24	28	21	34	40	21	17	30
Total	**689**	**970**	**818**	**818**	**1000**	**739**	**402**	**774**

Table 4.12: The duration reported by women for episodes recorded with and without probing

Duration of episode	**Without probing**		**With probing**		**Total**	
	Episodes	**Percent**	**Episodes**	**Percent**	**Episodes**	**Percent**
0-7 days	680	52.4	145	9.0	825	28.4
8-14 days	177	13.6	41	2.5	218	7.5
15-21 days	78	6.0	25	1.6	103	3.5
22-28 days	11	.8	3	.2	14	.5
29-365 days	155	12.0	429	26.6	584	20.1
1 to 5 years	100	7.7	564	35.0	664	22.8
5 to 10 years	30	2.3	176	10.9	206	7.1
More than 10 years	33	2.5	150	9.3	183	6.3
No Response	33	2.5	78	4.8	111	3.8
Total	1297	100.0	1611	100.0	2908	100.0

Table 4.13 Duration of episodes reported by women according to the type of morbidity

	Duration of episode					
Type of morbidity	**Up to 4 weeks**	**31-365 days**	**1- 10 years**	**More than 10 years**	**No response**	**Total**
Reproductive	46	147	281	77	29	580
	7.9	25.3	48.4	13.3	5.0	100.0
GIT	102	42	31	6	7	188
	54.3	22.3	16.5	3.2	3.7	100.0
Weakness	35	82	119	11	13	260
	13.5	31.5	45.8	4.2	5.0	100.0
Aches/pain	108	132	229	35	15	519
	20.8	25.4	44.1	6.7	2.9	100.0
Fevers	439	29	12	2	11	493
	89.0	5.9	2.4	.4	2.2	100.0
Respiratory	252	39	41	15	13	360
	70.0	10.8	11.4	4.2	3.6	100.0
Sense organs	113	69	105	15	13	315
	35.9	21.9	33.3	4.8	4.1	100.0
Injury/boil/burn	34	4	3		2	43
	79.1	9.3	7.0		4.7	100.0
Mental stress	2	13	20	9	4	48
	4.2	27.1	41.7	18.8	8.3	100.0
Others	29	27	29	13	4	102
	28.4	26.5	28.4	12.7	3.9	100.0
Total	**1160**	**584**	**870**	**183**	**111**	**2908**
	39.9	**20.1**	**29.9**	**6.3**	**3.8**	**100.0**

Note: Percentages are row percentages, Missing cases =1

Table 4.14 Stated reasons of illness for women of different age groups

Reason	**0-17 years**		**18-45 years**		**46 and above**		**No response**		**Total**	
Reproductive	36	**7.7**	434	**33.6**	42	**8.7**	12	**21.4**	524	**22.8**
Stress, Addiction	3	**0.6**	48	**3.7**	19	**3.9**	4	**7.1**	74	**3.2**
Weakness, Old age	1	**0.2**	104	**8.0**	130	**26.9**	12	**21.4**	247	**10.7**
Work, Fatigue	21	**4.5**	243	**18.8**	82	**16.9**	14	**25.0**	360	**15.7**
Epidemic	111	**23.8**	101	**7.8**	36	**7.4**	5	**8.9**	253	**11.0**
Food, Water, Weather	197	**42.3**	157	**12.1**	73	**15.1**	6	**10.7**	433	**18.8**
Other illness, Iatrogenic	29	**6.2**	80	**6.2**	51	**10.5**	1	**1.8**	161	**7.0**
Trauma, Injury	28	**6.0**	68	**5.3**	26	**5.4**			122	**5.3**
Others	40	**8.6**	58	**4.5**	25	**5.2**	2	**3.6**	125	**5.4**
Total	466	**100**	1293	**100**	484	**100**	56	**100**	2299	**100**

Table 4.15 Stated reasons of illness for women by type of morbidity

	Type of morbidity										Total
Reason for illness	Repro.	G.I.T	Weak-ness	Aches/pain	Fevers	Respi-ratory	Sense organ	Injury	Ment. Stress	Other	
Reproductive	436	7	32	28	2	3	3		2	11	**524**
Stress, Addiction			6	8	2	5	6	3	39	5	**74**
Weakness, Old age	28	8	91	61	7	15	33		1	3	**247**
Work, Fatigue	18	2	64	187	55	19	9	4	1	1	**360**
Epidemic		15		1	132	39	64			2	**253**
Food, Water, Weather	24	63	12	45	112	146	12	2		17	**433**
Other Illness, Iatrogenic	10	12	21	39	18	21	27	3		10	**161**
Trauma, Injury	4	7	7	26	18	10	16	30		4	**122**
Others	5	7	9	25	23	15	29	1	2	9	**125**
Total	**525**	**121**	**242**	**420**	**369**	**273**	**199**	**43**	**45**	**62**	**2299**

5. Utilisation of Health Care

Although the utilisation of health/curative services is only one aspect of health care, the services are important in securing good health for individuals and the lack of access to them is a reflection of an overall deprivation. Health services are known to be inaccessible for the poor and disadvantaged sections of our society, especially women.

Utilisation of health services is a complex phenomenon which is affected by various factors-people's perception about illness, severity of illness, need for health care, their knowledge about health care services, physical, economic and social accessibility of health care services, quality of care, the structure of the health system and the biases of the health care providers.

Measuring access to health care, especially in its varied forms in both the formal and informal sector is a challenge. This study has attempted to measure it by studying the type of health services available to the community, treatment of illness and utilisation of health care services.

The purpose is to understand some aspects of access to health services by looking at the **proportion of treated and untreated illness** episodes as well as **type of health facility** utilised for the treated illness episodes. Methodologically, this study defines health seeking or treatment of illness broadly, so as to incorporate all health care services and facilities. 'Treatment' includes even those services received in the form of self-care / self- medication, home remedy, healing rituals and practices (not including ceremonial rituals for good health). The idea was to include the entire gamut of utilisation of health care services in the community and to be able to analyse the health care provision without a bias in favour of formal health care services. This approach has helped arrive at the concept of "no treatment" which means episodes where *no action* has been taken to alleviate the situation, during the reference month.

'Treatment of illness' includes examination, cure and care of illness, symptoms reported and other health needs. Non -treatment is when an illness episode is reported within the recall period, and no action is taken. 'Utilisation' is defined to mean ald actions taken to access knowledge, facilities, items and services to ease, reduce, eliminate, or prevent illness or specific symptoms or to cater to their health needs.

Formal and informal facilities

Households' respondents report their actions which occur in varied settings and cannot be classified into categories based on only on either type of institution or ownership or provider. In order to classify them — informal/formal —, it becomes necessary to take into account all the three factors (See Table 5.1).

Informal services are defined as those provided by lay or unqualified providers, generally not based in specialised health institutions (chemist shops being an exception). They may be entrenched in the modern market, (as with self-medication and care by unqualified private practitioners) or may be organised according to religious or social custom (traditional practitioners). Largely, informal services are more accessible — physically, economically or socially.

Formal services are defined as those provided by 'doctors' without regard to the setting. Although paramedical staff and aanganwadi workers are not thus 'qualified', they are included in the formal sector because providing curative services is a part of their job. The assumption is that their services are within the limits of their training and expertise. Also these workers are one link in the complex public health system. As providers, they have access to referral services, expert advice and emergency services for their patients, which are not available to private unqualified practitioners. However, all the formal providers identified in the study were not necessarily trained and registered, especially in rural areas. Some of them had well equipped clinics in the taluka town with in patient facilities, while others arrived on motorcycle once or twice a week carrying an extremely limited range of drugs. They set up a temporary clinic either in a hut or even under a tree and attended to more than thirty patients in a couple of hours.

The paramedical workers were generally women – Auxiliary Midwife Nurses or aanganwadi workers residing in the village and were, thus, easily accessible. Government doctors were, perhaps, the only fully trained providers available to the rural households. They were generally to be found in the PHCs. In a few cases, the rural households accessed care from the government doctors in the sub centres or in camps. The private in-patient facilities used by the rural households were invariably in the neighbouring towns or Nashik.

There were some differences in the informal facilities used in the rural and urban households but self care practices were similar - drinking concoctions, massage, applying herbal pastes or plasters. The urban households accessed chemist shops that were mostly within walking distance where drugs were sold over the counter (without prescription). Often, people produced a foil of used tablets and obtained medicines. In rural areas, the use of self-medication was restricted to villages close to a town, or situated on the highway or main road. The traditional practitioners used by rural households could vary from the local herbalist to divine healers practising in another district. One unique case was of a family having three mentally ill brothers who were

taken every month by the family in a hired jeep to a swami who gave treatment in a temple in Ahmednagar district. The use of traditional practitioners by rural households was widespread. On the other hand, traditional providers were used by urban households only for specific problems such as jaundice or to cure infertility. The providers were also often located in another town or district.

The formal and informal services differ not so much in quality as in access and availability. The classification helped study the differences in the utilisation of health care by different socio-economic groups.

Formal care is not necessarily 'better' than informal care but it is more expensive and compels the user to enter into institutionalised health systems. It is also preferred in most situations. Whether it is a general practitioner or a large general hospital, there are same hierarchies and biases that are found in the society. Thus, access to these services is limited not only by physical but also social and economic factors. Therefore, the use of formal care becomes an important variable to consider while examining the socio-economic determinants of health care use. Informal services, often similarly trapped in the modern market system, are still organised differently. They are used to supplement formal care and sometimes as a substitute for unavailable formal care. Only occasionally, they are the first choice – for apparently incurable, chronic or supernatural problems.

Total neglect of health problems expressed as *no treatment taken in the reference month* is the most accurate measure of deprivation. The episode is not treated at all, either out of inability or unwillingness to use health care at all, despite an awareness of the health problem.

Background

Little information is available about health facilities existing in the sample area. There were seven public health centres (PHCs) in Igatpuri taluka in 1994-95 (EHO; Nashik; 1995). Apart from one PHC which was established in 1964 at Ghoti, all the others were established after 1983. There were 13 posts of medical officers approved in these PHCs, of which four were vacant in 1994-95. There were 235 general beds, 52 maternity beds and 15 beds of other category and apart from maternity cases, 339 patients had been treated as in-patients. In all, 43,189 persons used the out-patient facilities provided by the PHCs in that year.

Of the villages selected, three had a PHC and six had a sub centre each while four villages had no public health facilities at all. Of the villages having a sub centre, it was closed in one village and there was no Auxiliary Nurse Midwife (ANM) on duty. In most of the villages, the sub centre was located in the house of the ANM, who herself was living in a small rented hut. In two villages, the ANM used to commute to the village daily. The ANM had a very limited supply of drugs and equipment and had to refer cases requiring even very basic health care. In other villages, there were no curative services to speak of. A rural hospital was located in Ghoti, the largest village in the taluka. None of the sampled villages in the sample had a private in-patient facility. The nearest in-patient public facilities were located in Ghoti and Bhagur, and Igatpuri towns.

In Nashik City, there were two public hospitals, which were utilised. There was also a hospital reserved for the emplgyees of the Mint of the Reserve Bank of India. Apart from this, there were several private practitioners and nursing homes.

Use of health care

Using three indicators - no treatment, use of formal care and informal care, the study shows that the use of health care is greatly influenced by socio-economic factors. About 62.8 per cent of illness episodes are treated (2579 out of 4109 episodes) while 37.2 per cent are not treated (1530 of 4109) (Table 5.2).

Analysed in terms of rural and urban areas, more episodes are treated in rural areas 65.2 per cent against 56 per cent in urban areas. About 34.8 per cent remain untreated in rural areas while the figure for urban area is 44 per cent. This finding does not gel with the higher reporting of illness episodes in urban areas. **It is possible to say that greater awareness of health problems does not necessarily lead to greater utilisation of health services.** That the urban sample had a predominance of poor households is a pointer to economic factors influencing utilisation.

It must be noted that while the percentage of untreated episodes without probing ranges from 18 to 20 per cent for both males and females, among episodes recorded after probing, the percentage of no treatment is 65.4 per cent. (Table 5.2). This indicates the great effect that utilisation also has on perception. As women receive no care for particular illnesses, they tend not to report them in a survey.

Also, there is a difference in the facilities utilised for episodes reported with and without probing. The 'without probing' episodes showed that 77.3 per cent of the facilities used were in the formal sector while probing revealed that the extent was only 64.5 per cent (Table 5.3).

As noted earlier, the urban sample has proportionately more poor households who have very few means to purchase health care. So, despite the fact that both private and public facilities are more concentrated in urban areas, especially Nashik city, the utilisation is less — only 60 facilities of all kinds per 100 episodes while rural households used 72 per 100 (Table 5.4).

Regarding the type of facilities utilised (Table 5.5), there are some marked differences between rural and urban use. While rural households used 57 formal facilities for 100 episodes, the corresponding figure for urban households was only 37. More informal facilities were used in the urban areas, largely self-care and self-medication. The easy availability of drugs over the counter in urban areas also leads to greater use of informal facilities. Thus, **a pattern emerges in urban areas — a high rate of no treatment, more use of informal care and less use of formal care.**

Further, among the informal services used in urban areas, chemist shops account for more than half. This indicates the high use of self-medication by the urban households. In contrast, government doctors and paramedics together account for 23 per cent of the total rural health care services used and 29 per cent of the formal facilities used. The use of traditional practitioners is expectedly higher in the rural areas. In general, private practitioners account for more than half of the total facilities used by both urban and rural

households and more than 70 per cent of the formal facilities utilised. However, it is worth noting that 25.1 per cent of all facilities used are in the informal sector. Most surveys do not record the use of these services. When combined with the fact that a large proportion of episodes are not treated at all, it shows the extent to which people, especially women, have been marginalised from the formal health care system.

Regarding access to formal care, there were 0.38 visits per person to a private or government doctor in the rural sample, while there were 0.29 visits recorded per person in the urban sample. Taken together, this figure was 0.35. It is necessary to consider the information for men and women separately. While the figure for rural men was 0.31 visits per person per month, urban men recorded 0.23 visits. For rural women, the figure was 0.45 and for urban women 0.35. There was health care utilisation in some measure even for the additional morbidity, which is reflected, in the higher number of visits recorded for women.

About the rate of treatment for the different type of illnesses, there is a predictable pattern (Table 5.6). **The most neglected illnesses are mental illnesses, reproductive illnesses, weakness-related illnesses. Less than one third of these were treated. Importantly, women reported these illnesses predominantly.** While it is true that many of these episodes were reported with probing, there is reason to believe that reproductive problems and weakness would be more common among women than men. Neglect places a heavier burden on women's health. Conversely, acute infections are very frequently treated, with 86 per cent of 'fevers' receiving attention. Since these illnesses are most frequently reported in a general household survey, the rate of no treatment does not seem to be so high. However, a gender specific study such as this finds a very high rate of untreated illnesses because the pattern of illnesses reported is itself very different.

Utilisation of Health Care by Men

Of the 1200 episodes reported among men, 212 (17.7 per cent) were not treated (Table 5.7). There is a significant difference in the treatment rate for urban and rural men. While 16 per cent of rural episodes remained untreated, the figure was 23 per cent for urban areas despite the fact that reporting of morbidity in urban areas was lower for men. Also, urban men used 25 informal facilities for every 100 episodes of illness and 71 formal facilities were utilised. There is a variation in the type of facilities used by men in the rural and urban areas. While rural men used 16 informal facilities for every 100 episodes, urban men used 28 such facilities. In contrast, 75 formal facilities per 100 episodes are used in rural area, while only 56 formal facilities are used in urban areas. This indicates that not only is there more neglect in the urban areas, informal care is also used to substitute formal care in the urban sample.

This is the result of the urban sample selected which had a high predominance of poor households. Only 12 per cent of the episodes of men living in non-slum households were not treated, in comparison to 26 per cent in slum households. A similar disparity is to be found in the use of facilities. Men in the non-slum urban households used 22 informal facilities and 68 formal facilities per 100 episodes. In contrast, men in slum households used 30 informal facilities and only 53 formal facilities per 100 episodes. Also 22 per cent of the facilities used by the men in rural households were in the state sector, as compared to 9 per cent in urban households. The other major difference was that self-

medication from chemist accounted for 21 per cent of the total facilities and 64 per cent of the informal facilities in urban areas. Self care also accounted for 10 per cent of the facilities utilised in urban areas.

Utilisation of Health Care by Women.

The use of health care by women is significantly different from men. Not only is there a difference in the quantum of care used, but also in the type of facilities utilised and the nature of treatment sought. In this study, health care use was studied in relation to morbidity (i.e. 'what did you do for a particular illness'). As the purpose was to study women's illness, health care used by women must be studied separately from men. The choice between care in the formal or informal sector is dependent on many factors. Especially in the case of women, it would be wrong to assume that formal care would always be preferred to informal care. The nature of some of women's health problems makes the use of self-medication and self care an important and essential part of looking after oneself. This is especially true of chronic problems such as aches and pains that result from women's work routine.

However, it must also be acknowledged that, often, informal care, although inadequate, is used because the formal health care system is out of reach. Finally, the complete absence of any action (opportunity) to seek care must be taken into account in the study of use of health care. **In order to understand the various factors that influence the use of health care, three aspects have been studied in greater detail — The percentage of episodes left untreated, the percentage of episodes treated first in the formal system and in the informal system.** As discussed earlier, these are only approximate indicators of access to care, but when viewed in combination with the perception of illness and expenditure on health care, they provide credible answers to the question – what makes women vulnerable to neglect?

Geography

As noted in the earlier chapter, morbidity among women in urban areas was higher than among the rural women in terms of number of episodes, but lower in terms of number of women ill. In general, the rate of treatment for the illnesses was very low. Thus, 51.3 per cent of all the episodes among urban women were not treated at all (Table 5.8). In contrast, 42.9 per cent of the episodes in rural areas were not treated.

Among the urban women, there is a significant difference between the access to health care of women living in slum and non-slum localities. While 40.9 per cent of the episodes of non-slum locality women were not treated, 54.4 per cent of the episodes of slum locality women were not treated. **Given the fact that physical access is the same for both categories of women, it is the social and economic barriers to health care, which are insurmountable.**

In rural areas, 48 facilities in the formal sector were used for every 100 episodes, while for urban areas the figure is only 30. However, the use of informal care is significantly higher in the urban areas. This may be on account of the easy availability of medicines without prescription and greater confidence in using them without supervision. Also the pattern of illness in urban areas, with a high predominance of long-term non-infectious

illnesses, makes the use of services in the informal sector such as self-care and self-medication more likely. Women in non-slum localities, who have more access to formal health care use more of both formal as well as informal health care.

Access

Among rural households, physical access to health care and to other facilities varied considerably. Women in remote areas recorded lower morbidity than other rural women, which showed a lack of consciousness about health problems. The extent of their deprivation can be seen from the fact that as much as 47 per cent of the few episodes recorded were left untreated. Their access to formal health care was extremely poor. They used only 40 formal facilities for every 100 episodes. Surprisingly, their use of informal care is not considerably higher than other rural women.

It is no longer useful to conceive of health care in the informal sector as dependent on the use of indigenous resources. Informal sector care is also highly integrated into the market system, especially in the form of self-medication using allopathic drugs. As noted in the first chapter, **most of the remote rural households were land-less and poor. Given the fact that both their economic as well as physical access to services is low, it is not surprising that neglect, not self care, takes the place of absent formal health care services.**

Duration of settlement

Being a migrant reduces one's capacity to access health care because of a poorer social network as well as poorer knowledge about the availability of facilities. Also, **migrants usually have a lower socio-economic status which limits their access to health care**. In the use of health facilities, there is a fairly significant difference between migrant and non migrant households. While 47 formal facilities were used by old settlers for 100 episodes, the figure was 33 for migrants.

Also, 51.4 per cent of the episodes among the migrant women were not treated as opposed to 43.6 per cent in the old settlers. While the use of formal services by migrants is marginally higher in rural areas; the rate of treatment is similar to that of settled households. Migrant women used public health care marginally more often than old settlers, it means higher use of formal care. In urban areas, relative neglect is evident among the migrant households where the rate of treatment as well as the use of formal health care is lower. **In general, health care is utilised less by migrant women.**

There is a vast difference in the cost of health care used by settled and migrant households, the cost being almost twice as high for settled households. This is in spite of the fact that public i.e. free facilities are used in equal proportion by both groups. The only significant difference being that migrants resort more frequently to self medication than settled households.

Socio-economic class

Unlike morbidity, **there is a high degree of co relation between socio-economic status and use of health care. Both the rate of treatment and the use of formal health care are higher among women of the higher socio-economic group.**

The class bias in the use of formal care is very distinct. While 53.3 per cent of the episodes among households in the lowest class are not treated, 39.6 per cent of the episodes of the highest class are not treated. Significantly, the use of informal health care is equally prevalent among all the groups. This indicates that informal care is used to supplement formal health care by the upper class and not to substitute it. In the absence of formal health care, for the poorest class, complete neglect takes place as reflected in the higher percentage of untreated episodes. It is significant to note that among the poorest women in the urban areas, the use of informal care and formal care is both low. The disparity between the poorest and the second lowest class is greatest while there are only minor differences in the utilisation pattern of the upper three classes. This shows that the poorest section is completely marginalised, even in the highly developed health systems.

Caste/community

Cultural factors do play a significant role in determining access to health care (Table 5.9). In rural areas, where the minority community households were all located in villages on the main road their use of formal services as well as the rate of treatment is high whereas in urban areas, the morbidity of minority community women and scheduled caste women is greatly neglected.

Muslim/Christian women used only 19 formal facilities for every 100 episodes while upper caste Hindu women used 40 formal facilities for 100 episodes. 59.7 per cent of the episodes of urban scheduled caste women were not treated. Muslim urban women rely greatly on informal care. The minority and scheduled caste women resided primarily in the slums in the urban areas. Thus, their inability to access formal health care must be seen to result from a combination of cultural and economic factors. On the whole, we find that the access of scheduled caste women to health care is the poorest, as is their access to formal facilities.

Composition of the household

Morbidity among women was higher in smaller households as well as in households with fewer women — explained by the fact that a heavier burden of work is imposed on such women. However, there are only marginal differences in their health care seeking behaviour. Facilities in rural areas are at a much greater distance than in urban areas. Thus, not only does a women require more time to seek these services but also needs family members to accompany her. Hence those living in smaller families are disadvantaged.

The number of women in the households also affects the pattern of treatment for women in rural areas more visibly. Fewer episodes are left untreated in households with three or more women. The use of formal care for women is also much higher for such women. In urban areas, however, we find that the differences are very small and inconsistent though, here, too, the highest percentage of untreated episodes are to be found among single woman households. However, the health care seeking behaviour of

women in single woman households of varying sizes does not show any difference. This is contrary to the finding that morbidity is higher among women living in larger single-woman households.

To extend the understanding about the relationship between work and health for women, we must study the process of seeking health care in the household in much greater detail. With a better understanding of the value placed on women's work in households and the process by which women support each other in the household, these links will become clearer.

The position of the household is an important determinant of the opportunities available to women to seek health services. Intra-household factors alone are relied upon to provide a complete understanding of a woman's life situation but social research cannot neglect the traditional paradigms of class, caste and culture in a study of women's health. Not only do women see their lives and fates as inextricably linked to that of their households and community, they are also active players in evolving the relationship of these groups to the larger community. Though it is not possible here to analyse in detail how the class/caste consciousness is reflected in their everyday individual lives, we cannot lose sight of it

Life stage

The type of morbidity among women of different ages varies significantly. Still, it was possible to trace the history of women's health problems through their life and find that each life stage adds on a certain set of problems to the existing condition of ill health. Thus, women's morbidity continues to rise till old age. To complement this finding, **the study showed that young adult women's and aged women's access to health care was very poor (Table 5.10).**

While women between 18 and 45 reported the highest number of untreated episodes and the lowest use of formal care, the condition of aged women was not significantly better. On disaggregating data obtained with and without probing, there was no significant difference in the health care use of women and small girls. An equal proportion of episodes were left untreated for both (18 to 20 per cent). Thus, the stark difference in morbidity that was to be seen between women of different age groups was not to be found in the utilisation of health care where **the absence of health care seeking was uniformly high for women of all age groups.**

Marital status

In terms of marital status, currently married women had the lowest use of health care, as also of formal care. Ever married single women showed marginally higher use of health care. Unmarried women had the highest use of health care. This suggests that **there is no simple relationship between marital status and access to resources.** While, it is true that ever married single women are more likely to be heads of the household, it would be wrong to assume that they automatically have higher access to resources. This is because the freedom to make decisions is not accompanied by availability of resources. At the same time, to assume that currently married women are deprived due to their subordinate position in the household would be inappropriate. Their access to

health care depends greatly on the position of their households and the composition of the family.

Number of living children
Ts1
An interesting co-relation of use of health care is to be found with the number of living children that a woman has. In general, **the proportion of untreated episodes was marginally higher with an increase in the number of living children.** This complements the finding that morbidity is higher among women who have more children. However, disaggregating data for rural and urban women showed this trend among rural women but no distinct trend was visible among the urban women. This may, of course, be the result of the fewer numbers of women available for comparison. There was no difference in the use of facilities.

On analysing the information for women between 18-45 years, it showed that the proportion of untreated episodes increased with increase in the number of living children. However, the use of formal and informal facilities did not show any consistent trend. As noted in the earlier chapter, problems related to childbearing (aches, pains, reproductive problems) are more common among women with more children, as also those related to ageing. As both of these types of illnesses are most often ignored, it is certain that the quantum of care received by these women is not in proportion to the magnitude of their ill health.

Work

There was no direct relationship between earning status and health care access (Table 5.11). Instead, those women who bore the responsibility of running the household were more likely to be neglected. Thus, the rates of untreated episodes for earning women and house-workers were equally high. Marginally more formal care was used by earning women. However, the greatest contrast was with non-earning women where substantially more health care was provided. As the non-earners were most likely to be ygung girls, this pattern of health care is understandable. It must be remembered that since the probe did not include illness among young girls, the extent of care received by them may be misjudged.

Education

There was a slight increase in the use of health care with increase in education. In general, the proportion of untreated episodes decreases as education increases. Surprisingly, the use of informal care by women with higher education was very high, largely in the form of self-medication. However, there was no distinct trend to be found in the use of formal or informal services in relation to education.

Type of facilities utilised

Type of facility used in rural and urban households

The facilities used by women were different in the rural and urban households (Table 5.12). While, in both groups, private doctors accounted for the largest number of facilities used, **the use of self-medication by urban women was considerably higher as also the use of self-care.** Rural women used 23.2 per cent of the facilities in the public sector as opposed to 10 per cent in urban households. Of the formal facilities used by rural women, more than 30 per cent were public facilities. Surprisingly, although the urban sample was pre-dominated by poor households, the use of public facilities by urban women was very minimal.

In general, it was overwhelmingly the private sector that provided care. However, it is important to note that 27.8 per cent of the facilities were in the informal sector, of which 11.9 per cent was self-care. This indicates the importance of using women's own resources in health care. The high reliance on their own resources as well as easily accessible chemists was also evident, especially among urban women, where half the informal facilities utilised are chemist shops. Rural women relied greatly on traditional healers.

The high use of informal care makes it evident that no study can concentrate merely on health care institutions for information on what women do when they are ill. The strategies used by women are varied and they connect many different spheres of life. **The use of informal care is the result of many different factors, including the inaccessibility of health care services, the gender bias of health care system as well as a positive search for self-reliant strategies to cope with illness.**

As noted earlier, public health care facilities were utilised more often by rural women, however, public health care does not reach equitably to all villages (Table 5.13). A large share of the public health services was utilised by the households of villages where the PHC is located. Villages with neither a PHC nor a sub-centre are the most deprived. The entire concept of primary health care in India is based on creating a network of hierarchical structures. It is expected that a centrally located PHC will serve an entire circle of villages but its use remains concentrated in the village where it is located. As the component of outreach is very weak, people who do not see the PHC personnel everyday, rarely approach the health services when in need.

Hence, **while women in PHC villages received care by government doctor 19 times for every 100 episodes, women from sub centre villages utilised this service only 5 times and those from non sub-centre villages only once.** The use of the paramedic is the same in each category of village. This indicates that the outreach workers are not more active in non-PHC villages, as it is expected that they would be. Thus, neither the outreach workers nor the central PHC is able to meet the needs of villages in the surrounding area.

As expected, most of the health care is provided in out-patient institutions (Table 5.14). In patient facilities constitute 5.1 per cent of the facilities. However, it must be remembered that it is OPD services that are largely used in these in patient facilities. In the urban area chemist shops account for 20.8 per cent of the facilities utilised.

There is a distinct pattern between the structure of health facilities and type of ownership (Table 5.15). While a large majority of the private facilities are clinics or dispensaries (Outpatient Care Settings), 13.2 per cent of the public facilities were nursing homes/hospitals. PHCs constituted 46.6 per cent of the public facilities used. This

indicates that people are directly approaching the higher level facilities in the public sector possibly because the public outreach facilities and services remain neglected, under-staffed and under-equipped. Only 3.5 per cent of the private facilities were in-patient facilities; this indicates that general practitioners and pharmacist form the bulk of private providers. The religious and traditional practitioners usually worked from their own home or a place of worship such as temple, *dargah,* etc.

In teres of the individual providing care (Table 5.14), 69.2 per cent of the rural providers were 'doctors'. It is difficult to estimate how many of these were fully trained; many of them were not registered. Paramedical personnel provided care in 14.5 per cent of the cases in rural areas and 22 per cent in urban areas. However, while rural paramedics were more likely to be health workers, the urban paramedics were overwhelmingly chemists. Traditional practitioners provided care in 5 per cent of the cases in the rural areas and 3.3 per cent in urban areas. Lay providers were much more numerous in urban areas being 17.5 per cent as compared to 10.1 per cent in rural areas.

Expectedly, only 51.1 per cent of the facilities used by rural households are located in the village (Table 5.14) while 96.9 per cent of the urban households' facilities are located in the city itself. 19.3 per cent of the rural households' facilities are located in another village, a larger number (21.7 per cent) are in the taluka town and 7.7 per cent of the facilities used by them are located in the city - either Nashik or Mumbai. This indicates that the rural households have to travel considerable distances in order to secure health care. Both private and public health services are concentrated in urban and semi-urban areas. Travel increases the dependence of women on family members.

This lack of easy access to health care is also reflected in the rate of hospitalisation for rural households (Table 5.16). **While 2.2 per cent of the facilities were used for in patient care by rural households, barely 0.9 per cent were similarly used among urban households.** As rural patients have to travel over long distances for treatment, they have to be admitted for the same treatment that urban patients may avail of as outpatients. Often people are not able to commute back to their villages on the same day and are compelled to hospitalise the patient. Also, women substantially relied on family members to fetch medicines — common in both urban and rural areas.

The physical presence of services in the urban areas does not ensure access to the urban poor who take recourse in large numbers to informal care because, among other reasons, formal care is not affordable. It is worth noting that **most women are employed in the informal sector of the economy. As workers too, they get little access to the formal health care system. Thus, they also consume health care in the informal sector** where the state has very little direct intervention and are offered no protection.

The need for transport is felt more acutely in the rural areas where fewer facilities are accessible by foot (Table 5.14). 14 per cent of the facilities used by rural women are located at a distance of more than an hour by motor vehicle while only 2.4 per cent of the facilities used by urban households are located at a distance of more than an hour by vehicle.

Type of facility and socio-economic class

Analysing the type of facilities used by a socio-economic class of women, there are no marked differences (Table 5.17). The use of private doctors is 73.6 per cent of the formal facilities for the poorest, while public sector facilities constitute 24.7 per cent. The two middle classes make more extensive use of the public facilities than the poorest class. Although the use of public facilities is, itself, very low, the fact that the poorest class does not use it extensively indicates the low level of access to these services.

Type of facility and age

There is no difference in the type of facilities used by women of different ages. The use of private facilities ranges between 69 to 72 per cent of all formal facilities utilised for all ages. The use of public sector doctors was marginally higher for women above 45 years constituting 14 per cent of all facilities utilised. However, self care and self-medication is high for women of all age groups.

Type of treatment

A maximum of two services received were taken as treatment, also two services were combined together to enable an understanding about the combination of services received at the health centre. Then, this exercise was followed by a clubbing of services vis-à-vis the main service provided because it is the main service that determines expenditure.

There emerged seven categories of type of treatment received: (1) Home remedy and self medication (2) Examination and prescription (3) Dispensing of medicine (without injection) (4) Administration of injections (with or without dispensing) (5) Administration of saline and or/ pathological tests (6) Special procedures such blood transfusion, suturing, minor surgery, making cast, tooth extraction etc. (7) Surgery and/or hospitalisation.

The type of treatment received by an individual in rural and urban households varies to some extent (Table 5.18). **In general, the use of home remedies, self-care and rituals was quite high among women.** The use of injections is more pervasive in the rural areas as is the use of saline. Self-medication and home remedy are more prevalent in the urban areas. Also, saline and pathological tests were conducted more frequently in the rural areas. This may be due to the pervasive presence of malaria in Igatpuri taluka.

Co-relating the type of treatment received with the structure of health facility showed that only 25 per cent of the care received in the in-patient facility required hospitalisation. For the rest of the times that facility was used for out patient care. This indicates the degree of centralisation in both the private as well as public services, where even primary health care has to be accessed through tertiary care settings located at a considerable distance in urban areas.

There are some differences in the practice of private doctors and government doctors — the former use injections in a substantially greater proportion of cases. In the government sector, this is almost completely substituted by dispensing medicine.

Though nothing conclusive can be said about the rationality of their practice, the misuse of injections is very common in the private sector as it provides a rationale to charge higher fees. This has created a belief that injections are more effective than orally administered drugs. So widespread is the misconception about injections being more effective that often it is found that people refuse to use government services because they usually give only medicines.

Type of morbidity and utilisation

There is a great variation in the type of illness reported and the care received. (Table5.19) Gender related illnesses, such as reproductive problems and 'weakness' related problems were neglected to a great extent. Mental stress related problems received the least amount of care. Women are conditioned to accept many painful, discomforting bodily and mental states as 'part of life.' Thus, they were not even able to explain what was happening to them. Certain illnesses get transformed into 'legitimate' experiences — for e.g. anxiety manifesting itself as loss of appetite or indigestion. Though efforts were made tg correctly identify problems, some displacement may have occurred in several cases in this study. But the fact that women were able to articulate 'minor problems' in such large numbers in the absence of any care / use of health care indicates their great need for health care and knowledge.

An analysis of the type of care used for each type of illness showed (Table 5.20) that the use of private doctor is predominant in all the cases. Only 8.5 per cent of the facilities used in 'fevers' were informal. 63 per cent of the facilities used to treat sense organ problems were in the informal sector, largely self-medication. Though the numbers are very small, mental stress related problems are referred to traditional practitioners. It is also important to note that the government paramedic (mainly, the female MPW) is used frequently for treatment of fevers and GIT problems. It is likely that if provided with adequate training and resources, a larger proportion of infections would be referred to her. **Surprisingly, 71 per cent of the facilities used in reproductive illnesses are formal services as are 75 per cent used in 'weakness' related problems. This indicates that women prefer to use formal services for these problems**. However, access to these services is so poor, that the majority of these problems remain untreated. On the whole, however, the pattern of treatment does not differ radically with type of illness.

However, the rates of treatment for different types of illnesses themselves are very different. An important finding is that for those illnesses, which are frequently treated, the use of formal care is quite extensive while for the neglected ones, the use of formal care is limited**. When formal care is not available, women neglect those illnesses completely.** The existing services, private and public, are not sensitive enough to encourage women to use health care. **There is adequate evidence in this study to show that people, even women refer their ailments to trusted and accessible health providers without reference to the type of illness.** This presents a strong case for a comprehensive and accessible general health care service that would be able to identify and treat most types of illnesses.

Perceived efficacy of treatment

Even the meagre treatment taken for gender related problems and sense organ problems are not very effective (Table 5.21). Only in case of fevers, nearly three-fourths of the facilities effect a complete cure while in gender-related illnesses, less than 40 per cent of the cases are completely cured. The most effectively treated illness was 'fevers' followed by GIT problems. Also formal facilities were seen to be providing more effective treatment than the informal sector. It is interesting to note that there is only a marginal difference in the perceived efficacy of treatment by a public or private health provider. Anecdotal information suggests that the perception common among communities is that health care provided at the public health centres is not of good quality. However, when asked to relate information about specific illness episodes, there is no significant difference in perceived efficacy. In general, this analysis indicates that the use of informal facilities, especially self-care, does not provide adequate relief or cure in a majority of the cases.

Perceived efficacy and Duration of illness

The type of treatment also differs with the duration of illness. Long-term illnesses are treated more often with self-care; also less formal care is used. Of course, it must be remembered that self-care is used where formal care may have been utilised earlier, but unsuccessfully so. **The use of public care does not increase, but in fact, declines. This indicates that women do not seek public health care to manage long-term problems. Instead, they resort to home remedies or traditional practitioners.**

The inadequacy of using only informal care is clearly demonstrated in the analysis of perceived efficacy of treatment with the duration of illness. There is a dramatic difference in the effectiveness of treatment for short and long term problems. While treatment of episodes of less than a month's duration result in a complete cure, the long-term illnesses are rarely cured completely. However, treatment used for long-term health problems provides temporary relief. Thus, the use of health care for the most long drawn out problems is, in fact, more effective than treatment for illnesses of medium duration. This may be because the individual has developed a greater tolerance of the pain or discomfort and also has had time to evolve the best method of managing the problem.

Non-utilisation of health care

Surprisingly, in only 72.1 per cent of the cases, the use of health care seems to have any impact on the health problem. In only 51.8 per cent of the cases, a complete cure achieved. However, dissatisfaction with treatment or pessimism about its effectiveness is not the most important problem (Table 5.23). **Economic reasons are the most important obstacles in accessing health care, accounting for about 40 per cent of the untreated episodes.** Problems with health services and the treatment regimen itself accounted for 12.4 per cent of the untreated episodes. Among them, the inefficacy of treatment is a major factor. Not seeking treatment due to the nature of the illness was also an important factor in preventing access to care. 23.2 per cent of the untreated episodes were of this type. Social reasons accounted for 6.1 per cent of the untreated episodes.

There is a remarkable similarity in the reasons cited between rural and urban households for non-treatment. Economic reasons are predominant in both groups. There

is no difference in the proportion of the untreated episodes where access to health facilities is an obstacle. Even within this sub group of reasons, the poor quality and efficacy of treatment is the most important reason for not seeking care. **In both rural as well as urban women, the nature of the illness itself is an important factor in not seeking treatment. In about 16 to 18 per cent of the episodes, the illness is seen to be too minor to seek treatment. However, it must be remembered that in the remaining number of cases, it is inability of t`e women to seek care, not their unwillingness to seek care that results in neglect.**

Conclusions

The use of health care is deeply influenced by socio-economic factors. The household's caste, religion and socio-economic status play an important role in determining access to formal health services.

Besides these, **the woman's own position in the household also affects the use of health care.** Women who bear the most responsibility for the survival of the household, heads of households and spouses of male heads, use the least health care. Also women among whom morbidity is high — women with more children, housewives and employed women — receive very little health care in comparison to their needs.

Alarmingly, the use of health care for women declines in adulthood and remains low through the rest of her life. The presence of other women in the household may enable women to share household work and find time and resources to access health care.

In urban areas, poor women substitute the use of formal health care services with self-medication. This reflects their inability to access services that are physically so abundant in their area.

In general, the use of self-care and self-medication by women is considerable.

Many of women's health problems stem from the nature of women's work and the life cycle. Unable to reduce the stress of both, productive and reproductive labour, they learn to live with and endure suffering.

Not all of women's health problems are resolved with medical treatment. However, it is worth noting that the most frequently cited reason for seeking health care is lack of money. **It is not unwillingness, but inability to seek care that prompts women to neglect their illness. Thus, the need to stress that health care for all is a basic right is as urgent as ever.**

Table 5.1 Classification of health services as formal and informal services

Facilities
Informal services/care

Self care (consuming herbal or any other kinds of preparations, massage, inhaling vapours, application of ointments/lotions etc.)	287
Chemist (Self medication-buying drugs over the counter without doctor's advice)	298
Care by private sector compounder /untrained doctor/ nurse (approaching practitioners who are not registered or trained to give medical care and recognised by the respondent as being unqualified)	20
Traditional practitioners – Bhagats herbalists and indigenous practitioners (consulting the above who resort to herbal remedies or to spiritual treatment such as giving ash, sacrificing animals or giving talismans etc.	108
Total informal facilities	***713***
Formal services/care	
Care by private sector doctor (care provided by private practitioners in any setting, who to the best knowledge of the respondent are qualified doctors)	1526
Care by government sector doctor (approaching qualified doctor in any public health care institutions or in settings such as camps or village visits by PHC staff)	303
Care by government sector paramedic (care by multipurpose workers, auxiliary nurse midwives, lady health visitors or aanganwadi workers who are part of the public health system or the government run ICDS programme)	256
Care by NGO Company Charitable org' doctor (care provided by a doctor working in a dispensary/hospital run by the voluntary sector as an employee benefit measure)	19
Total formal facilities	***2104***
Not treated episodes	***1530***

Table 5.2 Rate of treatment for males and for females with and without the use of probing

Whether	**Male**		**Female**						**Total**	
treated			**Without probing**		**With probing**		**Sub-Total**			
	Episode	Percent	Episode	Percent	Episode	Percent	Episode	Percent	Episode	Percent
Treated	988	82.3	1034	79.7	557	34.6	1591	54.7	2579	62.8
Not treated	212	17.7	264	20.3	1054	65.4	1318	45.3	1530	37.2
Total	**1200**	**100**	**1298**	**100**	**1611**	**100**	**2909**	**100**	**4109**	**100**

Table 5.3 Type of facility used in episodes recorded with and without probing

Type of facility	**Without probing**		**With probing**	
Informal	509	22.7	204	35.5
Formal	1734	77.3	370	64.5
Total	**2243**	**100**	**574**	**100**

Table 5.4 Type of treatment for all episodes in rural and urban households

Sample	Informal Facilities	Informal Facilities Per 100 episodes	Formal Facilities	Formal Facilities Per 100 episodes	Untreated Per 100 episodes	Total Episodes
Rural	461	15	1705	57	34.9	**3010**
Urban	252	23	399	37	44.1	**1089**
Total	**713**	**17**	**2104**	**51**	**37.3**	**4099**

Table 5.5 Type of facility utilised in rural and urban households

	Rural		Urban		Total	
Type of facility	**Facilities**	**Percent**	**Facilities**	**Percent**	**Facilities**	**Percent**
Informal						
Self care	191	41.4	96	38.1	287	40.3
Chemist	161	34.9	137	54.4	298	41.8
Trad. Practitioners	89	19.3	19	7.5	108	15.1
Care by untrained pvt. practitioner	20	4.3	0	0.0	20	2.8
Sub total	*461*	*100.0*	*252*	*100.0*	*713*	*100.0*
Formal						
Care by pvt. doctor	1200	70.4	326	81.7	1526	72.5
Care by govt. doctor	267	15.7	36	9.0	303	14.4
Care by govt. paramedic	228	13.4	28	7.0	256	12.2
NGO, Company, any other	10	0.6	9	2.3	19	0.9
Sub total	*1705*	*100.0*	*399*	*100.0*	*2104*	*100.0*
No response	*10*	*100.0*	*1*	*100.0*	*11*	*100.0*
Total	**2176**		**652**		**2828**	

Table 5.6: The percentage of episodes treated for each type of illness

Type of morbidity	Treated episodes	Total episodes	Treatment rate
Mental stress	12	**50**	24.0
Reproductive	178	**582**	30.6
Weakness	97	**277**	35.0
Aches/pain	311	**605**	51.4

Sense organs	247	**457**	54.0
Others	80	**139**	57.6
Injury/boil/burn	48	**67**	71.6
Respiratory	527	**688**	76.6
GIT	244	**301**	81.1
Fevers	835	**943**	88.5
Total	**2579**	**4109**	**62.8**

Table 5.7 Type of facilities utilised by rural and urban males

Type of facility	**Rural**			**Urban**			**Total**		
	Facility	**Percent of**		**Facility**	**Percent of**		**Facility**	**Percent of**	
		Sub total	**Total**		**Sub total**	**Total**		**Sub total**	**Total**
Self care	57	37.7	6.7	23	29.5	9.8	80	34.9	7.4
Chemist	61	40.4	7.2	50	64.1	21.4	111	48.5	10.2
Trad. Practitioners	23	15.2	2.7	5	6.4	2.1	28	12.2	2.6
Care by pvt. Unqualified pract.	10	6.6	1.2				10	4.4	0.9
Sub-total	**151**	**100**	**17.8**	**78**	**100**	**33.3**	**229**	**100**	**21.1**
Care by pvt doctor	502	72.2	58.9	131	84.0	56.0	633	74.4	58.2
Care by govt. doctor	90	12.9	10.6	15	9.6	6.4	105	12.3	9.7
Care by govt. paramedic.	99	14.2	11.6	7	4.5	3.0	106	12.5	9.8
NGO, Company	4	0.6	0.5	3	1.9	1.3	7	0.8	0.6
Sub-total	**695**	**100**	**79.6**	**156**	**100**	**66.7**	**851**	**100**	**78.3**
No response	7		0.8				7		0.6
Total	**853**		**100**	**234**		**100**	**1087**		**100**

Table 5.8 Type of facilities utilised by rural and urban women

Sample	**Formal Care**		**Informal Care**		**Not treated**	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Total	**1323**	**45**	**418**	**14**	**1318**	**45.3**
		Geography				

Rural	1010	48	310	15	901	42.9
Urban	243	30	174	21	417	51.3
Accessibility of household						
Rural Easy Access	515	53	119	12	410	42.2
Rural Difficult Access	415	45	158	17	398	43.0
Rural Remote	80	40	33	17	93	46.7
Urban Non Slum	72	40	44	24	74	40.9
Urban Slum	171	27	129	20	343	54.4
Duration of settlement						
Original/old settlers	**998**	**47**	**325**	**15**	**930**	**43.6**
Rural	935	48	294	15	833	42.8
Urban	63	34	31	17	97	51.9
All year migrants, relocated migrants	**209**	**33**	**116**	**18**	**323**	**51.4**
Rural	57	52	13	12	46	41.8
Urban	152	29	103	20	277	53.4
Others	**46**	**31**	**43**	**29**	**65**	**43.6**
Rural	18	43	3	7	22	52.4
Urban	28	26	40	37	43	40.2
Socio- economic class of household						
Non-Worker, Unskilled	**229**	**33**	**110**	**16**	**367**	**53.3**
Rural	138	41	47	14	163	48.5
Urban	91	26	63	18	204	57.8
Formal Sector/Unskilled	**358**	**44**	**137**	**17**	**368**	**45.0**
Rural	287	49	86	15	253	43.1
Urban	71	31	51	22	115	49.8
Formal Sector Skilled	**475**	**48**	**163**	**16**	**424**	**42.4**
Rural	431	49	130	15	368	42.2
Urban	44	35	33	26	56	44.1
Professionals, Trade	**191**	**48**	**74**	**18**	**159**	**39.6**
Rural	154	51	47	16	117	39.0
Urban	37	36	27	26	42	41.2

Table 5.9 Type of facilities utilised by rural and urban women

Sample	**Formal Care**		**Informal Care**		**Not treated**	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*

Caste/community of household						
Upper castes	**246**	**44**	**94**	**17**	**252**	**45.1**
Rural	200	45	68	15	204	45.9
Urban	46	40	26	23	48	41.7
Scheduled castes	**177**	**38**	**64**	**14**	**245**	**52.1**
Rural	112	47	31	13	107	44.8
Urban	65	28	33	14	138	59.7
Other Hindu Castes	**278**	**47**	**110**	**19**	**234**	**39.9**
Rural	234	52	75	17	173	38.5
Urban	44	32	35	26	61	44.5
Scheduled tribes	**484**	**45**	**149**	**14**	**496**	**46.1**
Rural	426	47	124	14	401	44.5
Urban	58	34	25	14	95	54.9
Muslims, Christian	**68**	**31**	**67**	**31**	**91**	**41.6**
Rural	38	61	12	19	16	25.8
Urban	30	19	55	35	75	47.8
Number of women in h'hold (only respondents)						
One woman	**235**	**33**	**106**	**15**	**717**	**56.1**
Rural	164	38	54	13	428	53.3
Urban	71	25	52	18	289	60.2
Two women	**200**	**35**	**94**	**16**	**575**	**54.3**
Rural	151	37	64	16	410	53.7
Urban	49	30	30	18	165	55.8
Three or more women	**180**	**42**	**52**	**12**	**433**	**51.0**
Rural	162	45	38	10	363	49.6
Urban	18	26	14	20	70	58.6

Table 5.10 Type of facilities utilised by rural and urban women

Sample	**Formal Care**		**Informal Care**		**Not treated**	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Age group						
Upto 17 years	**373**	**61**	**124**	**20**	**150**	**24.7**
Rural	307	66	81	18	111	24.0
Urban	66	46	43	30	39	26.9
18 - 45 years	**612**	**38**	**254**	**16**	**814**	**50.7**
Rural	495	45	160	14	516	46.7

Urban	117	23	94	19	298	59.8
46 years and above	**257**	**40**	**99**	**16**	**309**	**48.4**
Rural	198	42	62	13	230	48.9
Urban	59	35	37	22	79	47.0
No response	**11**	**18**	**7**	**12**	**45**	**75.0**
Rural	10	17	7	12	44	75.9
Urban	1	50			1	50.0
Marital status						
Never married	**363**	**61**	**126**	**21**	**144**	**24.2**
Rural	295	68	77	18	100	22.9
Urban	68	43	49	31	44	27.8
Currently married, cohb.	**730**	**38**	**294**	**15**	**990**	**51.6**
Rural	591	43	200	14	672	48.5
Urban	139	26	94	18	318	59.4
Widowd/separated/deserted	**160**	**41**	**64**	**16**	**184**	**46.6**
Rural	124	45	33	12	129	46.9
Urban	36	30	31	26	55	45.8
Number of living children						
No children	**79**	**37**	**42**	**19**	**101**	**46.8**
Rural	71	40	34	19	78	44.1
Urban	8	21	8	21	23	59.0
Upto 2 children	**239**	**37**	**107**	**17**	**327**	**50.7**
Rural	174	41	69	16	199	47.4
Urban	65	29	38	17	128	56.9
Upto 4 children	**376**	**41**	**120**	**13**	**475**	**51.5**
Rural	304	45	78	11	337	49.6
Urban	72	30	42	17	138	56.8
More than 4 children	**195**	**37**	**87**	**17**	**267**	**51.0**
Rural	165	44	51	13	184	48.7
Urban	30	21	36	25	83	56.8
Not applicable	**363**	**61**	**126**	**21**	**144**	**24.2**
Rural	295	68	77	18	100	22.9
Urban	68	43	49	31	44	27.8

Table 5.11 Type of facilities utilised by rural and urban women

Sample	**Formal Care**		**Informal Care**		**Not treated**	
	Facilities	*Rate per 100 epi.*	*Facilities*	*Rate per 100 epi.*	*Episodes*	*Rate per 100 epi.*
Earning status						
Non earners	**349**	**61**	**115**	**20**	**150**	**26.3**

Rural	282	68	66	16	104	25.2
Urban	67	42	49	31	46	29.1
House workers	**264**	**36**	**108**	**15**	**383**	**52.5**
Rural	170	44	48	12	187	48.2
Urban	94	28	60	18	196	57.5
Earners	**640**	**40**	**261**	**16**	**785**	**48.8**
Rural	558	43	196	15	610	47.1
Urban	82	26	65	21	175	55.7
Education of women above 18 years						
Illiterate	**659**	**39**	**245**	**14**	**878**	**51.4**
Igatpuri taluka	558	43	169	13	639	49.1
Nashik city	101	25	76	19	239	58.7
Primary	**68**	**40**	**30**	**18**	**86**	**50.6**
Igatpuri taluka	49	44	26	23	49	43.8
Nashik city	19	33	4	7	37	63.8
Secondary	**105**	**41**	**48**	**19**	**113**	**44.3**
Igatpuri taluka	75	53	21	15	54	38.0
Nashik city	30	27	27	24	59	52.2
Higher secondary	**22**	**33**	**18**	**27**	**29**	**43.9**
Igatpuri taluka	7	41	6	35	4	23.5
Nashik city	15	31	12	24	25	51.0
College, tech, prof.	**12**	**32**	**12**	**32**	**14**	**37.8**
Igatpuri taluka	3	100		0	0	0.0
Nashik city	9	26	12	35	14	41.2

Table 5.12 Type of facilities utilised by rural and urban women

Type of facility	**Rural**			**Urban**			**Total**		
	Facility	**Percent of**		**Facility**	**Percent of**		**Facility**	**Percent of**	
		Sub total	**Total**		**Sub total**	**Total**		**Sub total**	**Total**
Self care	134	43.2	10.1	73	42	17.5	207	42.8	11.9
Chemist	100	32.3	7.6	87	50	20.8	187	38.6	10.7
Trad. Practitioners	66	21.3	5.0	14	8.05	3.3	80	16.5	4.6
Care by pvt. Paramedic/unqualified	10	3.23	0.8		0		10	2.07	0.6
Informal (sub total)	**310**		**23.5**	**174**		**41.6**	**484**		**27.8**

Care by pvt. Doctor	698	69.1	52.8	195	80.2	46.7	893	71.3	51.3
Care by govt. doctor	177	17.5	13.4	21	8.64	5	198	15.8	11.4
Care by govt. paramedic	129	12.8	9.8	21	8.64	5	150	12	8.6
NGO, Company, Any other	6	0.59	0.5	6	2.47	1.4	12	0.96	0.7
Formal (sub total)	**1010**		**76.5**	**243**		**49.1**	**1253**		**72.0**
No response	3		0.2	1		0.2	4		0.2
Total	**1323**		**418**		**1741**				

Table 5.13 Public facilities utilised by rural women

Type of village	Care by Govt. Doctor		Care by Govt. Paramedic		Total Number of episodes
	Facilities	**Per 100 episodes**	**Facilities**	**Per 100 episodes**	
PHC	131	19	37	5	688
Sub Centre	41	5	62	7	883
Non Sub Centre	5	1	30	6	525
Total	**177**	**8**	**129**	**118**	**2096**

Table 5.14 Profile of facilities utilised by rural and urban women

Structure Of Health Facility						
	Rural		**Urban**		**Total**	
	Facilities	**Percent**	**Facilities**	**Percent**	**Facilities**	**Percent**
Home	182	13.8	77	18.4	259	14.9
Clinic, Dispensary	743	56.2	211	50.5	954	54.8
PHC	159	12.0	3	.7	162	9.3
Hospital, Nursing home	63	4.8	25	6.0	88	5.1
Chemist, Pharmacist	100	7.6	87	20.8	187	10.7
Any Other	73	5.5	14	3.3	87	5.0
No response	3	.2	1	.2	4	.2
Location Of Health Facility						
At Home	182	13.8	77	18.4	259	14.9
Own Village/ City	494	37.3	328	78.5	822	47.2
Other Neighbouring Village	255	19.3	7	1.7	262	15.0
Neighbouring Town, Taluka Place.	287	21.7			287	16.5

Any Other (Nashik, Bom. Outside Nashik)	102	7.7	5	1.2	107	6.1
No Response	3	.2	1	.2	4	.2
Distance and vehicle used						
Less than one hour by foot	610	46.1	244	58.4	854	49.1
More than 1 hr. by foot	35	2.6	2	0.5	37	2.1
Less than 1 hr. by b.cart, cycle	46	3.5	7	1.7	53	3
More than 1 hr. by b.cart, cycle	17	1.3			17	1
Less than 1 hr. by bus, train, taxi, jeep	243	18.4	77	18.4	320	18.4
More than 1 hr. by bus, train taxi, jeep	185	14	10	2.4	195	11.2
Not applicable	182	13.8	77	18.4	259	14.9
No response	5	0.4	1	0.2	6	0.3
Type of provider						
Self, Relative, Neighbour	134	10.1	73	17.5	207	11.9
Trained Doctor	916	69.2	238	56.9	1154	66.3
Paramedic, MPW, Chemist,	192	14.5	92	22.0	284	16.3
Vaid, Hakim, Bhagat Etc.	66	5.0	14	3.3	80	4.6
Any Other	12	.9			12	.7
No Response	3	.2	1	.2	4	.2
Type of treatment						
Home remedy & self medic.	292	22.1	178	42.8	470	27.1
Examination and prescription	69	5.2	43	10.3	112	6.4
Dispensed Medicine	239	18.1	58	13.9	297	17.1
Injections	578	43.8	114	27.4	692	39.8
Saline and pathological tests	55	4.2	12	2.9	67	3.9
Special procedure	65	4.9	8	1.9	73	4.2
Surgery/hospitalisation	20	1.5	2	.5	22	1.3
No response	3	.2	1	.2	4	.2
Total	**1323**	**100**	**418**	**100**	**1741**	**100**

Table 5.15 Structure of health facilities according to type of health facilities

Structure Of Health Facility	Home Care	Private	Public	Religious, Traditional, Indigenous	NGOs, Company, Any Other	Total
Home	205 100%	39 3.6%	15 4.3%			259 14.9%

Clinic, Dispensary		823 75.4%	124 35.6%		7 63.6%	954 54.8%
PHC			162 46.6%			162 9.3%
Hospital, Nursing Home		38 3.5%	46 13.2%		4 36.4%	88 5.1%
Chemist, Pharmacist		187 17.1%				187 10.7%
Any Other		5 .5%	1 .3%	81 100%		87 5.0%
No response						4 .2%
Total	205 100%			81 100%	11 100%	1741 100%

(Percentages are column percentages)

Table 5.16 Location of facilities where care was received by rural and urban women

	Rural		Urban		Total	
	Episodes	**Facilities**	**Episodes**	**Facilities**	**Episodes**	**Facilities**
Non-hospitalised	1041 49.7	1157 87.5	353 43.4	374 89.5	1394 47.9	1531 87.9
Hospitalised	19 .9	24 1.8	1 .1	1 .2	20 .7	25 1.4
Non hosp. & Hospitalised	5 .2	5 .4	3 .4	3 .7	8 .3	8 .5
Someone Else Got Medicine	127 6.1	134 10.1	38 4.7	39 9.3	165 5.7	173 9.9
No Response	3 .1	3 .2	1 .1	1 .2	4 .1	4 .2
Not treated	901 43.0		417 51.3		1318 45.3	
Total	**2096**	**1323**	**813**	**418**	**2909**	**1741**

(Percentages are column percentages)

Table 5.17 Type of facilities utilised by women of different socio economic class

Socio-economic class	**Non worker Professionals unskilled**			**Formal sector unskilled**			**Formal sector skilled and trade**					
	Facility	*Percent of Sub total*	*Total*	*Facility*	*Percent of Sub total*	*Total*	*Facility*	*Percent of Sub total*	*Total*	*Facility*	*Percent of Sub total*	*Total*
Self care	42	*38.2*	12.3	66	*48.2*	13.3	72	*44.2*	11.3	27	*36.5*	10.2
Chemist	50	*45.5*	14.7	49	*35.8*	9.9	55	*33.7*	8.6	33	*44.6*	12.4

Trad. Practitioners	17	*15.5*	5	20	*14.6*	4	34	*20.9*	5.3	9	*12.2*	3.4
Care by unqual.prac.	1	*0.91*	0.3	2	*1.5*	0.4	2	*1.2*	0.3	5	*6.8*	1.9
Sub total	**110**		**32.3**	**137**		**27.7**	**163**		**25.5**	**74**		**27.8**
Care by pvt. doctor	170	*73.6*	49.9	229	*64*	46.3	339	*71.2*	53.1	155	*80.7*	58.3
Care by govt. doctor	35	*15.2*	10.3	63	*17.6*	12.7	78	*16.4*	12.2	22	*11.5*	8.3
Care by govt. paramedic	22	*9.5*	6.5	64	*17.9*	12.9	53	*11.1*	8.3	11	*5.73*	4.1
NGO, Company, any other	2	*0.9*	0.6	2	*0.6*	0.4	5	*1.1*	0.8	3	*1.56*	1.1
Sub Total	**229**		**67.2**	**358**		**72.3**	**475**		**74.3**	**191**		**71.8**
No response	2	*0.9*	0.6		*0*		1	*0.2*	0.2	1	*0.52*	0.4
Total	**231**		**100**	**358**		**100**	**476**		**100**	**192**		**100**

Table 5.18 Type of treatment received in the different types of facility

	Home Care	**Private**	**Public**	**Religious Traditio. Indigen.**	**NGOs, Company Any Oth**	**No response**	**Total**
H.Remedy Self Medi.	199 97.1%	192 17.6%		79 97.5%			470 27.1%
Examin. Prescript'		87 8.0%	23 6.6%		2 18.2%		112 6.4%
Dispensed Medicine	1 0.5%	112 10.3%	175 50.4%	1 1.2%	8 72.7%		297 17.1%
Injections		588	103	1			692
Saline & Path.Tests		51	16				67
Special Procedure	5 2.4%	40 3.7%	27 7.8%		1 9.1%		73 4.2%
Surgery/ Hospital'n		19 1.7%	3 0.9%				22 1.3%
No Response						4 100%	4 0.2%

(Percentages are column percentages)

Table 5.19: The rate of treatment per each type of illness reported by women

Type of illness	**Treated episodes**	**Total episodes**	**Rate of treatment**	**No of formal facilities used per 100 episodes**
Mental stress	10	48	20.8	8
Reproductive	177	580	30.5	22
Weakness	90	260	34.6	27
Sense organs	139	315	44.1	17

Aches/pain	257	520	49.4	32
Others	54	102	52.9	36
Injury/boil/burn	27	43	62.8	37
Respiratory	265	360	73.6	58
GIT	143	188	76.1	68
Fevers	429	493	87.0	89
Total	**1591**	**2909**	**55.0**	**43**

Table 5.20. Type of health facility utilised by type of illness (for women)

	Self care	Chemist	Private unqualified	Trad. Practitioner	Private Doctor	Govt. Doctor	Govt para-medic	NGO, Company	N.Res	Total
	Informal					Formal				
Reproductive	31	12		11	95	18	14	2	1	184
Percent	16.8	6.5		6	51.6	9.8	7.6			100
GIT	13	8	1	6	79	26	20	3		156
Percent	8.3	5.1	0.6	3.8	50.6	16.7	12.8	1.9		100
Weakness	12	4		8	52	13	5	1		95
Percent	12.6	4.2		8.4	54.7	13.7	5.3	1.1		100
Aches/pain	53	37	2	16	118	26	22	1	1	276
Percent	19.2	13.4	0.7	5.8	42.8	9.4	8	0.4	0.4	100
Fevers	10	21	4	10	310	69	56	4	1	485
Percent	2.1	4.3	0.8	2.1	63.9	14.2	11.5	0.8	0.2	100
Respiratory	38	38	2	4	154	29	24	1	1	291
Percent	13.1	13.1	0.7	1.4	52.9	10	8.2	0.3	0.3	100
Sense organs	31	57	1	6	38	10	6			149
Percent	20.8	38.3	0.7	4	25.5	6.7	4			100
Injur.boil.brn	12	3			10	4	2			31
Percent	38.7	9.7			32.3	12.9	6.5			100
Mental stress	2			5	3	1				11
Percent	18.2			45.5	27.3	9.1	0			100
Others	5	7		14	34	2	1			63
Percent	7.9	11.1		22.2	54	3.2	1.6			100

(Percentages are row percentages)

Table 5.21 Perceived efficacy of treatment recorded with use of each facility

	No effect		Partially better		Completely cured	
	Count	Row %	Count	Row %	Count	Row %
Type of morbidity						

Reproductive	52	30.8	54	32.0	63	37.3
GIT	38	25.5	26	17.4	85	57.0
Weakness	36	40.4	23	25.8	30	33.7
Aches/pain	98	37.5	76	29.1	87	33.3
Fevers	75	16.1	47	10.1	345	73.9
Respiratory	80	28.4	64	22.7	138	48.9
Sense organs	45	31.3	29	20.1	70	48.6
Injury/boil/burn	11	35.5	4	12.9	16	51.6
Mental stress	5	45.5	2	18.2	4	36.4
Others	23	41.8	11	20.0	21	38.2
Type of facility						
Self care	80	40.2	47	23.6	72	36.2
Chemist	47	25.5	36	19.6	101	54.9
Trad. Practitioners	25	33.8	17	23.0	32	43.2
Care by unqualified pr.	3	30.0	3	30.0	4	40.0
Informal care	**155**	**33.2**	**103**	**22.1**	**209**	**44.8**
Care by pvt. Doctor	210	24.7	168	19.8	472	55.5
Care by govt. doctor	55	29.1	34	18.0	100	52.9
Care by govt. paramedic	39	27.9	31	22.1	70	50.0
NGO, Company, Other	4	33.3			8	66.7
Formal care	**308**	**25.9**	**233**	**19.6**	**650**	**54.6**
Duration of illness						
0-28 days	192	19.6	126	12.9	662	67.6
29-365 days	120	41.5	74	25.6	95	32.9
1 to10 years	124	42.9	99	34.3	66	22.8
More than 10 years	20	32.8	28	45.9	13	21.3
No response	7	17.9	9	23.1	23	59.0
Total	**463**	**27.9**	**336**	**20.3**	**859**	**51.8**

Missing cases = 83

Table 5.22 Reasons for not seeking treatment stated by women in rural and urban areas

Reason For Not Seeking Treatment	**Rural**		**Urban**		**Total**	
	Episodes		Episodes		Episodes	
No Reason Given	7	0.8	3	0.7	10	0.8
Does Not Know	6	0.7	4	1.0	10	0.8
Will Be Going	39	4.3	15	3.6	54	4.1

No Response	41	4.6	3	0.7	44	3.3
	93	**10.3**	**25**	**6.0**	**118**	**9.0**
Services Are Far Away	6	0.7			6	0.5
No H F Available Close To The Village	5	0.6			5	0.4
Services Are Not Good, No Impact On Illness	86	9.5	40	9.6	126	9.6
Some Other Problems In Using H F	8	0.9	3	0.7	11	0.8
Doctor Unable To Cure	1	0.1	1	0.2	2	0.2
Does Not Like To Take Medicines	7	0.8	6	1.4	13	1.0
	113	**12.5**	**50**	**12.0**	**163**	**12.4**
Services Available But Financial Prob.	11	1.2	2	0.5	13	1.0
Financial Problems	301	33.4	128	30.7	429	32.5
No Time Free From Work	46	5.1	36	8.6	82	6.2
	358	**39.7**	**166**	**39.8**	**524**	**39.8**
Wrong Perception	3	0.3	1	0.2	4	0.3
Did Not Feel The Need, Illness Not Serious	146	16.2	79	18.9	225	17.1
Seasonal Illness	1	0.1	1	0.2	2	0.2
Linked To Menstrual Cycle	10	1.1	10	2.4	20	1.5
Chronic, Long Duration	42	4.7	11	2.6	53	4.0
Illness Due To Other Reasons	2	0.2			2	0.2
	204	**22.6**	**102**	**24.5**	**306**	**23.2**
Felt Shy Or Fearful	69	7.7	43	10.3	112	8.5
No Support From The Family	10	1.1	5	1.2	15	1.1
	79	**8.8**	**48**	**11.4**	**127**	**9.6**
Any Other	**54**	**6.0**	**26**	**6.2**	**80**	**6.1**
	901		**417**		**1318**	