RF_WH_11_13_PART_1_SUDHA

OUTLINES FOR THE PREPARATION OF REPORT ON TOTAL HEALTH CARE PROJECT, [illegible] PUR, CALCUTTA

i) Introduction

a) Interaction between the Family Planning Foundation and Amiadevi Charitable Trust.

b) Sanction of projects and related matters

ii) History of the clinic before the Foundation's assistance

iii) Initial plan to extend the clinic on the part of the Amiyadevi Bannerjee Charitable Trust - their perceptions for extensions and development.

iv) ~~Target~~ Project designs as evolved on the basis of discussions between Family Planning Foundation and Trust

v) Survey of the research and survey exercises by Dr ~~Bahumik~~ Bhowmick - report and implications for replications.

— Action programme following survey — procedural context

vi) Problems faced by the project

vii) Overall review of the work of the project

viii) Current-status and needs

ix) Future Plans of the project as envisaged by the Trust

x) Assessment and recommendations to the Family Planning Foundation.

TOTAL HEALTH CARE PROJECT, NARENDRAPUR (CALCUTTA)

Points For Report

(1) Background

- 1. Foundation's priority Area – Family Planning through Integrated Health Care.
- 2. Need For a well-tested and documented experience in India
- 3 Need For developing this type project around a hospital through an extension approach.

(2) Selection of Project

- 1 Motivation, flexibility considered important components of evolving such an approach – hence a private voluntary hospital considered ideal situation
- 2 Amiya Debi Trust Charitable Hospital in Narendrapur Calcutta identified as suitable agency because.
  - 1 Dr & Mr Mrs Tarun Banerjee – couple deeply involved in community service, teaching and practice.
  - 2 (Dr Banerjee one of the foremost gynaecologists in India and Dr Mrs Banerjee is an anaesthesiologist)
  - 2. Trust Hospital located in Narendrapur – 12 beds well equipped, and high degree of acceptance by local people because of quality of service.
  - 3 Clientele of Hospital come mostly from rural countryside and consist of most sections of a mixed Hindu and Muslim population.
  - 4 Doctors incharge interested in furthering Family welfare services through an integrated and extension approach

(3) Description of Hospital

- 1 Amiya Debi Charitable Trust established by the Banerjees in 1966.
- 2 Trust run by a Management committee of which the Chairman is Mr C R Irani, Managing Director of Statesman
- 3 Amiya Debi Charitable Hospital, Narendrapur established in May 1969

4. Hospital is an unostentatious single storied, white washed building, consisting of two consulting rooms, a small air conditioned operation theatre, an outpatients section, an inpatient section with 12 beds, a store and other basic facilities.

5. The hospital has visiting specialists including a Gynaecologist, Anaesthetist, Skin specialist and Chest specialist. On its permanent staff it has a trained staff nurse, pharmacist compounder, general duty attendants, Sweeper and Ayah.

6. The Clientele of the hospital come from villages about 10 miles radius around the hospital. The number of patients treated in the pre-project era was

1969

FAMILY PLANNING FOUNDATION

TOTAL HEALTH CARE PROJECT, CALCUTTA

Assessment Report and Suggested Action

Observations

This report pertains to assessment of the progress of the programme with regard to completion of baseline survey, preparation of operational design, working out requirements of the programme, defining concept of Total Health Care, determining various components of the health package and identifying target groups for them, and the progress made with regard to implementation of recommendations made earlier (refer previous note by the Foundation staff). This report also contains suggestions and recommendations for future action.

2. The baseline survey in the project area was to be carried out in two rounds. The first round has been completed for all the 13 project villages; four villages have also been covered under the second round of the survey. Data collected under the survey has a variety of information which can be used for programme planning, implementation and measurements. What is needed is to glean from this relevant information which can be of immediate use to the programme.

3. A preliminary report, based on the survey data, has been prepared. It is a fair description of the social situation as it prevails in the area. However, it would have to include more details to be able to provide effective indications for programme planning and development. This information has not been given in the preliminary report and perhaps because of this the operational design could not be formulated. As the things stand at present, it would take another two months time (end of February 1975) to complete the survey and a few more months to finalise the report and recommendations. If the implementation of action programme has to wait for completion of the survey report, it can not be launched before the month of May 1975.

4. The project has been sanctioned for a period of three years, of which a little more than one year has already passed. If the action programme is to be initiated from the month of May 1975, it would hardly leave 18 months time to assess its impact and formulate recommendations. No action research programme, more so in the field of health and family planning, can show impact on the behavioural practices of the people in such a short time. The primary need, therefore, is to launch the action programme as early as possible. This can be done in the four villages where second round of the survey has been completed. This can be treated as a pilot experiment which would help in getting necessary experience for extending the project activities in other villages when the baseline survey is also completed there. The second round of the survey should be continued simultaneously with the action programme. The flexibility of approach, however, needs to be maintained so that the methodology of programme operations could be changed, modified or adjusted according to the needs of the programme from time to time.

Recommendations and Suggestions

5. Recommendations pertaining to Research Components

a The first step would be to define the concept of Total Health Care as applicable under the project. Efforts should be made to formulate a package of programme which could be reached to the maximum number of people. Only those programmes should be included which could regularly and easily be provided to people for the entire tenure of the project.

b The family should be taken as a unit for providing necessary services, since it is a total health care project. This would help to reduce the mobility and duplication of visits by the workers which may otherwise be if action staff tries to tackle various target groups individually for different components of the programme. It is recommended that such target groups should be indicated within the family record/addition to listing them in a register. /in

c The data for the four villages where second round of the survey has been completed should be compiled and tabulated on priority basis for extracting essential information to prepare a programme plan. The following types of information would be necessary :-

i) List of pregnant women (those in the last trimester of pregnancy may be taken as high priority group).

ii) List of children upto five years of age (infants may be taken as high priority group).

iii) List of children under five years of age who had had their primary vaccination, those who also had secondary vacci nation and those who never underwent any type of vaccination (the last mentioned may form the high priority group).

iv) List of couples with wife's age ranging from 15 to 44 years.

v) List of couples with three or more children and those with less than three children; list of women with youngest child upto five years of age; list of pregnant women (the women with youngest child upto five years of age should be taken as high priority group. Pregnant women should be assigned second priority).

vi) List of couples where either of the spouses had been practising one or the other method of contraception.

vii) List of common diseases prevalent in the area as reported by people and also list of diseases for which people generally come to the hospital. The first type of information can be compiled from the survey data. For the second type of information analysis of a 5% sample of hospital records is recommended.

viii) Peoples' conception about causation, prevention and treatment of common disease in the area; what diseases are considered to be of serious nature and the stage at which they are usually

reported at the hospital; analysis and comparison of this information with the diseases recorded at the hospital (Dr P K Bhowmick should visit the project villages and carry out depth interviews with the village people).

ix) Sources and type of medical care generally resorted to by the village people.

x) Total number of births and deaths in the villages and illness in the family during the past 12 months (this information can be compiled from the survey data).

xi) A general report about the environmental sanitation and hygeine (Dr Bhowmick may visit villages and conduct depth interviews and observations on the topic).

xii) Villagewise list of community leaders.

xiii) List of available medical and health facilities from the Government's side.

xiv) A general report about economic, educational and occupational structure of the community.

d It would be possible to take out above information from the survey records.. For additional information, Dr Bhowmick should visit the project villages along with other investigators. The patient records at the Amiya Debi Hospital should also be analysed to compile information on the type of diseases for which people come to the hospital, stage of the disease at which institutionalised medical care is sought, distance from which the patients come, general educational and income level of the patients, and their sex and age composition. The above information would be useful for planning the programme, for working out the quantum of services that the different target groups would need and also for developing suitable programmes for educating the people.

e Evaluation:

Evaluation is defined as a method of judging whether a particular programme is moving in the right direction according to the envisaged goals and to find the causative factors in case its not being upto the expectations. This makes it imperative, that before embarking upon any action research programme, its goals and objectives are clearly and specifically defined in terms of "what is proposed to be done" and "how it is proposed to be done". The success of such programmes mainly depends upon a built-in system of evaluation to assess the impact of the programme as a result of efforts and performances by the workers. Programme evaluations are carried out at two stages, that is the "impact evaluation" and "performance and effort evaluation". The impact evaluation is directly related to the ultimate objective of the programme. On the other hand, the evaluation of the performance and efforts goes on concurrently with the programme with the sole aim of improving its operations and is based on analysis of the reports and records of the workers, field observations of the programme and the staff meetings. The main aim

of health and family planning. The research support, presently available to the programme, has been appropriate and useful to the existing needs, that is, completing the baseline survey related to social or behavioural aspects and preparing the report. The time has come to identify and engage expertise of an action oriented kind in health and/or development. Efforts may be made to locate consultants, if possible with requisite experience in Calcutta itself. The consultants should be associated from the beginning of the action programme and should be continued for the rest of the tenure of the project. Their specific functions would include development of project design, preparation of operational programme plan, development of indices for measurement, evaluation plan, development of instruments for documentation, suggestions for development of suitable educational material, description of roles and functions of different functionaries of the project, the type of help needed from other government functionaries, suggestions for training of project workers and provide necessary help in periodical evaluation of the project work.

6. Recommendations pertaining to the Action Programme

a Determining a Package of Health Services

The final package of health services would be based on the needs of the people, as emerging out the survey and on the basis of the data collected from hospital records. Tentatively, thefollowing services can be included as partof total health care to be provided to people.

i) Maternal and Child Health Care Services:

These services should include immunisation of pregnant women, ante-natal, natal and post natal care, and nutritional supplement where clinically indicated.

ii) Immunisation and Vaccination:

This should include all children under five years of age, to be covered under primary vaccination, intensive immunisation drives during epidemics and secondary vaccination of those children who come to hospital.

iii) General Medical Care:

This should include in-patient and out patient medical care.

iv) Family Planning:

This should include male and female sterilisation and termination of pregnancy at the hospital, and distribution of condoms at the community level.

v) Health Education :

This should be based on individual group and mass education through various media and methods, and should form part of each of the health component of the programme.

b Operational Steps

The subsequent step would be to draw out a plan of action consisting of various operational steps and their sub-steps. In this connection the following are recommended :-

i) Identification of various target and priority groups for each individual component of the programme.

ii) Based on the needs of various target groups as emerging out of the survey data, the minimum package of services should be defined.

iii) Determine suitable methods for providing the services.

iv) Determine a suitable staff structure on the basis of the needs and requirements of the people and the methods for delivering the services.

v) Arrange for training of the research and action staff.

vi) Describe various steps in starting the programme and a time schedule for it.

vii) Decide about a system of coordinating the activities of research and action staff.

viii) Lay down procedures for recording and reporting, decide about evaluation mechanism, develop instruments for documentation.

ix) Identify educational needs of the people and make efforts to collect/develop educational material accordingly.

x) Identify and try to mobilise human, physical and organisational resources for the programme.

xi) Work out a realistic time schedule for entire tenure of the project including that of the pilot experiment in four villages.

xii) Prepare a physical map of the entire project area, showing situation of all the project villages, Amiya Debi Hospital, important landmarks, place of posting of the Government functionaries, educational institutions, available medical and health facilities (both modern and indigenous), and approaches to different project villages from the project headquarters. This would help in planning the programme for different villages, development of staff and chalking out their movement schedule.

c Method of working

The action programme is to be launched within a period of two months. Efforts should, therefore, be made at this stage to define and describe the methods of working and approaches to be adopted for the programme. These would include determining a package of health services, systems for delivering the services, mobilising necessary resources, describing roles and functions of the staff, defining the role of Amiya Debi Hospital etc.

i) Package of Health Programmes:

As has been discussed earlier, efforts should be made to include only those services in the package whose continuity sufficiency, regularity and easy accessibility to people could be ensured for the entire tenure of the programme. As such, the programme would centre around maternal and child health care, immunisation, family planning, general medical care and health education. Presently, some of these services are being provided at the Amiya Debi Hospital. However, a system should be evolved out for domiciliary care.

ii) Method of delivering the services:

The subsequent step should be to evolve methods of delivering these services. This would include education for creating a demand for the services and developing a system for their delivery. A part of these services, as has been mentioned earlier, would be provided at the hospital whereas others would be provided at the door-steps of the people. Services for male and female sterilisation, termination of pregnancy and general medical care would be provided at the hospital. On the other hand maternal and child care, distribution of condoms and immunisation services would form part of domiciliary care. The system thus evolved out would have to be based on a mix of hospital based as well as home delivery services.

d Mobilising Resources for the Programme

Human Resources

The success of the programme would be contingent on efficiently and regularly reaching the needed services to people. Although the project would be engaging a number of workers, there would also be a number of Government functionaries in the area and unless efforts are made to coordinate work of the project staff with them, there would be confusion and overlapping. Besides, the services of the Government staff can also be utilised for the programme. For instance, the school teachers can be madeto participate in educating people and act as community leaders. Similarly, the resources of the health workers like vaccines for immunisation and condoms for family planning can also be procured for the project. They can also be mobilised during the intensive campaigns like mass sterilisation programmes and mass immunisation during epidemics. It would be advisable to identify these resources and make efforts to use them for the programme.

Organisational Resources

The health and agricultural extension departments usually produce educational material for free dostribution. The project organisers, by maintaining a liaison with them, can, as and when necessary and possible, procure these inputs. Likewise, the Government functionaries can also help project staff in establishing rapport with the people and mobilising support of the community leadership.

A cautious approach is recommended, however, while trying to seek support of the Government functionaries. The efforts should be to maintain effective liaison or a sort of working relationship with them. If necessary, senior officers of the concerned departments may be approached informally to seek their sanction. At no stage the Government staff should be made part of the project by assuming their technical or administrative control. Their co-operation would be necessary only to avoid confusion and duplication of efforts, avoid overlapping in the area of operation and to procure necessary inputs for the programme which may be difficult to obtain in open market.

e Supervision

Documentation, evaluation and supervision are closely interlinked. Documentation provides clues for evaluation and, in its turn, evaluation provides necessary information for supervision. Together these three contribute to improvements and thus lay foundation for success of the programme.

Supervision helps in developing staff capabilities for better performance. For the project work, it should include both field supervision as well as headquarters or hospital based supervision. Again this can be both technical and administrative. The technical supervision should be the direct responsibility of the Assistant Project Director (senior social scientist) who would operate under the guidance of the project director. His responsibilities would include both supervision of action programme as well as research. Specifically this would include field guidance, help in accurate documentation,assistance in solving work problems of the staff, help in establishing rapport with the leadership etc. The supervisory responsibilities of the project director would include providing technical guidance in matters related to health, solving administrative problems and periodically taking suitable decisions for smooth running and successful completion of the programme. It is recommended that the mechanisms for supervision and the supervisory responsibilities at different levels should be described in specific terms before taking the programme to field.

f Education

Education of the people for motivating them to avail the services provided by the project, to inculcate healthy habits and to provide correct information on different aspects of the programme would be an important component. Health education would form part of each of the individual programmes like family planning, immunisation etc.

The first step in planning educational programmes would be to identify needs of the people in terms of their attitudes, levels of knowledge and awareness, the linguistic contents and the methods and media to be adopted. This information should come out of the baseline survey. The subsequent step would be to identify the sources from where needed educational material could be collected. In case necessary material is not available or is not suited to the tastes of the people, efforts should be made to develop it within the project.

Presently, there are a few agencies like Red Cross, the Health Education Bureau, the Family Planning Department, the All India Institute of Hygiene and Public Health and a few other voluntary organisations from where such material could be collected. This is, however, likely to be a routine type of educational material created for wider use. The project staff, therefore, would have to develop and produce suitable literature and aids with the help of the available technical expertise in Calcutta.

Two types of educational material would be needed. Firstly, the project would need some aids and literature for individual or group education which can be used by the field workers. The second type would be for mass education and would be used with hospital as the centre with the objective of creating general awareness. Specific knowledge should be given through individual or group communication programmes where the audience can be selected specifically for the purpose and where the mode of communication would mainly be interactional.

7. Recommendations pertaining to staff structure

Effective and efficient delivery of services would be basically contingent on suitable deployment of trained staff. The project staff, based on the requirements of the programme, would consist of three types of functionaries, that is, the hospital staff, the field or action staff and the research staff. The needed strength of the hospital staff can be assessed only by the organisers of the programme according to the in-patient and out-patient load on the clinic. Here a staff structure is recommended only for the action and research parts of the programe

a Action or Field Staff:

Total population to be covered under this project has been estimated to be around 21,000. According to the latest thinking on the subject, there should be at least one Auxiliary Nurse Midwife (ANM) *1 per 5000 population to take care of the maternal and child health care, family planning and health education services. In addition, the project would also need at least two male workers *2 (equivalent to health assistants) for immunisation services, distribution of contraceptives (mainly condoms) and health education services. This would give an average of three workers per 10,000 population (one male and two females). Taking the birth rate to be around 350/00 in the project area (national average), there would be nearly 175 births in 5000 population in a year giving an average of nearly 15 births per month. This would also mean that there would be around 273 *3 pregnant women in a year within the operational area of an ANM. This should be the endeavour of project workers to reach MCH and immunisation services to all new born children and pregnant women and, thereby, make this programme a foundation for boosting family planning acceptance.

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*1 and *2 The main aim is to treat these functionaries as male and female multi purpose workers. As such the functions of ANMs and health assistants would essentially be like that of their counterparts under the proposed governmental pattern. The old nomenclature, however, is retained till suitable designations are decided.

*3 The number of pregnant women in a given area is generally calculated at one andhalf times of the number of births in a year within a given area.

The project would also need a Health Education Officer. His responsibilities would include developing and organising educational programmes and providing needed technical guidance to field workers.

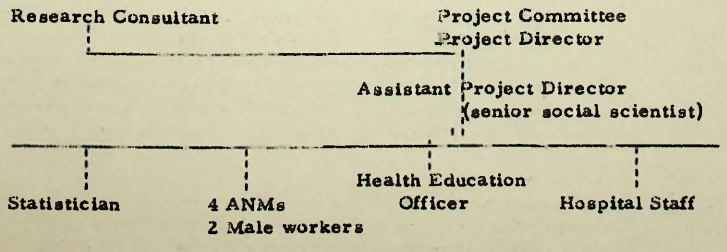
b Research Staff:

The primary objectives of this project are twofold. Firstly, to find out whether integration of family planning with maternal and child health care can augment its acceptance by the people. Secondly, to develop a methodology for delivering a package of health programmes with a voluntary clinic as nucleus for providing these services. The ultimate aim being the replication of such programmes in other areas, based on the methodology evolved under this project.

The success of the programme would depend upon experimenting with different delivery systems, assessing their impact, establishing a correlation between maternal and child health care and family planning acceptance, developing a programme for training of workers, collecting essential information for developing educational material, conducting special studies related to different aspects of the programme, evaluation of theprogramme progress both at the terminal and concurrent levels etc. As such, the project would have to have suitably competent and experienced research staff. Considering the available resources with the project and the needs of the programme, it is recommended that there should be at least one senior social scientist designated as Assistant Project Director and one statistician. The former, in addition to his responsibilities described earlier, can also help in organising the action programme, prepare education material, write reports pertaining to the project work, supervise the workers and assist in evaluation of the programme progress. In fact his supervisory functions would include both supervision of action programme as well as research work including report writing. The statistician, on the other hand, can help in compiling and tabulating research data, scrutinise field reports under the supervision of the social scientist and provide all the necessary statistical support to the programme.

c Overall Staff Structure

The overall staff structure of the project would be somewhat like the following:



d Role of the existing Research Staff

It is recommended that the question of retaining the existing research staff for their employment as field or action workers may also be considered at this stage. On the positive side, some of them may be having the requisite competence and their retention in the project would help in saving time, energy and money which may be needed for training and orientation of the new workers. By now, they must have developed understanding of the basic aims of the project, and should also have developed a working relationship with the leadership of the area, besides having complete knowledge about the area and people of the project villages.

Before taking a decision, however, the needed expertise for the project work, like training in Health Education Maternal and Child Care, techniques of vaccination and statistical experience be considered. The existing staff would be useful for action programme only when they have undergone the necessary training for these activities. Therefore, implications of this in terms of finances and time be assessed before taking a final decision.

8. Budget Implications:

The following is the likely item-wise break-up of the project budget:

a Recurring:

i) Staff Salary *1 (see footnotes on page 12)

plus 4 ANMs @ ₹. 200 each	800 x 12		9,600
" 2 male workers @ ₹ 250 each	500 x 12		6,000
" Asstt. Project Director (senior social scientist)	750 x 12		9,000
" Statistician @ ₹ 400	400 x 12		4,800
" Health Education Officer @ ₹400	400 x 12		4,800
" Stenographer/Acctt. Asstt./ Clerks @ ₹ 400	400 x 12		4,800
" Driver @ ₹ 200 x 12			2,400
" Messenger @ ₹ 100 x 12			1,200
" Hospital Staff @ ₹ 1,000 x 12 (including honoraria for doctors and petrol expenses on their transportation)			12,000
			54,600
ii) Travel expenses (travel by project staff, including expenses on movement of vehicle on their travel)			5,000
iii) Stationery, postage, printing etc.			1,000
iv) Maintenance of vehicle (repairs)			2,400
v) Misc. (including purchase of education material)			4,000
		Total	67,000 per year

b Non-recurring: *2

i) Cost of Vacurette		8,000
ii) 4 ANM kit boxes		500
iii) Educational equipment		10,000
iv) Bicycles for field workers		2,500
v) Annual expenses on medicines *3 @ ₹ 10,000 x 3		30,000
	Total	51,000

c The grant sanctioned by the Foundation is ₹. 1,50,000 for three years or ₹. 50,000 per year. As would be seen, the annual recurring expenses on the project come to ₹. 67,000 leaving a balance of ₹. 17,000 per year. In addition, non-recurring expenses would also come to nearly ₹. 51,000 if we also count expenses on medicines as part of it. Thus, the total amount of money to be managed from other national or international agencies for the remaining period of two years would come to ₹. 85,000.

d The organisers of the project should work realistic requirements of the project and approach OXFAM for the same. The Foundation, in its turn, should also make efforts to interact with OXFAM to help the project. In this connection, it would be advisable to approach the regional officer of the OXFAM to visit the project and discuss the requirements. Considering the fact that some of the inputs would be needed even to initiate the programme, efforts should be made to have this meeting at the earliest possible opportunity.

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*1 The suggestions with regard to scales of different functionaries are only indicative of approximate expenses. The salaries would finally be determined on the pattern of the salaries and scales as prevalent in West Bengal.

*2 Non-recurring expenses as given in this report are only tentative suggestions. Actual expenses would depend on the market prices.

*3 The Family Planning Foundation does not provide budget for purchase of medicines, equipment etc.

TOTAL HEALTH PROJECT - BUDGET

	Promised	Already Paid	To Be Paid
	Rs.	Rs.	Rs.
a) Banerjee Charitable Trust	50,000	30,000	20,000
b) Family Planning Foundation	1,50,000	75,000	75,000
Total	2,00,000	1,05,000	95,000

Money already spent -

a) On Research	Rs. 50,000	
b) On Hospital work	Rs. 36,000	86,000
Money at Hand		19,000
Promised money yet to be paid		95,000
Total available fund for Budget (for next $1\frac{1}{2}$ years)		1,14,000

Expected Expenses in Hospital -

As per present activity	Rs. 36,000	
Proposed increase of M.T.P. (with installation of Vacurette)	Rs. 12,000	48,000
Money available for Action Programme :		66,000

Expenses required for Action Programme

Items to be taken up :

A PROPHYLACTIC

1. Small Pox vaccination
2. Triple Antigen inoculation
3. T.A.B.C. injections
4. Multi-vitamins/Calcium for babies

B CURATIVE MEDICINES

1. Against Gastro Enteritis - 30%

a. Antiamoebic
b. Antidysenteric
c. Antihelmantic

B CURETIVE MEDICINES (Contd.)

2. Anti Infective drugs - 20%
a. Sulpha group
b. Broad Spectra group

3. Secondary to malnutrition - 40%
Supplementary vitamins/nutrition possible

4. Skin conditions and others - 10%

At present we are not taking up adult health education due to lack of capital for aduio-visual set up and no certainty for future recurrent expenses. (We have purchased an old Jeep for transport of doctors, but we are still using our personal car as the Project cannot afford a driver or petrol for the same).

C The family planning operations, including tubectomy and medical termination of pregnancy, are being carried out and will continue in the Amiya Debi Hospital as before, but with Vacurette the M.T.P. work will increase.

Though a concrete plan is not possible without a knowledge of financial resources and rising price index, the minimum requirements are given below.

In formulating a provisional Budget our aim would be -

a. To protect the families where the mothers have been ligated, particularly babies.

b. To give incentive to our Project population for family planning operations.

c. To allow some coverage to fringe areas outside the Project zone on humanitarian grounds.

The action programme plan is based on our knowledge of research already carried in the first schedule and analysis of hospital attendance over the years. We have taken for the purpose of calculation an average daily attendance of 100 in our out-patients department and average distribution of cases. This is in addition to the expenses for operations and indoor patient care being carried out in the Amiya Debi Charitable Hospital and which will continue.

Expected Expenses of Action Programme
(very provisional)

A. PERSONNEL - ₹. 26,100

1. Social Workers - ₹. 15,300
We shall require at least 3 Social Workers who would carry out house visits including inoculations and medicine distribution. They will be recruited from the field workers who have already carried out dor-to-door data collection and are conversant with local conditions. They are known to the local populace and the latter will feel more at ease in dealing with them. We intend to employ 3 of the female field workers whose services would be terminated otherwise, now that data collection for research is over. Though we have allowed them free accommodation in our residential house next to the hospital, their salary would be ₹. 850 per month. So for $1\frac{1}{2}$ years: ₹. 850 x 18 - ₹. 15,300.

A. PERSONNEL (Contd.)

2. Record-keeper cum Typist @ Rs. 300 per month - Rs. 5,400

3. Driver for jeep @ Rs. 300 per month - Rs. 5,400

B. METHODOLOGY - Rs. 3,600

1. Small Pox - door-to-door visit for all

2. Inoculations - part by home visit and part hospital based.

3. Distribution of medicines - mostly hospital based.

So some Peripheral working and use of the Jeep will need rough estimate for conveyance @ Rs. 200 per month - Rs. 3,600.

C. COST OF MATERIALS

If the Action programme is to be properly completed and, more important, evaluated in accordance with the Family Planning Foundation's guidelines, it is estimated that the following items of medicines with their quantities will be required. Against each item the cost has been worked out on the basis of wholesale prices quoted by pharmaceutical companies. It will be noticed that on this basis the total cost of medicines for the remaining $1\frac{1}{2}$ years works out to nearly Rs. 9 lakhs. This is obviously impracticable. What we intend to do is to tailor the work in this field to the quantities of medicines that we can procure with donations from international and other organisations. Needless to say, any part of this that can be supplemented by cash donations will be welcome.

Materials

	Rs.
1. Small Pox vaccine - will be available from State Govt. sources	Cost Nil
2. Triple Antigen inoculation - 5% of 20,000 - 1000 children @ 3 ampoules - 30,000 ampoules (from 2 to 5 years old children)	45,000
3. T.A.B.C. injections - 2000 10c.c. phials @ 6 monthly injections - 3 x 2000 - 6000 phials (for whole population)	12,600
4. Multivitamin tablets - for 1000 babies one daily - roughly 3,50,000 tablets	63,000
5. Calcium tablets - - do -	35,000
6. Against Gastro Enteritis - 30 patients daily - roughly 400 days - so total is 12,000 patients in $1\frac{1}{2}$ years	
a. Antiamoebic tablets @ 10 tablets of Enterogiunol per patient - 1,20,000	12,000
b. Antidysenteric tablets @ 10 tablets of Thalazol per patient - 1,20,000	15,600
c. Antihelmenthic - Decaris 1 tablet/patient - 12,000 adults	45,000

Anti-infective drugs - 20 patients per day @ 400 days in $1\frac{1}{2}$ years - total number of patients 8,000 — 25,200

a. Sulphanilamide @ 2 tablets twice daily for 5 days, i.e. 20 tablets, therefore for 50 patients - 4000 x 20 - 80,000 tablets — 10,400

b. Terramycin - do - - 4000 x 20 - 80,000 capsules — 54,000

8. Secondary to Anaemia (and malnutrition) - 40 patients per day @ 400 days in $1\frac{1}{2}$ years
Total number of patients 16,000
@ 1 tablet daily for 1 month -
16,000 x 30 - 4,80,000
Fero-redoxin or the like — 8,89,600

April 23, 1975.

676/IT

Providing Total Health Care including Family Planning to a Population of 20,000 in a Suburb of Calcutta

Background

One of the Foundation's priority areas for funding from the very early stages was promoting family planning through integrated health care. This idea has been very much in the air for quite some time and still continues to be so. But a well tested and documented experience in the Indian context is still not really available. The idea of developing this approach around a private hospital was considered important particularly for demonstration purposes. It was felt at the time that a private hospital would have enough flexibility and interest for such a demonstration.

For this purpose the Amiya Debi Trust in Calcutta was considered a suitable agency. This trust was founded in 1966 by Dr and Mrs Tarun Banerjee, a couple deeply involved in community service (Dr Tarun Banerjee is one of the foremost gynaecologists of India and Mrs Banerjee is a well known doctor of Calcutta and by training an anaesthesiologist). The hospital is located at Narindrapur, 10 miles away from Calcutta. It has 12 beds with necessary equipment. The hospital although located in a politically sensitive area, has a high degree of acceptance of its work among all people because of its impartial and high quality services. The Trust is run by a Management Committee drawing its members from civic minded citizens of Calcutta with Mr C R Irani, Managing Director of the Statesman, as its Chairman. The services are being provided by Dr and Mrs Banerjee and a core staff and a number of specialists from Calcutta, of various backgrounds on an honorary and free basis. With its high degree of community acceptance

Contd...2

and with a rural population under considerable urban influence consisting of both Muslims and Hindus, it was considered a suitable place for an innovative kind of demonstration.

Objectives

The main objective was to demonstrate that it was possible to have an integrated health care project with optimal inputs of family planning through the infrastructure of a private hospital with strong community base. The idea was to work out the quantum and nature of inputs of integrated health care consisting of curative and preventive medical and health care, family planning, nutrition, maternal and child health and medical termination of pregnancy. The basic idea was to demonstrate the concept of integrated health care through galvanising private effort.

Methodology

The methodology visualised three phases. Phase One - a survey of the area with a view to find out the socio-demographic profile of the population to identify priorities in health and family planning needs and a meaningful identification of infrastructural support that could be utilised from the Government and other agencies for the project. Phase two - develop a project design based on the findings of the phase one for developing a demonstration project. Phase three - active demonstration of the project.

Importance of the project

The project was considered important for several reasons (i) While the idea of integrated health care was accepted in theory, there was no exact practical definition for purposes of actual implementation. This was particularly true in the case of voluntary organisations which needed to take

Contd...3

up the idea in a way that would suit them. The project, therefore, had special value for this purpose. (ii) The project would help to identify ways and means of galvanising social service minded citizens with or without medical expertise to be involved in the programme. The project if demonstrated well would have replicative value for the government's own programmes.

Operationalisation of the Scheme:

The Scheme got up to a good start. The Management Committee of the project accepted the idea and the project was also launched by no less a person than the Governor of West Bengal - Mr Dias.

The hospital had from the very beginning a strong bias in favour of sterilisation. They also strongly imbued with the idea of serving the people, the "charity" concept of the well-to-do helping the needy and /or helpless. The idea of community orientation for health services where people's involvement matters - was rather alien to some of the key individuals. It also seemed to cramp their style as providers of charity. Orientation of the key people to appreciate the need and relevance of the community health approach continues to be a real challenge to the Foundation. The positive support of Mr Irani and one or two members of the Committee has been a helpful one in continuing the project.

Foundation's staff, therefore, had to make a few visits to Calcutta and help the Directors to conceptualize as having innovative possibilities. Also it was decided to requisition the services of a Professor of Social Anthropology in conducting the initial survey for designing the project. The normal work of the hospital with accent on sterilization continued for most of the time, except for the period of the emergency when the work slowed down considerably.

Administration & Finances

The Governing Board at its meeting held on 12th September, 1972 sanctioned

Contd....4

a grant of Rs 1,50,000 for this project. Out of this a sum of Rs 1,20,000 has already been disbursed.

Later in August 1974, the Governing Board sanctioned a sum of Rs 36,000 to cover expenses on research consultancy. This amount has not been utilised so far.

Follow up & Future Action

This project for good part of the time has been a difficult one. While the work of the hospital has been kept at a steady pace, the experimental part of it, did not pick up in time or sufficiently. The difficulties, some of which had been indicated above can be summarised as follows :

(1) The shift from a clinic oriented hospital to a community hospital has been a very difficult process particularly because of the mental attitude of medical leadership who although deeply committed to community service, it was difficult for the Foundation to help them move in this direction rapidly and adequately. This delayed the progress. It may be added that the Chairman, Managing Committee was all along appreciative of the community approach. His influence in greater part helped in the slow change that currently is taking place.

(2) The survey report prepared for purposes of project work by the social scientist was too anthropologically oriented and did not provide adequate information for developing a programme with strong programme content. This is now being remedied by gathering more facts for the project work.

(3) The project was expected to get medical and other support from an international agency, which did not materialize at all. This is and was a continuing problem and has not helped to increase the programme content.

(4) The project although delayed is now being recast to reflect community orientation including identification of local community health workers to

work with the hospital. There is a mid-course correction, although somewhat delayed. The next phase is likely to be more useful and helpful.

Further Reading

1. File 676/HF
2. Survey Report by Dr Bhowmick (Social Scientist)

Total Health Care Project

Narendrapur, Calcutta

(1) Introduction

a) Interaction between the Family Planning Foundation and Banerjees Charitable trust

b) Sanction of projects and relative matters

Nat. Med College
(Part of National Movt
↓
For Revolutionary
(Gandhiji/CP Dane k)

Idea - Promoting FP through integrated health care (considered) around a private hospital

Reasons i) Flexibility
ii) Interest of workers

- Why particular area?
  - i) Acceptable services
  - ii) Rural population under considerable urban influence
  - iii) Hindu + Muslim population

Objectives. To demonstrate

i) Possibility of having integrated health care project with critical inputs of FP through infrastructure of a private hospital with strong community base.

ii) Work out quantum and nature of inputs of integrated health care - curative medical health care
preventive "
Family planning
Nutrition "
MCH
Med. termn of pregnancy.

Basic object. Integrated health care through galvanising private effort

- Identify ways and means of galvanising social service minded citizens with or without medical expertise to be involved in the programme

+ If successful - then replicative value for Govt programme

2) History of the clinic before the Foundations assistance
Bannerjee Charitable Trust - 1966
Amiya Debi Trust of Calcutta - 1966 - founded by Dr and Mrs Tarun Bannerjee (Gyn / Anaesth - couple)
— Amiya Debi Charitable Hospital - May 1969
Project at Narenderpore - 10 miles from Calcutta

Hospital - 12 beds — High degree of acceptance ∵ of quality of service Impartiality
- Politically sensitive area
-

- Trust run by Management committee - Chairman - CR Iran Managing director of Statesman
- Services provided by Dr & Mrs Bannerjee + Core Staff ?? + number of specialists from Calcutta
Honorary and free basis

Personal money + Friends (help)

1961 -

villagers come from a radius of 10 miles

3 bighas of land in Narenderpore

2 rooms + small operating room
↓
OPD + 12 Indoor beds + air conditioned operating theatre +

Gynecologist
Anaesthetist
Skin Specialist
Chest Specialist

Centre employs
Trained staff nurse
Pharmacist compounder
General duty attender
Sweeper
Ayah

Project inaugurated 15th August 1973 (Governor Dias)
(Photographs?)

Building - unostentatious, single storied, white washed

1969 - 1194
1970 - 9537
1971 - 11891
1972 - 15444

Two Eye camps - Lions Club (1972

Cases which require specialised treatment are referred to Calcutta Hospitals

3) Initial plan to extend the clinic on the part of the Banerjee Charitable Trust – their perceptions for extension and development.

- Strong bias in favour of sterilization
- Charity concept ++ . Well to do helping the needy and/or helpless

---

Tubal ligated cases → Children – Smallpox, DPT, TABC

Protein Imintha
Anemic
V. Vitamins

Sources of Finances
- FPF
- Governor
- Advertisements for Charity Show
- Others.

4) Project design as evolved on the basis of discussions between Family Planning Foundation and Trust.

Methodology – 3 phases visualised.

Phase one – Survey of area: To find out
i) Socio-demographic profile of population
ii) identify priorities in Health + FP needs
iii) identification of infrastructural support (existing) (Govt or other agencies)

Phase two – Develop a project based on findings of Phase one

Phase three – Active demonstration of the project

Weekly

i) Gen OPD
Monday – Friday = 2-5 P.M.

ii) Wed + Sat = + Gyn Clinic (Dr. Banerjee)

iii) Operation: Wed + Sat 11-2 P.M.

Resident Staff

1. Staff Nurse
2. Duty Assistant
3. Chowkidar/Helper
4. Nursing Aides 2

Compounder during OPD

5) Survey of the Area - Research and survey exercises by Dr. Bhowmick - report and implications for replications

Survey Team trained in Gandhigram and 8th Aug 1978

— 5 Reports traced

— Survey 2 - not yet completely analysed or reported

— No clear cut demarcation / definite proposal of

i) Job responsibility of Soc. Scientist
ii) Remuneration
iii) Time period for survey
iv) How to use results of survey for planning Phase II

— Misunderstanding / suspicion

— Problems regarding payment

— Survey (2) forms are still with Indian Statistical Institute

— Payments pending

6) Action programme following the survey ~~Faced by the project in a procemical~~
Context

Other Health fact

MR Bangur Hospital (District HQ - 24 parganas)
15000

PHC - Subashgrame 4.5 km

8 - Allopath
4.5 Homeopath

Drugs
Budget

7) Problems Faced by the project in a professional context

— No clear cut demarcation of work components / recording research work or components of integrated health package
— Dr Bhamidis work & Trusts Needs / expectation not coordinated
— No understanding of what will be the type of results from survey and how it should be used
— No concept of Time required for phases

C.H orientation of — Project?
People?

Peoples involvement?

↓

No involvement of Panchayat

⇒

— No idea of record analysis or record linkage
— No idea of research methodology or evaluation techniques

8) Overall review of the work of the project

- No link between survey and services
- work in Yuso is isolated compartments
- Hence impact of services cannot be judged since even the services-recorded cannot be separated into those of Bullagen and those for people from outside the area.

(Reports signed by Mr C.P Irani - 26th Aug 1974)

9) Current status and needs

— Dr Bannerjee's want expansion.
— Money for Medicines
Resident MO
— No

Observations (Mr Subal Raha)

1. Very poor area.
2. Illiterate - 90-95% → 20% Prim. School outof 10% H School out of 2-5% Colleg
3. Traditional occupation - Agr. activities → Rice/Jute/Ishoot Vegetables → Cash
4. Subsidary . fishing/day labourer/maid servant
5. Other Health Facilities
   i) Subash gram - ? PHC
   ii) RKM Dispensary - Narendrapur.
   iii) No Private practitioner - Typhoid/Injury
   iv) Homeopaths - Symptomatic
   v) Ojhas + Temple(s) Smallpox, Diarrhoea
6. ~~A~~ D Charitable Hospital - People's impression - good
   Attitude to Doctor/Nurse good Free -
   Lack of medicines now ↓ ∴ impression ↓.
7. F.W → acceptance ↑
   urban influences ↑ - Garia/Sonarpur

Poultry
Cow keeping.
Sheep/Goat farming
Agro-engineering

RKM - (details?

i) Gram Sevak Training Centre - organised by RKM, financed by GOI.
   (Training in Agriculture
   Cow Farming
   Poultry)
   (V. Kum / Nin / Bh / Ram Ch).
   High School Graduate (10th Std)
ii) Recreation Clubs (RKM)
iii) Cottage industries - Umbrella making (RKM) (women)

Educn
Primary School / Madrasa / Tol
↓
Rajpur / Garia. Junior High School
↓
Garia - College.

CPM - political organisation?

Communication: On Foot

Poster
Group discussion
Film strips (RKM uses it)
Jatra / Kathas

Elachi Cooperative system possible
Literacy ↑ Resettled, Incomes ↑
TA - at RKM Consciousness ++

Cooperatives Grocery in RKM camp... for staff

Changing possible = villages can pay
(Nis/UKH/Ram ch)

Records Maintained

(1) Tubectomy Register

Name Age Address / village Date of operation

(2) OPD Register

Daily new registrations + Total No. of old cases
Name/Age/Sex No. of visits seen

(3) OPD Card No. Name/Age/Sex/village
Illness and treatment record and date seen

(4) Surgery Register
Name Age Address Date of operation
Type of operation including D+C and Ant. hysterectomy

(4) List of children who have been given DPT

(5) " who have been given T.T.

(6) List of women who have been given Fe/Folic
Name Age No. of tablets
date of administration

	1973	1974	1975	1976	1977	1978
Capital						
Land	3500					
Building	1,52.238					
Tubewell	361.00					
Furniture Fitting	10701					
Med. Eqp	1183					
Expenditure						
Salary	12084	3	38377	30475	22650.23	
Medicine	16075		11298.82	1119.24	615.52	
Repairs to Building	7000.00					
others						
Total	34214.19		55.511.21	51542.22	41900.23	

1976

Medicine (Purchased)

Flagyl
Decadron
Intestopan
Mixture Chemicals
Injn Pethidine
Inj Morphine
Injn Thiopenta
Injn Atropine Sulpha
Injn Flaxedil
Elkosin
Enteroquinol
Celoralon
Dextrose
Ergometrin
Syntocinon
Gentian Violet
Anaesthetic Ether
Tetanus Toxoid
Savlon
Syringes
Needles
Cotton
Gauze
Plaster
Piriton

	1970	1971	1972	1973	1974	1975	1976	1977	1978
1. TOTAL NO OPD	7360	12213	15760	11798	9019	8172	5338	7152	2806
2. TOTAL NO INPATIENT	36	77	34	48	73	106	102	41	32
FAMILY PLANNING OPERATION									
3. A) TUBECTOMY	19	55	30	32	63	99	77	24	9
B) MTP ANTHYS, D&C	4	24	2	12	8	11	20	13	17
4. OTHER OPERATIONS	28	18	11	14	21	19	32	34	27
5. SMALL POX									
6. TRIPLE ANTIGEN						22	40	51	39
7. TET. VACC.						38	116	71	74
		3372 / 419	6288 / 749	11985 / 1218		3372 / 419	6288 / 740	11085 / 1218	3890 / 370
8. IRON & FOLIC ACID									
~~9. MU~~									

DATA on Villages

	No. of Families	No. of Person	Average No/family	M	F	M+F 0-4	M+F 5-14	F 15-44	Eligible couples	T	V	~~Target~~ LUCD	Target
Chowhaki	569	3315	5.8	1736	1579	396	951	658	462	30	13	0	
Kusumba	276	1555	5.6	826	729	228	484	314	~~465~~ 99	0	0	0	
Hogalkuria	183	1097	6.00	571	526	145	385	198	153	8.	9	0	
Ramchandrapur	176	1060	6.0	520	540	151	338	204	124	20	8	0	
Kumarkhali	372	2134	5.7	1139	995	268	668	402	306	2	1	0	
Jayenpur	97	536	5.6	280	256	62	176	104	81	9	10	0	
Nischintapur	78	505	6.5	270	235	43	174	100	61	7	4	0	
Dangalpara	156	913	5.9	483	430	98	321	155	120	16	7	0	
Banhoogly	711	4290	6.0	2234	2056	602	1437	769	604	28	32	7	
Jagannathpur	193	1191	6.2	621	570	164	377	221	~~175~~ 169	0	0	0	
Ukhila	240	1296	5.4	677	619	162	421	246	176	0	0	0	
Elachi	304	1731	5.7	916	815	199	532	357	245	32	9	3	
Jagaddal	298	1679	6.3	979	900	174	543	407	250	22	7	2	
													Target
Total	3653	21305	5.9	11252	10054	2652.	6807	4135	2956	182	100	12	2562
				52.33%	47.61%	(12.33%)	(31.66%)	(20%)				294	
						2664		4133					
								Child Woman Ratio					

Overall data

(1) Caste / Religion

	No of families	Total No of pers	Family size	% families	% people
i) Hindu					
High caste	601	3452	5.7		
Middle "	471	2812	6.0		
Low caste	1185	7058	6.0		
All	2234	13410	5.9		
ii) Muslim	1261	7465	5.9		
iii) Christian	108	629	5.8		
	3653	21504	5.9		

(2) Education level

i) Illiterate	51.6%
ii) Literate	10.5%
iii) School	34.8%
iv) College	3.1%
Total	100%

(3) Occupation

Total M + F = 10799
15-59

Total working force = 5825 (53.9%)

		Person
Agriculture	0.8%	47
Labourer	51.1%	2974
Service	32.6%	1901
Business	15.5%	903
		5825

(4) Marital status

	M	F	T	
Married	3714	3700	7414	36%
Unmarried	7361	5531	12912	63%
widowed	147	994	1141	5.2%
divorced	10	27	37	0.2%

(5) Family Type

Joint	1034	28.3%
Nuclear	2619	71.7%
T	3653	100%

(6) Size of Household

		%
1-3	707	19.35
4-6	1585	43.39
7-9	1039	28.44%
10+	322	8.82%
Total	3653	100%

(7) Demographic data

Child women ratio

No of 0-5 children / No of women in 15-49 age group

Hindu = 54
Muslim = 84
Christian = 63

Anterior Hysterotomy and D&C (MTP)

	1976	1977	1978
Chowhali	1	x	x
Kusumba	x	x	x
Hogal Kuria	1	x	1
Kumra Khali	x	x	x
Ramchandra Pur	x	x	x
Jogen Pur	x	1	x
Nischinta Pur	x	x	x
Singel Pota	x	x	1
Bonhoogli	1	1	1
Jagannath Pur	x	x	x
Ukhila	x	x	x
Relachi	x	x	1
Jagaddal	1	x	x

Tubeelomies

	1976	1977	1978
Chowkati	1	x	x
Kusumdea -	1	x	x
Hagal Kuria -	4	1	x
Kumrakhali -	x	x	x
Ramchandra Pur	8	2	x
Jayen Pur	x	x	x
Nischinta Pur	x	x	x
Dingel Pota	3	x	2
Bonhoogli	2	x	1
Jagannath Pur	x	x	x
Ukhila	x	1	1
Kalachi	7	2	2
Jagaddal	2	1	x

Anterior Hysterotomy and D&C (MTP)

	1976	1977	1978
Chowhali	1	x	x
Kusumba	x	x	x
Hogal Kuria	1	x	1
Kumra Khali	x	x	x
Ramchandra Pur	x	x	x
Joyen Pur	x	1	x
Nischinta Pur	x	x	x
Singel Pota	x	x	1
Bonhoogli	1	1	1
Jagannath Pur	x	x	x
Ukhila	x	x	x
Kalachi	x	x	1
Jagaddal	1	x	x

WH-13.2

REPORT on the Total Health Care Project in 24 Parganas, West Bengal

INTRODUCTION

The Banerjee Charitable Trust was founded by Dr. Tarun Banerjee and his wife, Dr. Anima Banerjee, in 1966. In 1969, the hospital called the Amiya Debi Hospital was built in the rural setting at Narendrapur, 24 Parganas district, 9 miles from Calcutta. The hospital contained 12beds, an airconditioned operating theatre, and an out-patients clinic with a dispensary; all medical services, both for indoor and outdoor patients, are absolutely free. The hospital is run mainly on the voluntary services of Drs Tarun and Anima Banerjee and their friend, Dr. Ajit K Dutta. As the hospital became popular, it was necessary to take on some salaried staff - a part-time medical officer, a resident qualified trained nurse, two female nursing assistants, three male duty assistants and a part-time pharmacist. All expenses are borne by the Trust and medicines and other medical help is provided for the village population, but the main emphasis is on family planning operations on females.

In early 1972, through some mutual friends contact was established with the Family Planning Foundation in New Delhi. A scheme was presented for a Total Health Care Project serving a population of about 20,000 people spread over 13 villages in this predominantly rural area, comprising both Hindus and Muslims. Professor S.C. Kavoori, Executive Director of the Foundation, visited the hospital and its surroundings soon thereafter. He inspected the activities of the hospital and discussed the feasibility of the Total Health Care Project. The Foundation ultimately decided to provide Rs. 1,50,000 over a period of three years with the Trust contributing Rs. 50,000 over the same period.

A programme was drawn up, divided into three phases :

Phase I To have a research programme for deriving certain basic data (base-line of this population) through the work of research assistants who will be collecting these datas by house-to-house visits.

Phase II The datas were to be further qualified and specified with more emphasis on family planning and in relation to other health care like immunisation, sanitation, health education etc.

Phase III There will be an action programme with a view to provide prophylactic and curative health care, the quantitative and qualitative measures of which were to be assessed from scanning of the datas collected from the first and second research programmes.

These activities were to be directed from the Amiya Debi Hospital. It has been the experience of the Trust that the motivation for family planning operations can be generated very satisfactorily by providing comprehensive medical care and attention for the entire family.

(2) //As the Trust was now involved with the finances provided by the Family Planning Foundation, the trustees of the Banerjee Charitable Trust decided that a separate organisation should be set up to undertake the The Total Health Care Project. A committee consisting of the following was brought into being:

Mr. C.R. Irani	Chairman
Dr Mrs Anima Banerjee	Hony. Treasurer
Dr Tarun Banerjee)	
Mrs Threety C Irani)	Members
Dr Ajit K Dutta))	

On the 30th September, 1972 His Excellency the Governor of West Bengal, Shri A.L. Dias, formally opened the Project at the hospital premises where Dr. J.C. Kavoori handed over a cheque for ₹. 50,000,being the first contribution from the Foundation, to the Chairman of the Project, Mr. C.R. Irani.//

The plan of the Project is set out below :

Planning Programme:	Action Programme:
Phase I	
Collection of basic data of the population and analysis	Medical service and family planning operation at Amiya Debi Hospital
Phase II	
Collection of data with emphasis on family planning	
Phase III	
Preventive aspect (i) immunisation (ii) child health care (iii) adult health education	Medical service and family planning operations at Amiya Debi Hospital

The first phase of the work was completed on 31st December, 1974 and included -

(1) the appointment of the Research Scientist, Dr. P.K. Bhowmick, D.Sc. (Calcutta), Reader of the Department of Anthropology, Calcutta University. He was entrusted with the research work on an honorarium of ₹. 400 per month.

(2) the appointment of research field workers and statisticians after scrutiny and selection by the Project committee. A field supervisor was provided on an honorarium of ₹. 325 per month and the other workers ₹. 275 per month. In addition, Dr and Mrs Banerjee made available the ground floor of their house adjacent to the hospital to enable the workers to stay on the project.

(3) drawing up of the pro forma incorporating door to door visits

visits covering the entire population of about 20,000 people spread over 13 villages in an area extending over five miles from the hospital. The mass of information collected in this fashion is now being statistically analysed and a preliminary report prepared by Dr. P.K. Bhowmick is attached.

The second part of the programme of the research wing consisting of data collection with main emphasis on family planning and health care is in progress. This will be completed by the end of March 1975.

As for the curativeaspect of the work of the hospital, we have to report the average out-patient attendance is noted in a register kept for the purpose and is 60 per day; ligation operations were performed on 74 females during the period under review.

The working committee of the Project is set out below:

Project Chairman: Mr. C.R. Irani
Director: Dr. Tarun Banerjee

Co ordinator:	Social Research Scientist:
Dr. A. Banerjee	Dr. Ajit K. Dutta	Dr. P.K. Bhowmick

Surgical Specialist
Gynaecological Specialist
Medical Officer
Nursing Sister
Female Assistant
Male Assistant

Demographer
Statistician
Male Field Worker
Female Field Worker
Auxiliary Nurse

Before commencing work on the Project, Dr. Ajit K Dutta and Dr. P.K. Bhowmick and two field workers visited Gandhigram by courtesy of the Family Planning Foundation to watch their operations. Recently, Dr. S.K. Misra, Research Specialist attached to the Foundation, visited the Project twice, once in the company of Commodore Mehta and again with Prof J.C. Kavoori. Dr. Misra spent two days at Narendrapur watching the field workers in action and helped to assess and guide them in their field work. We are anxiously awaiting his report, on the basis of which we propose to plan the third phase of the Prophylactic Health Programme.

Problems and Difficulties

A major difficulty encountered by field workers is lack of cooperation from the population due to ignorance and exaggerated expectations. Initially, there was some resistance to the concept of family planning largely based on communal considerations, but this has been gradually overcome and the confidence of the villagers has been earned by the work done in the hospitalmainly in the out-patient department. It would be of great help if slide projectors and other audio-visual aids could be made available.

The Project considered providing a skeletal nutrition programme for under-nourished children but has decided to put this off for the time being because of administrative problems.

As regards the curative aspect, the Project is trying to secure a Vacurette and if we are successful in this effort we expect a major dent to be made in the task of limiting families.

Administrative and Financial aspects

The programme commenced in October 1973 and by the end of March 1975 the Family Planning Foundation will have contributed R. 75,000 and the Banerjee Charitable Trust R. 30,000. We accept the need for adequate statistical data but cannot help making the observation that most of the assistance provided by the Foundation has been absorbed by the research programme and the curative aspects of the work at the hospital has not received any direct benefit. We are apprehensive that in the third phase the action programme related to prophylactic care, including consultancy fees, is likely to be so expensive that all the financial commitments made by the Foundation will be absorbed, with no direct benefit to the curative work at the hospital - so vital for the achievement of our common objectives.

Also, it would be of great assistance to the doctors if the Foundation felt able to give some indication as to what is likely to happen at the end of the three-year programme. If the Foundation feel that it will not be able to assist thereafter, the Trust will have to take decisions now on the future work of the Amiya Debi Hospital. Needless to say, continued work on these lines is imperative if the results achieved so far are not to be lost and for work of this kind a slightly longer perspective is also, in our view, necessary.

C. R. IRANI
Chairman

23.i.1975.

DH - 13.3

TOTAL HEALTH CARE PROJECT : 1973-74

REPORT
On
FAMILY PLANNING ACTIVITIES
in 11 villages and 2 Semi-urban
Settlements of Sonarpur P.S.,
24-Parganas district,
West Bengal, 1974

--- EXPOSITIVE REPORT ---

(September 1976)

SUMMARY OF THE FINDINGS ON FAMILY PLANNING ACTIVITIES BY THE ELIGIBLE COUPLES IN SONARPUR P.S. (1974)

1. In Sonarpur P.S. 11 rural and 2 semi-urban settlements were investigated in the beginning of 1974 to elicit information about the extent of family planning activities by the eligible couples. Altogether 2856 eligible couples were found in these settlements. Social group wise breakdown of these couples was as follows:

	Rural	Semi-urban	Total
a) Hindu :	1321 (75.4)	430 (24.6)	1751 (100.0)
b) Muslim :	957 (93.6)	65 (6.4)	1022 (100.0)
c) Christian:	83 (100.0)	0 (0.0)	83 (100.0)
Total :	2361(82.7)	495 (17.3)	2856 (100.0)

2. Out of 2856 couples only 19 per cent were found to have ever-practised any family planning F.P. method. Social group-wise classification of these couples reporting use of F.P. methods reveals the following picture:

	Rural	Semi-urban	Total
a) Hindu:	307(71.2)	124(28.8)	431(100.0)
b)Muslim:	83(91.2)	8(8.8)	91(100.0)
c)Christian:	22(100.0)	0(0.0)	22(100.0)
Total:	412(75.7)	132(24.3)	544(100.0)

3. Out of 544 eligible couples who had some F.P. experiences 51 per cent declared to have adopted sterilization measures. Socialgroupwise distribution of the sterilized couples was as follows:

	Rural	Semi-urban	Total
a)Hindu:	152(70.0)	65(30.0)	217(100.0)
b)Muslim:	41(91.1)	4(8.9)	45(100.0)
c)Christian:	14(93.3)	1 (6.7)	15(100.0)
Total	207(74.7)	70 (25.3)	277(100.0)

4. Out of 277 sterilized couples 36 per cent declared to have opted for sterilization of male sponses (vasectomy) and the rest 64 per cent was for sterilization of female spouses (tubectomy). Social group-wise breakdown of the cases of vasectomy and tubectomy showed the following picture:

	TUBECTOMY CASES		VASECTOMY CASES	
	Rural	Semi-urban	Rural	Semiurban
a) Hindu :	103	50=153	49	15=54
b)Muslim:	18	3= 21	23	1=24
c)Christian:	2	1= 3	12	0=12
	123	54=177	84	16=100

5. Out of 177 sterilized wives 67 per cent were found to be 31 years and more in age. Classification of these wives by social group, age and location showed the following picture:

	Sterilized wives					
	age 30years and less			age 31years and more		
	Rural	semiurban	Total	Rural	Semiurban	Total
a) Hindu:	37	12	49	66	38	104
b) Muslim:	7	1	8	11	2	13
c) Christian:	1	1	2	1	0	1
Total	45	14	59	78	40	118

6. Out of 100 sterilized husbands 86 per cent were observed to be 36 years and more in age. Distribution of these male spouses by social group, age and location reveals the following:

	Sterilized husbands					
	age 35 yrs.and less			age 36 yrs.and more		
	Rural	Semiurban	Total	Rural	Semiurban	Total
a) Hindu:	6	1	7	43	14	57
b) Muslim:	3	1	4	20	0	20
c) Christian:	3	0	3	9	0	9
Total:	12	2	14	72	14	86

7. Among 177 sterilized wives the large majority were relatively aged and these wives were observed to possess already 4 and more kliving children to look after in high as 69 per cases. They were, thus, sustaining larger families before they got themselves sterilized to stop for ever further childbirth disbribution of the sterilized female spouses by social group, number of living children and location has been shown below:

	Sterilized Wives					
	with 3 and less living children			with 4 and more living chilsren		
	Rural	Semiurban	Total	Rural	Semiurban	Total
a) Hindu:	29	18	47	74	32	106
b) Muslim:	5	1	6	13	2	15
c) Christian:	2	0	2	0	1	1
Total:	36	19	55	87	35	122

8. Among 100 sterilized husbands those who were relatively aged were again dominating and 51 per cent of these husbands reported to have already 4 and more living children. Sterilized husbands with smaller or larger famulies were found in almost eaual strength. Classification of the sterilized male spouses by social group, number of living children and location is noted below:

	Sterilized husbands					
	with 3 and less living children			with 4 and more living children		
	Rural	Semiurban	Total	Rural	Semiurban	Total
a) Hindu:	24	10	34	25	5	30
b) Muslim:	9	1	10	14	0	14
c)Christian:	5	0	5	7	0	7
Total:	38	11	49	46	5	51

9. Family planning activities of the eligible couples over the eleven villages under study were not at all uniform. Proportions of the couples who reported to have ever-practised any F.P. methods varied from a high 29% (village Kumarkhali) to a low 2% (villages Jagannathpur and Ukhila).

10. In the following six villages it was found that 20% or more of the eligible couples concerned ever-practised F.P methods: a) Kumarkhali (29%), (b) Jayenpur (27%), (c) Dingolpota 27%) (d) Chowhati (23%), (e) Mischintapur (23%) and (f) Ramchandrapur (20%).

11. In the semi-urban settlements of MLACHI the eligible couples having some F.P. experiences explained for 29% cases, where as in semi-urban Jagaddal the comparable couples accounted for only 24%. Bulk of the couples without any F.P. activities dominated, thus, both rural and semi-urban areas under study.

12. As far as sterilization experiences of the eligible couples having F.P. activities are concerned it has been obtained that in 8 out of 11 villages such experiences had duly been recorded In semi-urban settlements sterilization cases were also available. In the following four villages adaption of sterilization method by the eligible couples for the most effective family planning was most markedly noticed. (a) Ramchandrapur, (b) Jayenpur, (c) Dingelpota and (b) Mischintapur.

13. In this context, special attention is drawn to the villages Jagannathpur, Ukhila and Kusumba. Eligible couples of these three villages appeared to be apathetic to any family planning activities. In Jagannathpur as good as 169 eligible couples were found and among them only and only 3 Hindu couples reported to have ever-practised any F.P. methods. None of these couples had also opted for sterilization. In Ukhila out of 176 eligible couples only 4 couples (2 Hindu and 2 Muslim) evinced practise of F.P. method and here agan, more of these couples went for sterilization. Lastly, in Kusumba 99 eligible couples were found and only 3 couples (1 Hindu and 2 Muslim) had F.P. experiences. Here also no case of sterilization was reported. Eventually, the eligible couples of these three villages should have the topmost priority in any family planning programme that might be in operation in the area.

14. In the sample villages when 82 per cent of 2361 eligible couples reported no family planning activities it goes xh without saying that enough graundwork is still needed to motivate the couples towards birthcontrol. Of these couples 37 per cent were found to prexxx possess already 1-3 living children and they must be reached immediately with a bold family planning programme and action-programme for sterilization has to be launched without further delay. This programme is equally urgent for the semi-urban couples.

15. Favourable attitude towards and effective adoption of F.P. methods had already been shown by a segment of the total eligible couples of Sonarpur P.S. and the same needs now to be intensified among the non-adopters. In this direction, the Hindus of both higher and lower caste groups had given the lead. Initial resistence against family planning measures had noticably been broken. More perusation and patient shall no doubt, help in the longwun to remove this resistance in favour of the programme of population control.

16. It was true that relatively a little aged male or female spouses among the group of eligible couples with F.P. experiences and more than three living children had in majority opted for sterilization method to do away fully with further procereation, yet these sterilized couples shall play the most vital role in the local society in motivating their neighbour families as well as their counterparts of younger age-groups. Family Planning education for sterilization must be intensified among the eligible couples, especially among those who had already three or more living children in their individual family.

24-4-76

REPORT ON FAMILY PLANNING ACTIVITIES IN
SONARPUR VILLAGES AND SEMIURBAN AREAS

During the survey for family-oriented basic Health Services in the selected 11 villages and 2 semi-urban settlements of Sonarpur P.S., 24-Parganas district, West Bengal (1974) an attempt was made to collect information about Family Planning (F.P) activities of the eligible couples per household of the survey-areas. From each male sponse of the couples relevant records were also taken on following items of information: a) Religion and caste affiliation, (b) Occupational status, (c) age, (d) education, (e) number of living children.

For the purpose of the present study a couple has been defined as follows: a husband and a wife, both living together with or without any living child at the time of survey formed a couple. If a husband had more than one wife, therewere as many couples as the number of wives. Further, only those husbands whose wives were between 15 and 45 years in age constituted the group of eligible couples. Family Planning activities of these eligible couples have been studied here with special reference to social group, age, occupation, education, number of living children of each male sponse.

Family Planning activities have been measured by the practice of different birth control methods either by the male or female sponse. Special attention was given to elicit information about vasectomy and /or tubectomy cases among the eligible couples of both rural and semi-urban areas under study.

Husbands reporting 0-3 living children have been examined in terms of smaller family, where as those reporting 4 and more living children were considered to posses larger families. Age-wise distribution of the husbands has been shown in terms of three braad age-group, namely, (i) 30 years and below, (ii) 31-40 years, and (iii) 41 years and above. On the basis of religions affiliation the husbands have been examined under three broad social groups: (a) Hindus, (b) Muslims, and (c) Christians. Occupation-status wise the husbands have been classified under five principal groups: (1) Agricultural workers (cultivations, agricultural labourers and other workers related to agricultural activities taken together), (2) Service, (3) Manual labours, (4) Others, and (5) No Occupation. Educationally the husbands have been classified into two major groups: (1) Illiterate and (ii) Literate.

A) FAMILY PLANNING IN GENERAL:

After a through shifting of the information elicited by the couples it has been formed that altogether 2856 couples satisfied the criterion of eligibility. Of these eligible couples 82.7 resided in eleven villages under survey and the rest was from two semi-urban settlements of Elachi and Jagaddal. Among the rural-bred eligible couples only 17.5 reported that they practised one or other methods of family planning. The large majority never practised any F.P. methods to check family size.

Among the ever-practised sub-group of households those who were 41 years and more in age dominated as a single major group (&& 8.2%) . Those who were 30 years and below in ghd age a very negligible portion (1.4%) reported to have some form of F.P. activities. As a matter of part, it is found that in villages out of 412 husbands who ever-practised F.P. methods as many as 378 were 31 years and more in age. Young

adult husband aging 30 years or below had yet to respond favourably for birth control measures.

Among the ever-practised sub-group as high as 74.5% were the Hindus. The Muslims accounted for only 20.2%. The remaining proportion was explained by the Christians.

Within the ever-practised sub-group of the Hindu husbands (307) it is interestingly observed that those who maintained smaller families (1-3 living children) reported use of F.P. methods in majority cases (52% 52.1%) and next was the position of those having larger families (4 and more living children). Among this sub-group only 3 per cent reported no living children and even then they practised F.P. methods. The Hindu husbands who declared to possess smaller families and to practise F.P. methods were mostly middle aged (31-40 years). In contrast, the Hindu husbands who were practising F.P. methods and prossesing larger families were mostly 41 years or more in age.

Within the ever-practised sub-group of the Muslim husbands (83) the majority reported to have larger families (54.2%) and they were 41 years and more in age. Similar trend was also true for the ever-practised sub-group of the Christian husbands.

Thus, it may be summarized that in rural areas the middle aged Hindu couples having smaller families showed greater inclination towards F.P. activities, were as the aged Muslim couples possessing larger families evinced stronger inclination towards F.P. activities. In general, the Hindu couples, inespective of age and family size, were more motivated to ever-practise some form of F.P. method.

On the otherside, among the never-practised sub-group of the rural couples (1949) the large majority (37.1%) was found to prossess smaller families. But those reporting to have larger families

families were not insignificant in maguitude (34.5%). It is important to note that of this never-practised sub-group as good as 11 per cent declared to prossess no living children. On the other hand, it is also observed that with the increasing age of the hushands who never practised any F.P. methods the magnitude of larger families increased in each of three social groups in question.

Within the never-practised sub-group of the Hindu husbands 1014 smaller families dominated in the majority cases (47.3%). While within their counterparts of the Muslim husbands (874) larger families (45.1%) dominated, this very trend was also true among the Christian husbands.

In general, it may be observed that the 'never-practised'-sub-group of the group of couples living in the villages under survey should form the target group ~~of~~ for F.P. activities and of this sub-group those who declared to possess already 1-3 living children must be the immediate target group. Since within this immediate target group the eligibile husbands aging 31-40 years formed, inespective of religion and caste affiliation, the dominant segment, F.P. education and services has to be concentrated first among this particular age-group.

Husbands with smaller families but no family planning activities were found to fall mostly within the age-group 31-40 years in every social group and eventually they are to be given topmost priority in any action-programmes related to family planning. Through relatively speaking, the Hindu husbands had shown greater inclination towards F.P. activities than the Muslims or the Christians, yet the over-all social climate was not found encouraging enough to favour any quick change in traditional motives which guide family building activities of the rural couples of the area.

Scanning the level of F.P. activities of the eligible couples of the sample 11 villages we find that they evinced a wide variation. Unequal response for and acceptance of F.P. methods were markedly present within the villages. Ingeneral, the villages which were dominated by the Muslim families showed quite a lower level of ~~ms~~ response as well as acceptance. On the other hand, the Hindu-dominated villages maintained a good level. The range of variation in the magnitude of the husbands practising F.P. methods the sample villages was from a very low of 2% (villages Jagannathpur and Ukhila) to as high has 29% (village Kumarkhali).

Villages Jagannathpur and Ukhila are both ~~prx~~ populated mostly by the Muslims. Though the Muslims are the major inhabitants of village Kumarkhali, yet the Hindus reported use of F.P. methods in greater number of cases. In village Kumarkhali out of 308 eligible couples the Muslims explained for 55.5% and th rest was for the Hindus. of these couples 29 per cent reported to have practised F.P. methods. The Hindu husbands who practised F.P. methods accounted for 20.8 per cent out of the said 29 per cent. Thus, though village Kumarkhali happened to be dominated by the Muslims, yet the highest level of F.P. activities as was observed in this village, was due to the Hindus.

Next to Kumarkhali were the position of the villages Jayenpur and Dingelpota . Jayenpur yielded 81 eligible couples and 27 per cent of these couples were found to practise one or other kind of F.P. method. On the other hand, Dingalpota had 120 eligible couples and again, 27 per cent of these couples, declared to have followed some F.P. methods.

Villages Chowhati and Nischintapur were found to occupy the third rank in this respect. Chowhati is a populars village and 462 eligible couples were record from here. This was the second best concentration of eligible couples in any one village. Among these couples only 23 per cent were observed to have practised F.P. methods. Quite a big chunk of the couples were yet to go for family planning. They deserved immediate attention. In contrast, village Nischintapur is relatively a small settlement. It yielded only 61 eligible couples. But the couples showed greater awareness for F.P. activities. Of these couples as good as 23 per cent admitted use of family planning methods.

In contrast to the above, villages Jagannathpur, Ukhila and Kusumba exhibited a deplorable situation as far as family planning behaviour of the eligible couples, are concerned. In Jagannathpur and Ukhila as high as 98 per cent of the couples were found to have practised no F.P. methods, while in village Kusumba such proportion was 97%. The eligible couples of these three villages were, no doubt, extremely apathetic towards family planning . These villages were inhabited most dominantly by the Muslims. But for their own religions attitude and social education these Muslims were still hesitant to accept modern family planning practices and accordingly, we can not expect to find any noticable progress in family planning activities in their settlements.

Special attention is drawn to the village Bonhoogly which is fairly a big rural settlement. In this village the largest magnitude of eligible couples was met with. But, the level of F.P. activities among 604 couples was not satisfactory. 84 per cent of these couples reported to have practised no family planning methods. For this state of development one factor is important to note that the village was inhabitated by the Muslims in majority strength.

Another interesting feature is noted here. In 5 villages, namely, Ukhila, Kusumba, Hogalkuria, Chowhati and Kumarkhali the eligible couples who reported use of family planning methods in varying magnitude (2% to 29%) were found to possess already relatively more smaller families with 1-3 living children. But in another 5 villages, namely, Bonhoogly, Ramchandrapur, Nischintapur, Jayenpur and Dingalpota, the ever-practised sub-group of the eligible couples were observed to have already relatively more larger families with 4 and more children. It appears them that in the former group of 5 villages the eligible couples with relatively more smaller families are to be encouraged to sustain their current family size, but in the latter group of 5 villages the eligible couples with relatively less smaller families have to be strongly activated to go for family planning methods in checking further increase in their individual family size.

It is further noticed in the first 5 villages the husbands of 'ever-practised'sub-group were mostly falling in the age-group 31-40 years and they were maintaining smaller families with 1-3 living children. In contrast, in the second 5 villages the husbands of 'ever-practised' sub-group were mostly 41 years and above in age and they reported to have larger families with 4 and more living children.

From the above it becomes, thus, evident that in going for F.P. practices two district patterns were upheld by the eligible couples of the sample villages under study. One pattern was developed by the husbands of young adult ages (31-40 years) in small sized families and they were mostly the Hindus. The second pattern was generated by the husbands of older ages (41 years and more) in large sized families and they were mostly the Muslims .

In two semi-urban settlements, namely, ELACHI and Jagaddal the Survey could locate altogether 495 eligible couples. These semi-urban couples accounted for 17.3 per cent of the total 2856 eligible couples of the areas under study. Of these 495 couples the Hindus explained for 86.9 per cent and the remaining 13.1 per cent were the Muslims. Among the Hindus (430) only as good as 28.8 per cent reported to have practised one or other F.P. methods. In contrast, among the Muslims (65) as low as 12-3 per cent evinced use of some form of F.P. methods. That the Hindu husbands practised F.P. methods in larger magnitude than their Muslim counterparts was beyond any debate.

A closer look reveals that among 124 Hindu husbands reporting F.P. practices as good as 60 per cent had already 1-3 living children to look after in their individual smaller family, whole in only one case the husband concerned was found to have no living child. In the remaining 39 per cent cases the Hindu husbands possessed already 4 and more living children, but reported to have practised some family planning methods. Among the semi-urban Muslim eligible couples (65) only 8 husbands reported to have practised F.P. methods. Of these 8 husbands as many as 6 had already 4 and more living children in their individual larger family.

On the other side, among the semi-urban husbands of the sub-group of 'ever-practised' those who were 41 and more years in age formed the most dominant segment. Of the total 132 of husbands having F.P. experiences as high as 58 per cent were found to fall in the age group of 41 + years. This age-distribution was true for both the social groups of Hindus and Muslims.

Thus, it becomes clear that in Elachi and Jagaddal those who accepted F.P. practices were mostly of higher ages and possessed already 4 and more living children at the time of survey. But those who were in middle ages (31-40 years)

were were not insignificant in numerical strength, but they were mongly observed to have already 1-3 living children during survey.

In this connection it may be pointed out that among 363 semi-urban husbands who did not practise any F.P. methods in checking family size as many as 44 (12 per cent) reported to have no living child at the time of survey. Of this 12 per cent the Hindu husbands also accounted for about 11 per cent. These childless Hindu husbands were mostly within the age group 31-40 years.

Among the Hindu eligible couples (430) as many as 306 husbands had no F.P. experiences. 54 per cent of them reported to have already 1-3 living children, while 33 per cent had already 4 and more living children. Those who reported smaller families (1-3 living children) were mostly of the age-group 31-40 years, but those who had larger families (4 and more living children) were very larvely aged (41 years or more). On the other hand, among the Muslim husbands (65) of Elachi and Jagaddal as many as 57 declared that they did not practise any F.P. method. Of these 65 Muslim husbands 25 and 26 had smaller and larger families respectively. Muslimx Him Husbands with 4 and more living children were mostly 41 years and above in age, while those with 1-3 living children weremostly 40 years and below in age.

Thus, it may be mpkx noted in general that in semi urban areas of Elachi and Jagaddal only a little more one fourth of the total eligible couples formed the sub-group of 'ever-practised' and the large majority was yet to go for any F.P. methods. Under the circumstances, it is needless to emphasise that this large bulk of 'never-practised' eligible couples w has to be properly motivated for F.P. practices. In this direction, performance of Jagaddal couples seemed to be less encouraging.

In Jagaddal the Hindu couples were virtually the group that determined the level of development in F.P. activities. Of the total 250 eligible couples of this semi-urban settlement only 1 Muslim couple was met with . Among the Hindu couples (249) as good as 24 per cent reported to have practised some F.P. methods. Those Hindu husbands who formed the 'ever practised' sub-group were mostly 65 per cent having already smaller families with 1-3 living chilsren andthey were 31 years and above in age. The remaining husbands had larger families with 4 and more living children and they were mostly 41 years and above in age. On the other hand, among the Hindus the husbands who never practised F.P. methods (181) were in majority cases mainting already 1-3 living children. But 21 out of these 181 husbands reported that they had no living child at the time of survey. Those who maintained already 4 and more living children were not insignificant in numerical strength.

In ELACHI altogether 245eligible couples were encountered. Among them 181 were the Hindus. Of the Hindu husbands as good as 35 per cent were found to have practised some F.P. methods, where as of the Muslim husbands (64) only 12.5 per cent showed practice of F.P. methods. The 'ever-practised' sub-group in the Hindu group was mostly possessing already 1-3 living children (56%). Those who maintained smaller families were in majority 31-40 years in age. But those who formed larger families with 4 and those w living children were most naticably 41 years and more in age. On the other hand, among the 'ever-practised' sub-group in the Muslim group large majority had already 4 and more living children, and they were also 41 years and more in age.

Among the Hindus those husbands (117) who never practised any F.P. methods were mostly (61 per cent) having already 1-3 living children. But those Hindu husbands who had no living children already never practised F.P. methods accounted for 14.5 per cent cases. The remaining 25 per cent of the 'never practised'

children and never practised F.P. methods accounted for 14.5 per cent cases. The remaining 25 per cent of the 'never practised' sub-group reported to possess already 4 and more living children. On the other hand, among the Muslims a large majority (87.5 per cent) of the husbands formed the sub-group of 'never practised' in Elachi. They were found to maintain smaller families (with 1-3 living children) and larger families (with 4 and more living children) in matching strength. Those Muslims having smaller families were mostly 40 years and below in age, but those with larger families were in majority cases 41 years and more in age.

In summary it may be observed that family planning activities were maintained more organizedly by the eligible couples, especially the Hindu couples, of Elachi than their counterparts of Jagaddal. In such organization the middle and more aged husbands 31 years + above , pxx particularly the Hindu husbands, played a more dominant role. But those who practised F.P. methods and at the same time had already 1-3 living children (smaller families) were most dominantly 31-40 years in age. In comtrast, those who practised F.P. methods and possessed simultaneously 4 and more living children (larger families) were mostly 41 years or more in age . This feature was shared by the semi-urban male sponses of the group of eligible couples, irrespective of their religions status. Though the Muslim couples were lagging behing their Hindu counterparty in adopting F.P. methods, yet in the over-all context of their own social way of life and family-building attitude their performances are quite remarkable. They need abviously and persuation to make a break through. This can certainly be achieved by making their Hindu counterparts more family planning minded. More the Hindu eligible couples would go for regular family planning practices, more the apathetic altitude of the Muslim couples would begin to dissipiate.

But in two semi-urban settlements out of 495 eligible couples 26.7 per cent declared to have some F.P. experiences. Thus, relatively speaking, the semi-urban couples of Sonarpur P.S. were observed to be more family planning minded that their rural counterparts. And there is no speciality in this state of development, as the non-rural couples are generally expected to be socially advanced to catch innovations.

In the above ground it is further most interestingly noted that in 8 out of 11 sample villages cases of both tubectomy and vasectomy were reported. The families of only 3 villages, namely Jagannathpur, Ukhila and Kusumba did not cite any single case strilization. These were the three rural settlements which showed the minimum level (2-3%) of family planning practices. These three settlements were on the otherhand, inhabited most dominantly by the Muslims. Number of eligible couples in each one of three villages was not meagre. Under the circumstances, it appears that the eligible couples of the three villages do require a special treatment in bringing them within the orbit of the country-wide F.P. movement. In any case, sterilization programme has to be concentrated in these three villages as the top-most piority at the sametime intensive F.P. education has to be especially spread over these villages.

Now for the remaining 8 villages we have 402 eligible couples who ever practised F.P. methods. Of these couples in 84 cases (20.9%) sterilization by Vasectomy method was reported, while in 123 cases (30.6%) sterilization by tubectomy method was declared. This was certainly no mean achievement. When about 52 per cent of 402 eligible couples of eight villages reported to have undergone (by 1974) a permament family planning device through sterilization, the prospect of a sizable decline in future population increase in these settlements can be well understood

That more than half of the eligible couples of at least 8 villages of Sonarpur P.S. could be permanently proctected from further childbirth is nodoubt the most encouraging development in the local society.

Examining the vasectomy cases by social and age-groups it is further obtained that out of 84 sterilized husbands 58 per cent were the Hindus, 27 per cent the Muslims and the rest being the Christians. Among the Hindus the higher castes accounted for 24 per cent of the given 58% the remaining proportion being due to the Hindu husbands of lower caste group. As far as age structure of these sterilized males was concerned it is found that as good as 86 per cent were 36 years and more in age and of this 86 percent as high as 49 per cent reported to have already 4 and more living children in their individual larger families. The rest 37 percent possessed already 1-3 living children in their individual smaller family. Those sterilized males who were 35 years and below in age (14%) were mostly having smaller families and the Hindus were in majority.

It is thus very clear that in 8 villages in question as many as 38 male Spouses having 1-3 living children got themselves sterilized to enjoy the opportunities of a better family life with lesser number of children. On the otherhand, the remaining 46 male spouses with already 4 and more living children could through sterilization ensure permanent check in the growth of their u individual family size. But for these sterilized persons, at least 84 rural families shall have a permanent negative role for making any further addition to population of the given 8 villages.

Similarly, another 123 rural families of these 8 villages shall have the same negative role since in these families the wives concerned were reported to have undergone tubectomy operation.

Of these 123 sterilized female spouses 84 per cent were the Hindus and 15 per cent only the Muslims. Among the Hindus only 32 per cent belonged to the higher caste group and the remaining 52 per cent originated in the lower caste group. On the otherhand, of these 123 sterilized wives as high as 63 per cent were 31 years and more in age and again, of this 63 per cent 52% were found to possess already 4 and more living children. Thus, it is found that as a dominant group the relatively more aged wives with more than 3 living children under went sterilization. But this should not mean that the relatively less aged wives were lagging behind in this respect.

As a matter of fact, of all the sterilized wives those who were 30 years and below in age constituted as good as 37 per cent cases. These younger sterilized wives were found to have smaller (with 1-3 living children) and larger (4 and more living children) families in almost matching strength. Among these younger wives the Hindus were of course, dominanting.

Irrespective of age, the sterilized wives were observed to maintain at the time of survey smaller families in only 29 per cent cases, whereas in the remaining 71 per cent cases the sterilized wives were already possessing larger families. Thus, in quite a good number of cases further increase in family size was definitely checked but for these sterilized wives.

In general, it is evident that the husbands or wives having already 4 and more ~~k~~ living children showed relatively greater inclination for permanent family planning method of sterilization. That is, the number of surviving children per eligible couple seems to have a major role in determining the favourable attitude towards sterilization, and in this respect both the Hindu and Muslim couples evinced

the same behaviour. Another feature is important to reveal that sterilisation, appermanent device of birth contro, was favoured more perhaps by the aged married women who had already satisfactory number of surviving children to look after.

In 8 villages out of 402 eligible couples as good as 52 per cent were permanently protected from for the children birth. But it should be noted that 33 out of 52 per cent had 4 and more living children. These couples had already contributed what they could in the rural population-reaorvoir, but they won't contribute any further. Here lies the real success of the family planning movement of the state.

On the otherside, in the two semi-urban settlements of ELACHI and Jagaddal we have found that out of 495 eligible couples only 27 per cent reported to have everpractised F.P. methods. Of these couples 132 who had same experiences of family planning ashigh has 53 per cent were perticularly met with sterilization experiences. It is, indeed, a quite revealing that 53 out of every 100 eligible couples of the given semi-urban settlements of Sonarpur P.S. of 24 Parganas district were permanently protected by vasectomy and tubectomy methods. But in comparison to the achievement of the rural couples shown in adopting sterilization the above performance of sterilization activities by the semi-urban couples was definitely not spectacular. In eight villages as good as 50 per cent of 402 eligible couples reporting use of family planning methods got themselves sterilized to avert any further children birth.

Again, in these semi-urban areas the cases of tubectomy were relatively more frequent. Out of the total 70 cases of sterilization as high as 77 per cent were constituted by the sterilized wives the Hindus were almost the single contributory group (93%). Only 3 sterilized muslim wives and 1 sterilized Christian wife were met with in the settlements. Whatever progress in

promoting a permanent family planning device among the semi-urban ever-practised sub-group of eligible couples could be achieved was devinitely due to the Hindu couples, especially the Hindus of lower castes. Among the Hindu, sterilized wives (50 in number) as good as 64 per cent were found to belong to lower castes.

Further, among the given sterilized wives of semi-urban settlements as high as 74 per cent reported to be 31 years and more in age and 67 per cent of these relasively more aged but tubectomised-wives were found to possess already 4 and more living children. Those sterilized wives who happened to look after 1-3 living children account for 35 per cent cases. In any case, it becomes clear that the sterilized wives, irrespective of age, were mostly maintaining already larger families with 4 and more living children. Nevertheless, it is quite noteworthy that about two thirds of the total sterilized wives above 30 years in age did adopt the permanent method of birth control to put an end to production of addition child. Paucity of relatively younger aged wives among the strelized group of the married women presents itself as a distressing element. Necessary actions are, no doubt, forth with called for to improve the situation.

Another disturbing finding relates to the pressence of only andonly 16 sterilized husbands among 495 eligible couples found in the given two semi-urban settlements. These 16 male sponses accounted for only 12 per cent of the total 132 husbands who reported to have some F.P. experiences. Only 1 Muslim husband having sterilization was found during survey. Of these 16 sterilized husbands as good as 14 (all Hindus) were 36 years or more in age. Sterilized husbands of relatively younger ages were practically negligible.

Of these 16 sterilized husbands 9 were found in ELACHI and the love case of Muslim husband with vasectomy record came from this semi-urban settlement. In Elachi 72 eligible couples reported use of F.P. methods and of these couples 57 per cent adopted sterilization to register permanent birthcontrol. In Jagaddal

50 eligible couples reported practice of F.P. methods and among them 48 per cent underwent sterilization. Nevertheless, the family planning activities are still required to be intensited among the semi-urban eligible couples and campaign for more and more sterilization has to be accelevated without delay.

Looking closely to the family planning behaviour of the eligible couples, irrespective of their religion/caste or age, of the sample villages under study it is immediately noted that the couples of four villages namely Jayenpur, Ramchandrapur, Dingelpota and Nischintapur evinced relatively the most remarkable achievement. These four villages stood distinguished from the remaining villages under examination registering relatively a higher level of motivation and inclination towards effective control of procreatice activities of their married couples.

In Jayenpur village 27 per cent of 81 eligible couples reported to have ever-practised family planning methods in controlling family size. It is, indeed, remarkable that as good as 23 per cent of these eligible couples did adapt sterilization as a permanent device for birthcontrol. This was the largest single concentration of sterilized couples. In comparison to the smaller magnitude of eligible couples of the village such greater concentration of sterilized cases was no mean achievement. This achievement was effected, of course, relatively more by the Hindu couples having already 4 and more living children in majority cases. In this village only 3 Muslim husbands reported to have undergone vasectomy operation. There was not a single case of tubectomy among the Muslim couples of Jayenpur. On the otherhand, among the sterilized group the cases of vasectomy and tubectomy were present in almost equal strength. Though 73 per cent of the eligible couples of Jayenpur were yet to adopted F.P. methods, yet those who did practise such method had very largely opted to go for a permanent method of birth control.

These sterilized couples are expected to influence the 'never practised-sub-group among the eligible couples of Jayenpur Moreover, all the sterilized Hindu couples happended to Belong to lower caste group only.

Next was the position of village Ramchandrapur. Here also the number of eligible couples was relatively not many. Out of 128 eligible couples 20 per cent were observed to have practised F.P. methods. But the most interesting fact was that all the couples who belonged to the 'ever-practised' subgroup had already experienced sterilization to have a permanent F.P. method. This village happened to record a special state of development in adopting sterilization as the only device of birthcontrol. Other conventional methods of family planning were yet to become popular among the eligible couples. To achieve such state of development the Hindu couples especially the lower castes having already 4 and more living children played relatively the ~~maxx~~ salutory role. Only 6 Muslim couples of Ramchandrapur reported to have sterilization experiences and they were also possessing already 4 and more living children in large majority cases. The eligible couples of Ramchandrapur should be treated on a special footing so as to popularize sterilization more.

The third important village was Dingelpota. Here the magnitude of eligible couples was also small. Out of 120 such couples as good as 27 per cent reported practice of F.P. methods and again, 19 out of this 27 per cent were faound to have sterilization experiences. In this village, the tubectomy cases were reported relatively more (13 per cent). That Dingelpota pra possessed such a high order of concentration of tubectomized cases is really noteworthy. Most of the sterilized wives of the village were, of course, found to maintain already 4 and more living children, the same feature was also exhibited by the sterilized husbands. Not a single non-Hindu couple was met with sterilization record in the village. This is a development to be noted carefully. All the sterilized couples were the Hindus of lower caste group only. The sterilized wives were mostly 31 years and more in age.

Village Nischintapur occupied the fourth rank in offering the sterilized couples among all the eligible couples (61). 23 Per cent of the total eligible couples were found to have ever-practised F.P. methods and out of this 23 per cent as high as 18 per cent reported sterilization. All the sterilized couples were the Hindus and they belonged to the higher castes Only, The large majority of the sterilized couples were found to have already 4 and more living children. On the otherhand, among the sterilized group the cases of tubectomy was relatively more in number and the sterilized wives were mostly 31 years and more in age. In any case, 77 per cent of all eligible couples of Nischintapur still required intensive F.P. education.

In this connection immediate attention is drawnts the villages Bonhooghly and Chowhati. These two villages are relatively more largely populated, though in the former village the Hindus and in the latter village the Muslims dominanted. In Bonhooghly as good as 604 eligible couples were found and only 16 per cent of them reported to have ever-practised any F.P. methods. of this 16 per cent about 10 per cent declared to have undergone sterilization. When as high as 84 per cent of the eligible couples of theIs populars village had no family planning experiences it was no wonder that such a poor respouse for permanent device of birthcontrol would be exposed by the couples concerned. Under the circumstances, it is imperative that intensive campaign for sterilization as well as for other conventional methods of F.P. has to be concentrated in this village.

Among the sterilized couples of Bonhoogly it is interesting that the Muslims were present relatively in greater strengthy/ when one-half of the sterilized couples of the village were found to be the Muslims, one has to rethink about the plan and programme of family planning which might havebeen drawn for Bonhoogly. On the otherhand, within this Muslim group though the cases of vasectomy were found relatively more, yet the magnitude of tybectomy-cases were not insignificant, among the

Hindu sterilized couples we find relatively higher concentration of tubectomy cases. In both Hindu and Muslim groups the sterilized wives were mostly 31 years and more in age and per possessed already 4 and more living children. Among the Hindu group of sterilized couples it was the lower caste couples who dominated relatively more. Again, among both Hindu and Muslim groups the sterilized husbands, were mostly 36 years and more in age.

Village Chowhati is and the family large settlement and here we find 462 eligible couples. Only 23 per cent of these couples reported to have ever-practised F.P. methods. 11 out of 23 per cent were found to have undergone sterilization operation, of 51 cases of sterilized couples only and only 1 was explained by t the Muslim. The Hindus played the single dominant role in sterilization-front. 74 per cent of 50 sterilized Hindu couples reported that they had opted for tubectomy operation. Among the sterilized Hindu wives those who were 31 years and more in age concentrated maximum and they were possessing already 4 and more living children in most of the cases. On the other hand, in going for sterilization the Hindu couples of higher caste group evinced relatively greater inclination than their counterparts in the lower caste group. Inspite of this level of achievement the Chowhati couples did not in general register any remarkable mx progress in family planning field.

Village Kumarkhali presented the poorest picture of sterilization-activities. Here though 308 eligible couples were recorded and 29 per cent of them reported to have ever-practised F.P. methods, yet the sterilized couples were found in less than one per cent cases. The village was dominated mostly by the Muslims and none of the Muslim couples had opted for sterilization, only a single casex of vasectomy and a single case of tubectomy

were evinced by two Hindu couples belonging to lower caste group. None of the Hindu couples of higher caste group was also observed to have sterilization.

In general, family planning activities were not of low order in village KumarKhali, yet motivation for permanent method of birth control was extremely lacking. When Kumarkhali presented relatively speaking the highest proportion of eligible couples with F.P. experiences among all the eight villages under study, the same village should offer lesser resistance towards sterilization programme. This village must be given top priority in angmenting proper action programmes fro permanent birthcontrol method. In any case, the Hindu eligible couples who had already some F.P. activities but larger number of swiming children can be made the target for the said sterilization programme. For the Muslim couples of the village extensive F.P. education programme has to be launched to motivate them more and more within a short span.

24.9.76

TABLE: 1

DISTRUBUTION OF HUSBANDS REPORTING SMALLER FAMILY (0-3 LIVING CHILDREN) OR LARGER FAMILY (4 + LIVING CHILDREN) BY SOCIAL GROUP, AGE GROUP AND FAMILY PLANNING EXPERIENCE IN ELEVEN VILLAGES AND TWO SEMI-URBAN SETTLEMENTS OF SONARPUR P.S.,24-PARGANAS DISTRICT, WEST BENGAL, 1974

Social Group/ age group	Husbands reporting use of F.P.methods				Husbands reporting no use of F.P.methods				Total
	Small without child	Family children	Large family children	Sub Totals	Small without child	Family children	Large family children	Sub Total	
	0	1-3	4+		0	1-3	4+		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
		VILLAGE:	CHOWHATI						
-30		6		6	18	33	1	52	58
Hindu 31-40		38	9	47	18	89	26	133	180
41+		18	33	51	7	60	97	164	215
Total		62	42	104	43	182	124	349	453
-30									
Muslim 31-40						1	2	3	3
41+			1	1	1	2	2	4	6
Total			1	1	1	3	4	8	9
G.Total		62	43	105	44	185	128	357	462
%		13.4	9.3	22.7	9.5	40.0	27.7	77.3	100.0
		VILLAGE:	KUSUMBA						
-30									
Hindu 31-40		1		1					1
41+						2	2	4	4
Total		1		1	4	2	2	4	5
-30		1		1	4	15		19	20
Muslim 31-40		1		1	1	20	16	37	38
41+					2	18	16	36	36
M.Total		2		2	7	53	32	92	94
G.TOTAL		3		3	7	55	34	96	99
%		3.0	3.0	3.0	7.1	55.6	34.3	97.0	100.0

Continued.....

VILLAGE: HOGALKURIA

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
-30		1		1	11	7	1	19	20
Hindu 31-40		5	2	7	7	20	10	37	44
41+		2	1	3	1	6	38	45	48
Total		8	3	11	19	33	49	101	112
-30					2	2		4	4
Christan 31-40			3	3	1	7	7	15	18
41+		4	1	5		1	13	14	19
Total		4	4	8	3	10	20	33	41
G.Total		12	7	19	22	43	69	134	153
%		7.8	4.6	12.4	14.4	28.1	45.1	87.6	100.0

VILLAGE: KUMARKHALI

-30	4	8		12	3	7		10	22
Hindu 31-40	1	27	4	32	7	17	4	28	60
41+	1	11	8	20		15	20	35	55
Total	6	46	12	64	10	39	24	73	137
-30	1	6		7	7	9		16	23
Muslim 31-40		9	4	13	6	26	25	57	70
41+			4	4	4	19	51	74	78
Total	1	15	8	24	17	54	76	147	171
G.Total	7	61	20	88	27	93	100	220	308
%	2.3	19.8	6.5	28.6	8.8	30.2	32.5	71.4	100.0

VILLAGE: RAMCHANDRAPUR

-30		1		1	7	11	2	20	21
Hindu 31-40		6	6	12	4	22	7	33	45
41+		1	10	11	1	5	20	26	37
Total		8	16	24	12	38	29	79	103
-30					3	2		5	5
Muslim 31-40		1		1		5	2	7	8
41+			1	1		2	9	11	12
Total		1	1	2	3	9	11	23	25
G. Total		9	17	26	15	47	40	102	128
%		7.0	13.3	20.3	11.7	36.7	31.3	79.7	100.0

Continued.....

VILLAGE: JAINPUR

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
-30					4	6		10	10
Hindu 31-40		5	1	6	6	7	5	18	24
41+		4	8	12	2	6	6	14	26
Total		9	9	18	12	19	11	42	60
-30					2	2		4	4
Muslim 31-40		1		1	1	5	1	7	8
41+			3	3		1	5	6	9
Total		1	3	4	3	8	6	17	21
G.Total		10	12	22	15	27	17	59	81
%		12.4	14.8	27.2	18.5	33.3	20.9	72.8	100.0

VILLAGE: NICHINTAPUR

-30					3	9	1	13	13
Hindu 31-40		4	3	7	1	11	2	14	21
41+		1	6	7	1	6	11	18	25
Total		5	9	14	5	26	14	45	59
-30					1			1	1
Muslim 31-40									
41+							1	1	1
Total					1		1	2	2
GeTotal		5	9	14	6	26	15	47	61
%		8.2	14.8	22.9	9.8	42.6	24.6	77.0	100.0

VILLAGE: DIGALPOTA

-30		1	1	2	3	14	1	18	20
Hindu 31-40		5	6	11	5	17	15	37	48
41+			19	19		8	25	33	52
Total		6	26	32	8	39	41	88	120
-30									
Muslim 31-40									
41+									
Total									
Go.Total		6	26	32	8	39	41	88	120
%		5.0	21.7	26.7	6.7	32.5	34.2	73.3	100.0

Continued.....

VILLAGE: BONHOOGLY

	-30	1		1	21	16	1	38	39
Hindu	31-40	7	9	16	8	51	19	78	94
	41+	5	12	17	9	30	65	104	121
Total		13	21	34	38	97	85	220	254
	-30	1		1	14	23	7	44	45
Muslim	31-40	11	9	20	4	59	29	92	112
	41+	5	23	28	4	37	83	124	152
Total		17	32	49	22	119	119	260	309
	-30				3	2		5	5
Christian	31-40	1	1	2	1	5	4	10	12
	41+	4	7	11	1	1	11	13	24
Total		5	8	13	5	8	15	28	41
G.Total		35	61	96	65	224	219	508	604
%		5.8	11.0	15.9	10.8	37.1	36.25	84.1	100.0

VILLAGE: JAGANATHPUR

	-30					2		2	2
Hindu	31-40	3		3		1		1	4
	41+					2	5	7	7
Total		3		3		5	5	10	13
	-30				6	19	2	27	27
Muslim	31-40				7	35	14	56	56
	41+				5	18	50	73	73
Total					18	72	66	156	156
G.Total		3		3	18	77	71	166	169
%		1.8		1.8	10.7	45.6	42.0	98.2	100.0

VILLAGE: UKHILA

	-30							
Hindu	31-40	2		2	2	1		3	5
	41+								
Total		2		2	2	1		3	5
	-30	1		1	19	18		37	38
Muslim	31-40		1	1	4	24	23	51	52
	41+				5	20	56	81	81
Total		1	1	2	28	62	79	169	171
G.Total		3	1	4	30	63	79	172	176
%		1.7	0.6	2.3	16.5	36.4	44.9	97.7	100.0

Continued.....

ALL VILLAGES
(No. of eligible husbands: 2361)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Hin-	-30	4	18	1	23	70	105	7	182	205
du	31-40	4	100	40	144	58	235	88	381	525
	41+	1	42	97	140	21	140	290	451	591
Total		9	160	138	307	149	480	385	1014	1321
Mus-	-30	1	9		10	56	88	9	153	163
lim	31-40		23	13	36	23	175	112	310	346
	41+		5	32	37	21	117	273	411	448
Total		1	37	45	83	100	380	394	874	957
Chr-	-30			1	1	5	4		9	10
istan	31-40		1	4	5	2	12	11	25	30
	41+		8	8	16	1	2	24	27	43
Total			9	13	22	8	18	35	61	83
G.Total		10	206	196	412	257	878	814	1949	2361
%		0.4	8.7	8.3	17.4	10.9	37.2	34.5	82.6	100.0

SEMIURBAN: ELACHI

Hin-	-30		1		1	3	10		13	14
du	31-40		22	7	29	8	48	6	62	91
	41+	1	13	20	34	6	13	23	42	76
Total		1	36	27	64	17	71	29	117	181
Mus-	-30					3	11	1	15	15
lim	31-40			2	2	2	9	11	22	24
	41+		2	4	6	1	5	13	19	25
Total			2	6	8	6	25	25	56	64
G.Total			38	33	72	23	96	54	173	245
%		0.4	15.5	13.5	29.4	9.4	39.2	22.0	70.6	100.

SEMIURBAN: JAGADDAL

Hin-	-30	4		4	8	17		25	29
du	31-40	17	3	20	10	44	12	66	86
	41+	18	18	36	3	34	61	98	134
Total		39	21	60	21	95	73	189	249
Muslim	-30								
	31-40								
	41+						1	1	1
Total							1	1	1
G.Total		39	21	60	21	95	74	190	250
%		15.6	8.4	24.0	8.4	38.0	29.6	76.0	100

Continued.....

SEMIURBAN AREA (ELACHI & JAGADDAL)

(No. of eligible couples: 495)

	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)
Hin-	-30		5		5	11	27		38	43
du	31-40		39	10	49	18	92	18	128	177
	41+	1	31	38	70	9	47	84	140	210
	Total	1	75	48	124	38	166	102	306	430
Mus-	-30					3	11	1	15	15
lim	31-40			2	2	2	9	11	22	24
	41+		2	4	6	1	5	14	20	26
Total			2	6	8	6	25	26	57	65
G.Total		1	77	54	132	44	191	128	363	495
%		0.20	15.6	10.9	26.7	8.9	38.6	25.9	73.3	100.0

TABLE 2

DISTRIBUTION OF HUSBANDS AND WIVES REPORTING VASECTOMY OR TUBECTOMY BY SOCIAL GROUP, AGE-GROUP AND NUMBER OF LIVING CHILDREN IN DIFFERENT VILLAGES OF SONARPUR P.S., 24-PARGANAS DISTRICT, WEST BENGAL, 1974.

Social group ↓ children →	No of Husband reporting Vasectomy age-group - 35		36 +		total	No. of Wives reporting Tubectomy age- group -30		31 +		total	IUCD
	0-3	4+	0-3	4+		0-3	4+	0-3	4+		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
VILLAGE: RAMCHANDRAPUR (No.of eligible couples:128)											
1.Hindu higher Caste	-	-	1	2	3	2	1		3	6	
2.Hindu Lower Caste	-	-	2	2	4		3	1	4	8	
3.All Hindus	-	-	3	4	7	2	4	1	7	14	0
4.Non Hindu (Muslim)	-	-	-	1	1	2	1	-	3	6	0
All-groups	-	-	3	5	8	4	5	1	10	20	0
%	-	-	37.50	62.50	100.00	20.00	25.00	5.00	50.00	100.00	
VILLAGE: CHOWHATI (No. of eligible couples: 462)											
1.Hindu higher Caste	2	-	3	7	12	7	2	4	9	22	0
2.Hindu Lower Caste	-	-	-	1	1	2	2	4	7	15	0
3.All-Hindus	2	-	3	8	13	9	4	8	16	37	0
4.Non Hindu (Muslim)	-	-	-	-	-	-	-	-	1	1	0
5.All-groups	2	-	3	8	13	9	4	8	17	38	0
%	15.38	-	23.08	61.54	100.00	23.68	10.53	21.05	44.74	100.00	
VILLAGE: KUMARKHALI (No.of eligible couples:308)											
1.Hindu higher Caste	-	-	-	-	-	-	-	-	-	-	0
2.Hindu Lower Caste	-	-	1	-	1	-	1	-	1	2	0
3.All-Hindus	-	-	1	-	1	-	1	-	1	2	0
4.Non Hindu (Muslim)	-	-	-	-	-	-	-	-	-	-	0
5.All-groups	-	-	1	-	1	-	1	-	1	2	0
%	-	-	100.00	-	100.00	0	50.00	-	50.00	100.00	

Continued.....

VILLAGE: NISCHINTAPUR
(No. of eligible couples: 61)

	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1. Hindu higher caste			2	5	4	1			6	7	0
2. Hindu Lower Caste											0
3. All-Hindus			2	2	4	1			6	7	0
4. Non Hindu (Muslim)											
5. All-groups			2	2	4	1			6	7	0
%			50.0	50.0	100.0	14.3			85.7	100.0	

VILLAGE JAYANPUR:
(No. of eligible couples: 81)

1. Hindu higher Caste										
2. Hindu Lower Caste			4	3	7	3	2	4	9	
3. All-Hindus			4	3	7	3	2	4	9	
4. Non Hindu (Muslim)	1			2	3					
All-groups	1		4	5	10	3	2	4	9	
%	10.00		40.00	50.0	100.0	33.3	22.2	44.5	100.0	

VILLAGE: DINGAL POTA
(No.of eligible couples: 120)

1. Hindu higher Caste										
2. Hindu Lower Caste	1		1	5	7	1	4	11	16	
3. All-Hindus	1		1	5	7	1	4	11	16	
4. Non Hindu (Muslim)										
5. All groups	1		1	5	7	1	4	11	16	
%	14.3		14.3	71.4	100.0	6.3	25.0	68.7	100.0	

VILLAGE: HOGALKURIA
(No. of eligible couples: 153)

1. Hindu higher Caste										
2. Hindu lower Caste			3		3		1	2	3	5
3. All Hindus			3		3		1	2	3	5
4. Non Hindu (Christian)		3	3		6					3
5. All Caste		3	6		9		1	2	3	8
%		33.3	66.7		100.0		33.3	66.7	100.0	

VILLAGE: BON-HOOGLY

(No.of eligible couples: 604)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1.Hindu higher Caste		1			1		1	1	2	4	1
2.Hindu Lower Caste	1	1	3	1	6	1	3	2	5	11	2
3.All-Hindus	1	2	3	1	7	1	4	3	7	15	
4.Muslim	2		6	11	19	2	2	1	6	11	
5.Christian			2	4	6	1		1		2	4
6. Non-Hindus	2		8	15	25	3	2	2	6	13	
7.All-groups	3	2	11	16	32	4	6	5	13	28	7
%	9.4	6.2	34.4	50.0	100.0	14.3	21.4	17.9	46.4	100.0	

ALL VILLAGES : 8 VILLAGES*

(No.of eligible couples: 1971)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1.Hindu higher Caste	2	1	6	11	20	10	4	5	20	39	1
2.Hindu Lower Caste	2	1	14	12	29	7	16	7	34	64	7
3.Hindu-all	4	2	20	23	49	17	20	12	54	103	8
4.Muslim	3		6	14	23	4	3	1	10	18	
5.Christian		3	5	4	12	1		1		2	7
6.Non Hindus	3	3	11	18	35	5	3	2	10	20	7
7.All-groups	7	5	31	41	84	22	23	14	64	123	15
%	8.3	6.0	36.9	48.8	100.0	17.9	18.7	11.4	52.0	100.0	

* 3 Villages: Jagannathpur, Ukhila, ~~Kumira~~ Kusumba did not report any Vasectomy or Tubectomy case.

SEMIURBAN: ELACHI

(No.of eligible couples:245)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1.Hindu higher Caste			4	2	6		1	4	5	10	1
2.Hindu lower Caste			1	1	2	3	3	2	10	18	2
3.All-Hindus			5	3	8	3	4	6	15	28	3
4.Muslim	1				1		1	1	1	3	
5.Christian							1			1	
6.Non Hindu	1				1		2	1	1	4	
7.All groups	1		5	3	9	3	6	7	16	32	3
%	11.11		55.6	33.3	100.0	9.4	18.8	21.9	50.0	100.0	

SEMI-URBAN: JAGGADAL

(No.of eligible couples:250)

1.Hindu higher Caste	1		1		2	1		2	5	8	2
2.Hindu lower Caste			3	2	5	2	2	4	6	14	
3.All-Hindus	1		4	2	7	3	2	6	11	22	2
4.Muslim											
5.Christian											
6.Non Hindu											
7.All groups	1		4	2	7	3	2	6	11	22	2
%	14.3		57.1	28.6	100.0	13.6	9.1	27.3	50.0	100.0	

SEMI-URBAN AREAS

(No. of eligible couples: 495)

1.Hindu higher Caste	1		5	2	8	1	1	6	10	18	3
2.Hindu lower Caste			4	3	7	5	5	6	16	32	
3.All-Hindus	1		9	5	15	6	6	12	26	50	3
4.Muslim	1				1		1	1	1	3	
5.Christian							1			1	
6.Non Hindus	1				1		2	1	1	4	
7.All groups	2		9	5	16	6	8	13	27	54	3
%	12.5		56.3	31.3	100.0	11.1	14.8	24.1	50.0	100.0	

TABLE 2

DISTRIBUTION OF HUSBANDS AND WIVES REPORTING VASECTOMY OR TUBECTOMY BY SOCIAL GROUP, AGE-GROUP AND NUMBER OF LIVING CHILDREN IN DIFFERENT VILLAGES OF SONARPUR P.S., 24-PARGANAS DISTRICT, WEST BENGAL, 1974.

Social group	No of Husband reporting Vasectomy age-group					No. of Wives reporting Tubectomy age-group					IUCD
	- 35		36 +		total	-30		31 +		total	
↓children→	0-3	4+	0-3	4+		0-3	4+	0-3	4+		
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
VILLAGE: RAMCHANDRAPUR (No.of eligible couples:128)											
1.Hindu higher Caste	-	-	1	2	3	2	1		3	6	
2.Hindu Lower Caste	-	-	2	2	4		3	1	4	8	
3.All Hindus	-	-	3	4	7	2	4	1	7	14	0
4.Non Hindu (Muslim)	-	-	-	1	1	2	1	-	3	6	0
All-groups	-	-	3	5	8	4	5	1	10	20	0
%	-	-	37.50	62.50	100.00	20.00	25.00	5.00	50.00	100.00	
VILLAGE: CHOWHATI (No. of eligible couples: 462)											
1.Hindu higher Caste	2	-	3	7	12	7	2	4	9	22	0
2.Hindu Lower Caste	-	-	-	1	1	2	2	4	7	15	0
3.All-Hindus	2	-	3	8	13	9	4	8	16	37	0
4.Non Hindu (Muslim)	-	-	-	-	-	-	-	-	1	1	0
5.All-groups	2	-	3	8	13	9	4	8	17	38	0
%	15.38	-	23.08	61.54	100.00	23.68	10.53	21.05	44.74	100.00	
VILLAGE: KUMARKHALI (No.of eligible couples:308)											
1.Hindu higher Caste	-	-	-	-	-	-	-	-	-	-	0
2.Hindu Lower Caste	-	-	1	-	1	-	1	-	1	2	0
3.All-Hindus	-	-	1	-	1	-	1	-	1	2	0
4.Non Hindu (Muslim)	-	-	-	-	-	-	-	-	-	-	0
5.All-groups	-	-	1	-	1	-	1	-	1	2	0
%	-	-	100.00	-	100.00	0	50.00	-	50.00	100.00	

Continued.....

VILLAGE: NISCHINTAPUR
(No. of eligible couples: 61)

	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1. Hindu higher caste			2	5	4	7			6	7	0
2.Hindu Lower Caste											0
3.All-Hindus			2	2	4	1			6	7	0
4.Non Hindu (Muslim)											
5.All-groups			2	2	4	1			6	7	0
%		50.0		50.0	100.0	14.3			85.7	100.0	

VILLAGE JAYANPUR:
(No. of eligible couples: 81)

1. Hindu higher Caste										
2. Hindu Lower Caste			4	3	7	3	2	4	9	
3.All-Hindus			4	3	7	3	2	4	9	
4.Non Hindu (Muslim)	1			2	3					
All-groups	1		4	5	10	3	2	4	9	
%	10.00		40.00	50.0	100.0	33.3	22.2	44.5	100.0	

VILLAGE: DINGAL POTA
(No.of eligible couples: 120)

1. Hindu higher Caste										
2. Hindu Lower Caste	1		1	5	7	1	4	11	16	
3.All-Hindus	1		1	5	7	1	4	11	16	
4. Non Hindu (Muslim)										
5.All groups	1		1	5	7	1	4	11	16	
%	14.3		14.3	71.4	100.0	6.3	25.0	68.7	100.0	

VILLAGE: HOGALKURIA
(No. of eligible couples: 153)

1. Hindu higher Caste			3		3		1	2	3	5
2. Hindu lower Caste			3		3		1	2	3	5
3.All Hindus			3		3		1	2	3	5
4.Non Hindu (Christian)		3	3		6					3
5. All Caste		3	6		9		1	2	3	8
%		33.3	66.7		100.0		33.3	66.7	100.0	

VILLAGE: BON-HOOGLY

(No.of eligible couples: 604)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1.Hindu higher Caste		1			1		1	1	2	4	1
2.Hindu Lower Caste	1	1	3	1	6	1	3	2	5	11	2
3.All-Hindus	1	2	3	1	7	1	4	3	7	15	
4.Muslim	2		6	11	19	2	2	1	6	11	
5.Christian			2	4	6	1		1		2	4
6. Non-Hindus	2		8	15	25	3	2	2	6	13	
7.All-groups	3	2	11	16	32	4	6	5	13	28	7
%	9.4	6.2	34.4	50.0	100.0	14.3	21.4	17.9	46.4	100.0	

ALL VILLAGES : 8 VILLAGES*

(No.of eligible couples: 1971)

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)
1.Hindu higher Caste	2	1	6	11	20	10	4	5	20	39	1
2.Hindu Lower Caste	2	1	14	12	29	7	16	7	34	64	7
3.Hindu-all	4	2	20	23	49	17	20	12	54	103	8
4.Muslim	3		6	14	23	4	3	1	10	18	
5.Christian		3	5	4	12	1		1		2	7
6.Non Hindus	3	3	11	18	35	5	3	2	10	20	7
7.All-groups	7	5	31	41	84	22	23	14	64	123	15
%	8.3	6.0	36.9	48.8	100.0	17.9	18.7	11.4	52.0	100.0	

* 3 Villages: Jagannathpur, Ukhila, ~~Kumira~~ Kusumba did not report any Vasectomy or Tubectomy case.

WH-13.7-39

Table B: Distribution of population by age and sex in 10 out of 13 villages surveyed in Sonarpur p.s., 24-Parganas 1974

Sex	AGE GROUPXRNXG OF POPULATION							Total
(%)	0-4	5-14	15-24	25-34	35-44	45-59	60+	(%)
~~(1)~~	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)
1. NISCHINTAPUR								
male	23	94	54	33	27	23	16	270
female	20	80	40.	35	25	22	13	235
total	43	174	94	68	52	45	29	505
percent-age	8.51	34.46	18.61	13.47	10.30	8.91	5.74	100.00
2. UKHILA								
male	90	199	130	83	79	60	36	677
female	72	222	88	103	55	44	35	619
total	162	421	218	186	134	104	71	1296
percent-age	12.55	32.49	16.82	14.35	10.34	8.02	5.48	100.00
3. JAGANNATHPUR								
male	71	200	121	77	66	53	33	621
female	93	177	85	90	46	47	32	570
total	164	377	206	167	112	100	65	1191
percentage	13.77	31.65	17.30	14.02	9.40	8.40	5.46	100.00
4. KUMARKHALI								
male	132	351	204	163	144	95	50	1139
female	136	317	135	174	93	75	65	995
total	268	668	339	337	237	170	115	2134
percentage	12.56	31.30	15.88	15.79	11.11	7.97	5.39	100.00
5. KUSUMBA								
male	115	271	149	100	85	72	34	826
female	113	213	123	117	74	62	27	729
total	228	484	272	217	159	134	61	1555
percentage	14.66	31.13	17.49	13.95	10.23	8.62	3.92	100.00
6. MOGOLKURIA								
male	78	190	67	55	35	56	35	571
female	67	195	78	64	56	41	25	526
total	145	385	168	131	111	97	60	1097
percentage	13.22	35.10	15.31	11.94	10.12	8.84	5.47	100.00

contd.....

Table B: continued

7. JAYANTUR

male	30	91	56	31	38	25	9	280
female	32	85	42	35	27	17	20	258
total	62	176	98	66	65	42	29	538
percentage	11.52	32.71	18.22	12.27	12.08	7.81	5.39	100.00

8. RAMCHANDRAPUR

male	79	152	90	69	61	40	29	520
female	72	186	93	68	43	42	36	540
total	151	338	183	137	104	82	65	1060
percentage	14.25	31.89	17.26	12.92	9.81	7.74	6.13	100.00

9. BLACHI

male	112	283	137	141	125	59	59	916
female	87	249	155	136	66	74	48	815
total	199	532	292	277	191	133	107	1731
percentage	11.50	30.73	16.87	16.00	11.04	7.68	6.18	100.00

10. DINGALPOTA

male	47	170	99	60	40	44	23	483
female	51	151	59	55	41	42	31	430
total	98	321	158	115	81	86	54	913
percentage	10.73	35.16	17.31	12.59	8.87	9.42	5.92	100.00

11. JAGADDAL

male	94	262	231	119	121	93	59	979
female	80	281	185	122	100	64	68	900
total	174	543	416	241	221	157	127	1879
percentage	9.26	28.89	22.14	12.83	11.76	8.36	6.76	100.00

12. CHANDATI

male	185	480	348	240	200	155	128	1736
female	171	471	323	182	153	157	122	1579
total	356	951	671	422	353	312	250	3315
percentage	10.74	28.69	20.24	12.73	10.65	9.41	7.54	100.00

13. BANRUGAI

male	278	731	425	246	220	213	121	2234
female	324	706	293	259	217	172	85	2056
total	602	1437	718	505	437	385	206	4290
percentage	14.03	33.50	16.74	11.77	10.99	8.97	4.80	100.00

ALL VILLAGES

male	1334	3474	2134	1429	1261	988	632	11252
female	1318	3333	1699	1440	996	859	607	10252
total	2652	6807	3833	2869	2257	1847	1239	21505
percentage	12.33	31.66	17.82	13.34	10.50	8.59	5.76	100.00

Table C: Distribution of household by its size in 10 out of 13 villages surveyed in Sonarpur p.s., 24-parganas, 1974

Village	size of household 1-3	4-6	7-9	10+	Total (%)
(1)	(2)	(3)	(4)	(5)	(6)
1. Mischintapur	10 12.82	33 42.31	25 32.05	10 12.82	78 100.00
2. Ukhila	66 27.50	92 38.33	67 27.92	15 6.25	240 100.00
3. Jagannathpur	33 17.10	87 45.08	50 25.91	23 11.91	193 100.00
4. Kumarkhali	83 22.31	158 42.47	99 26.61	32 8.60	372 100.00
5. Musumba	48 17.39	138 50.00	73 26.45	17 6.16	276 100.00
6. Mogolkuria	31 16.94	82 44.81	55 30.05	15 8.20	183 100.00
7. Jayenpur	20 20.62	52 53.61	17 17.52	8 8.25	97 100.00
8. Ramchandrapur	38 21.59	71 40.34	49 27.84	18 10.23	176 100.00
9. Elachi	67 22.04	133 43.75	79 25.99	25 8.22	304 100.00
10. Dingelpota	31 19.87	61 39.10	53 33.97	11 7.06	156 100.00
11. Jagaddal	41 13.76	137 45.97	90 30.20	30 10.07	298 100.00
12. Chauhati	112 19.68	237 41.65	165 29.00	55 9.67	569 100.00
13. Bonhogli	127 17.86	304 42,76	217 30.52	63 8.86	711 100.00
ALL VILLAGES	707 19.35	1585 43.39	1039 28.44	322 8.82	3653 100.00

Table D: Distribution of family and average number of person per family by community/caste affiliation in 10 out of 13 villages surveyed in Sonarpur p.s., 24-parganas, 1974

Community / Caste affiliation.	number of families	total no.of persons	Average no.of person perfamil
(1)	(2)	(3)	(4)
1. M I S C H I N G A P U R			
(a) Hindu:			
High caste	4	18	4.5
Middle "	64	441	6.9
Low "	8	30	3.8
All Hindus	76	489	6.4
(b) Muslim:	2	16	8.0
Total (a+b)	78	505	6.5
2. UKHILA			
(a) Hindu :			
High caste	3	5	1.7
Middle "	3	20	5.3
Low "	8	56	7.0
Non-Bengali	3	7	2.3
All Hindus	17	88	5.2
(b) Muslim:	223	1208	5.4
Total(a+b)	240	1296	5.4
3. J A G A N N A T H P U R			
(a) Hindu:			
High caste	4	29	7.3
middle "	11	71	6.5
Low "	0	0	–
All Hindus	15	100	6.7
(b) Muslim :	178	1091	6.1
Total (a+b)	193	1191	6.2
4. KUMARKHALI			
(a) Hindu :			
High Caste	76	417	5.5
middle "	25	126	5.0
Low "	55	323	5.9
Non-Bengali	9	27	3.0
All Hindus	165	893	5.4
(b) Muslim:	207	1241	6.0
Total (a+b)	372	2134	5.7

Continued........

Table D: (continued)

5. K U S U M B A			
(a) Hindu:			
High caste	48	276	5.6
middle "	11	53	4.8
Low "	57	340	6.0
Non-Bengali	1	6	6.0
All Hindus	117	677	5.8
(b) Muslim:	159	878	5.5
Total (a+b)	276	1555	5.6
6. HOGOLKURIA			
(a) Hindu:			
High caste	0	0	-
middle "	131	788	6.0
Low "	0	0	-
All Hindu	131	788	6.0
(b) Christian :	52	309	5.9
Total (a+b)	183	1097	6.0
7. JAYENPUR			
(a) Hindu:			
High caste	0	0	-
middle "	0	0	-
low "	68	373	5.5
All-Hindus:	68	373	5.5
(b) Muslim:	28	159	5.7
(c) Christan :	1	6	6.0
Total (a+b+c)	97	538	5.6
8. A M G H A T I A			
(a) Hindu:			
High caste	13	75	5.8
middle "	50	285	5.7
Low "	81	474	5.9
Non-Bengali	1	2	2.0
All Hindus 24	145	836	5.8
(b) Muslim:	31	224	7.2
Total (a+b)	176	1060	6.0
9. E L A C H I			
(a) Hindu:			
High caste	69	361	5.2
middle "	67	379	5.7
Low "	88	516	5.9
Non-Bengali	9	31	3.4
All Hindus	233	1289	5.5
(b) Muslim:	71	442	6.2
Total (a+b),	304	1731	5.7

Table: D.

10. DINGALPOTA

(a) Hindu:			
High caste	0	0	-
middle "	0	0	-
Low "	155	907	5.9
All Hindu	155	907	5.9
(b) Christian	1	6	-
Total (a+b)	156	913	5.9

11. Jagaddal

(a) Hindu:			
High caste	104	630	6.1
middle "	23	130	5.7
low "	168	1101	6.6
Non-Bengali	2	9	4.5
All Hindus	297	1870	6.3
(b) Muslim:	1	9	9.0
Total (a+b)	298	1879	6.3

12. CHAUHATI

(a) Hindu:			
High caste	259	1514	5.8
middle "	54	312	5.8
Low "	241	1417	5.9
All Hindus	556	3249	5.8
(b) Muslim:	13	66	5.1
Total (a+b)	569	3315	5.8

13. BONHUGLI

(a) Hindu:			
High caste	21	125	6.0
middle "	32	207	6.5
Low caste	256	1519	5.9
All Hindus	309	1851	6.0
(b) Muslim:	348	2131	6.1
(c) Christian:	54	308	5.7
Total (a+b+c)	711	4290	6.0

ALL VILLAGES

(a) Hindu:			
High caste	601	3452	5.7
middle "	471	2812	6.0
Low "	1185	7058	6.0
Non-Bengali	27	88	3.3
All Hindus	2284	13410	5.9
(b)(Muslim :	1261	7465	5.9
(c) Christian :	108	629	5.8
Total (a+b+c)	3653	21504	5.9

Table E. Distribution of persons by level of education in 10 villages surveyed in Sonarpur p.s., 24-parganas, 1974

Village	Level of education				Total (%)
	Illiterate	Literate	School	College	
(1)	(2)	(3)	(4)	(5)	(6)
1. Nischintapur	209 (41.4)	91 (18.0)	194 (38.4)	11 (2.2)	505 (100.0)
2. Ukhila	736 (56.8)	224 (17.3)	318 (24.5)	18 (1.4)	1296 (100.0)
3. Jagannathpur	768 (64.5)	148 (12.4)	253 (21.2)	22 (1.9)	1191 (100.0)
4. Kumarkhali	934 (43.8)	272 (12.7)	854 (40.0)	74 (3.5)	2134 (100.0)
5. Kusumba	730 (47.0)	154 (9.9)	621 (39.9)	50 (3.2)	1555 (100.0)
6. Hogolkuria	875 (79.8)	89 (8.1)	131 (11.9)	2 (0.2)	1097 (100.0)
7. Jayenpur	371 (69.0)	21 (3.9)	133 (24.7)	13 (2.4)	538 (100.0)
8. Ramchandrapur	547 (51,6)	97 (9.2)	399 (37.6)	17 (1.6)	1060 (100.0)
9. Elachi	698 (40.3)	137 (7.9)	719 (41.6)	177 (10.2)	1731 (100.0)
10. Dingolpota	577 (63.2)	50 (5.5)	268 (29.4)	18 (1.9)	913 (100.0)
11. Jagaddal	649 34.6	196 10.4	933 49.6	101 5.4	1879 100.0
12. Chauhati	1248 37.6	426 12.9	1519 45,8	122 3.7	3315 (100.0)
13. Bonhugli	2778 64.8	347 8.1	1126 26.2	39 0.9	4290 (100.0)
ALL VILLAGES	11120 51.6	2252 10.5	7408 34.8	664 3.1	21540 100.0

Table F. Distribution of total labour force and persons gainfully employed by sex and age-groups

sex	total persons in age-group 15 - 59	persons gainfully employed (working force) in age-group - 15	15-34	35-59	60+	total working force
(1)	(2)	(3)	(4)	(5)	(6)	(7)
		1. Nischintapur				
male	140	2	48	49	9	108
female	119	0	4	4	0	8
total	259	2	52	53	9	116
percent	(100.0)	(0.8)	(20.1)	(20.4)	(3.5)	(44.8)
		2. Ukhila				
male	352	3	152	131	23	309
female	290	0	6	21	4	31
total	642	3	158	152	27	340
percent	(100.0)	(0.5)	(24.6)	(23.7)	(4.2)	(53.0)
		3. Jagannathpur				
male	317	9	138	117	27	291
female	268	0	8	6	4	18
total	585	9	146	123	31	309
percent	(100.0)	(1.5)	(25.0)	(21.0)	(5.3)	(52.8)
		4. Kumarkhali				
male	606	4	232	238	30	504
female	477	1	5	13	7	26
total	1083	5	237	251	37	530
percent	(100.0)	(0.5)	(21.8)	(23.2)	(3.4)	(48.9)
		5. Kusumba				
male	391	0	174	159	22	351
female	385	0	6	13	1	20
total	776	0	180	168	23	371
percent	(100.0)	-	(23.2)	(21.6)	(3.0)	(47.8)
		6. Hogolkuria				
male	268	7	130	110	29	276
female	239	1	22	24	2	49
total	507	8	152	134	31	325
percent	(100.0)	(1.6)	(30.0)	(26.4)	(6.1)	(64.1)
		7. Jayenpur				
male	150	2	57	61	4	124
female	121	1	9	10	3	23
total	271	3	66	71	7	147
percent	(100.0)	(1.1)	(24.4)	(26.2)	(2.6)	(54.3)
		8. Ramchandrapur				
male	260	7	114	95	22	238
female	246	3	19	22	6	50
total	506	10	133	117	28	288
percent	(100.0)	(2.0)	(26.3)	(23.1)	(5.5)	(56.9)
		9. Elachi				
male	462	19	201	181	34	435
female	430	6	49	29	1	85
total	892	25	250	210	35	520
percent	(100.0)	(2.8)	(28.0)	(23.6)	(3.9)	(58.3)
		10. Dingelpota				
male	243	8	117	85	19	229
female	197	1	11	16	2	30
total	440	9	128	101	21	259
percent	(100.0)	(2.0)	(29.1)	(23.0)	(4.8)	(58.9)

Table F. (contd.)

s e x	total persons in age-group 15 - 59	persons (working force) 15	gainfully employed in age-group 15-34	35-59	60+	total working force
(1)	(2)	(3)	(4)	(5)	(6)	(7)
11. Jagaddal						
male	364	1	198	209	42	450
female	471	1	21	16	5	43
total	1055	2	219	225	47	493
percent	(100.0)	(0.2)	(21.2)	(21.7)	(4.5)	(47.6)
12. Chauhati						
male	943	6	334	339	76	755
female	815	6	28	47	10	91
total	1758	12	362	386	86	846
percent	(100.0)	(0.7)	(20.5)	(22.0)	(4.9)	(48.1)
13. Ban Hugli						
male	1104	34	537	423	99	1093
female	941	4	80	93	11	188
total	2045	38	617	516	110	1281
percent	(100.0)	(1.9)	(30.1)	(25.2)	(5.4)	(62.6)
ALL VILLAGES						
male	5800	102	2432	2193	436	5163
female	4999	24	268	314	56	662
total	10799	126	2700	2507	492	5825
percent	(100.0)	(1.2)	(25.0)	(23.2)	(4.5)	(53.9)

Table G. Distribution of persons by sex and marital status

sex	marital status of persons				total
	unmarried	married	widowed	divorced	(%)
(1)	(2)	(3)	(4)	(5)	(6)
		1. Mochintapur			
male	181	88	1	0	270
female	127	86	22	0	235
total	308	174	23	0	505
percent	(61.0)	(34.5)	(4.5)	-	(100.0)
		2. Ukhila			
male	441	223	13	0	677
female	329	225	62	3	619
total	770	448	75	3	1296
	(59.4)	(34.6)	(5.8)	(0.2)	(100.0)
		3. Jagannathpur			
male	415	197	8	1	621
female	308	199	61	2	570
total	725	396	69	3	1191
	(60.7)	(33.2)	(5.8)	(0.3)	(100.0)
		4. Kumarkhali			
male	747	379	13	0	1139
female	523	377	94	1	995
total	1270	756	107	1	2134
	(59.5)	(35.4)	(5.0)	(0.1)	(100.0)
		5. Kusumba			
male	555	259	11	1	826
female	393	259	75	2	729
total	948	518	86	3	1555
	(61.0)	(33.3)	(5.5)	(0.2)	(100.0)
		6. Hogolkuria			
male	366	199	6	0	571
female	291	198	37	0	526
total	657	397	43	0	1097
	(59.9)	(36.2)	(3.9)	-	(100.0)
		7. Jayenpur			
male	184	93	3	0	280
female	130	96	32	0	258
total	314	189	35	0	538
	(58.4)	(35.1)	(6.5)	-	(100.0)
		8. Ramchandrapur			
male	334	170	13	3	520
female	312	174	53	1	540
total	646	344	66	4	1060
	(60.9)	(32.5)	(6.2)	(0.4)	(100.0)
		9. Bhabhi			
male	593	308	14	1	916
female	418	310	82	5	815
total	1011	(35.7)	(5.5)	(0.4)	(100.0)
		10. Dingelpota			
male	325	152	6	0	483
female	229	145	54	2	430
total	554	297	60	2	913
	(60.7)	(32.5)	(6.6)	(0.2)	(100.0)

11. Jagaddal

(1)	(2)	(3)	(4)	(5)	(6)
male	644	323	12	0	979
female	498	316	86	0	900
	(60.8)	(34.0)	(5.2)	-	(100.0)

12. Chauhati

male	1128	586	19	3	1736
female	837	577	161	4	1579
total	1965	1163	180	7	3315
	(59.3)	(35.1)	(5.4)	(0.2)	(100.0)

13. Ban Hugli

male	1468	737	28	1	2234
female	1136	738	175	7	2056
total	2604	1475	203	8	4290
	(60.7)	(34.4)	(4.7)	(0.2)	(100.0)

ALL VILLAGES

male	7381	3714	147	10	11252
female	5531	3700	994	27	10252
total	12912	7414	1141	37	21504
	(60.0)	(34.5)	(5.3)	(0.2)	(100.0)

Table H. Distribution of Family type over the villages

Family type	Village with identification number													All villages
	V_1	V_2	V_3	V_4	V_5	V_6	V_7	V_8	V_9	V_{10}	V_{11}	V_{12}	V_{13}	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)
1. Single member	2	15	4	16	6	1	1	6	10	4	6	27	26	124
	2.6	6.3	2.1	4.3	2.2	0.5	1.0	3.4	3.3	2.6	2.0	4.7	3.7	3.4
2. Single member & 'complex'	3	2	3	2	2	1	5	2	0	4	1	6	2	33
	3.8	0.8	1.6	0.5	0.7	0.5	5.2	1.1	-	2.6	0.3	1.0	0.3	0.9
3. Married couple	1	12	3	21	6	11	3	6	12	2	4	20	24	125
	1.3	5.0	1.6	5.6	2.2	6.0	3.1	3.4	3.9	1.3	1.3	3.5	3.4	3.4
4. Married couple &'complex'	0	0	0	0	1	3	0	1	2	1	1	2	5	16
	-	-	-	-	0.4	1.7	-	0.6	0.7	0.6	0.3	0.4	0.7	0.4
5. Nuclear	44	138	125	222	187	121	62	105	181	105	185	303	405	2216
	56.4	57.5	64.8	59.7	67.8	66.1	63.9	59.6	59.5	62.8	62.2	53.3	62.5	60.7
6. Nuclear + 'Complex'	2	13	1	8	10	4	0	7	10	5	6	22	17	105
	2.6	5.4	0.5	2.2	3.6	2.2	-	4.0	3.3	3.2	2.0	3.9	2.4	2.9
7. Joint (extended)	20	42	33	75	45	30	16	36	49	33	49	111	130	669
	25.6	17.5	17.0	20.2	16.3	16.4	16.5	20.5	16.1	21.2	16.5	19.5	18.3	18.3
8. Joint + 'complex'	6	18	24	28	19	12	10	13	40	9	46	78	62	365
	7.7	7.5	12.4	7.5	6.8	6.6	10.3	7.4	13.2	5.7	15.4	13.7	8.7	10.0
9. ALL TYPES (percent)	78 (100.0)	240 (100.0)	193 (100.0)	372 (100.0)	276 (100.0)	183 (100.0)	97 (100.0)	176 (100.0)	304 (100.0)	156 (100.0)	298 (100.0)	569 (100.0)	711 (100.0)	3653 (100.0)

Table I. Distribution of gainfully employed persons by occupation - affiliation

Village :	Occupational affiliation of the gainfully employed persons				: Total
	Agriculture :	Labourer:	Service :	Business	
(1)	(2)	(3)	(4)	(5)	(6)
1. Nischintapur	1 0.9	50 43.1	33 28.4	32 27.6	116 (100.0)
2. Uchila	19 5.6	158 46.5	113 33.2	50 14.7	340 (100.0)
3. Jagannathpur	3 1.0	226 73.1	44 14.2	36 11.7	309 (100.0)
4. Kumarkhali	9 1.7	187 35.3	241 45.4	93 17.6	530 (100.0)
5. Kusumba	0 -	140 37.3	155 41.8	76 20.5	371 (100.0)
6. Nogalkuria	0 -	294 90.5	19 5.8	12 3.7	325 (100.0)
7. Jayenpur	0 -	108 73.5	24 16.3	15 10.2	147 (100.0)
8. Ramchandrapur	1 0.3	154 53.5	92 32.0	41 14.2	288 (100.0)
9. Blachi	1 0.2	155 29.8	298 57.3	66 12.7	520 (100.0)
10. Dingelpota	4 1.5	190 73.4	48 18.5	17 6.6	259 (100.0)
11. Jagaddal	4 0.8	136 27.6	248 50.3	105 21.3	493 (100.0)
12. Chauhati	0 0.0	259 30.6	427 50.5	160 18.9	846 (100.0)
13. Ban Hugli	5 0.4	917 71.6	159 12.4	200 15.6	1281 (100.0)
ALL VILLAGES	47 0.8	2974 51.1	1901 32.6	903 15.5	5825 (100.0)

Table J. Distribution of Bengali-speaking persons by sex and community/caste group per village

	Bengali-speaking						
	HINDUS				MUSLIMS	CHRISTIANS	Total (%)
Sex	High caste	Middle caste	Low caste	All Hindus			
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
			1. Nischintapur				
male	11	234	16	261	9	0	270
female	7	207	14	228	7	0	235
both	18	441	30	489	16	0	505
sexes	(3.6)	(87.3)	(5.9)	(96.8)	(3.2)	-	(100.0)
			2. Ukhila				
male	3	11	36	50	623	0	673
female	2	9	20	31	585	0	616
both	(0.4)	(1.6)	(4.3)	(6.3)	(93.7)	-	(100.0)
both sexes	5	20	56	81	1208	0	1289
			3. Jagannathpur				
male	16	34	0	50	571	0	621
female	13	37	0	50	520	0	570
both	29	71	0	100	1091	0	1191
sexes	(2.4)	(6.0)	-	(8.4)	(91.6)	-	(100.0)
			4. Kumarkhali				
male	218	77	175	470	653	0	1123
female	199	49	148	396	588	0	984
both	417	126	323	866	1241	0	2107
sexes	(19.8)	(6.0)	(15.3)	(41.1)	(58.9)	-	(100.0)
			5. Kusumba				
male	150	28	177	355	467	0	822
female	128	25	163	316	411	0	727
both	278	53	340	671	878	0	1549
sexes	(18.0)	(3.4)	(21.9)	(43.3)	(56.7)		(100.0)
			6. Hogolkuria				
male	0	0	409	409	0	162	571
female	0	0	379	379	0	147	526
both	0	0	788	788	0	309	1097
sexes	-	-	71.8	71.8	-	28.2	(100.0)
			7. Jayenpur				
male	0	0	193	193	84	3	280
female	0	0	180	180	75	3	258
both	0	0	373	373	159	6	538
sexes	-	-	69.3	69.3	29.6	1.1	(100.0)
			8. Ramchandrapur				
male	41	137	226	404	114	0	518
female	34	148	248	430	110	0	540
both	75	285	474	834	224	0	1058
sexes	(7.1)	(26.9)	(45.0)	(79.0)	(21.0)	-	(100.0)
			9. Elachi				
male	182	206	271	659	241	0	900
female	179	173	247	599	201	0	800
both sexes	361	379	518	1258	442	0	1700
	21.2	22.3	30.5	74.0	26.0	-	(100.0)
			10. Dingalpota				
male	0	0	479	479	0	4	483
female	0	0	428	428	0	2	430
both sexes	0	0	907	907	0	6	913
	-	-	99.3	99.3	-	0.7	(100.0)

11. Jagoddal

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
male	324	70	576	973	5	0	975
female	306	60	525	891	4	0	895
both sexes	630	130	1101	1861	9	0	870
	33.7	6.9	58.9	99.5	0.5	-	(100.0)

12. Cheubali

male	794	165	740	1699	34	0	1733
female	720	147	677	1544	32	0	1576
both sexes	1514	312	1417	3243	66	0	3309
	45.8	9.4	42.8	98.0	2.0		(100.0)

13. Ban Hugli

male	74	105	601	980	1092	162	2234
female	51	102	718	871	1039	146	2056
both sexes	125	207	1319	1851	2131	308	4290
	2.9	4.8	30.4	43.1	49.7	7.2	(100.0)

ALL VILLAGES

male	1813	1067	4099	6979	3893	331	11203
female	1639	957	3747	6243	3572	298	10213
both sexes	3452	2024	7846	13222	7465	629	21416
	16.1	9.5	36.6	62.2	34.9	2.9	(100.0)

13.2.75

Table 13: Distribution of women by marital status and age
Village: BONHOOGLY

age-group	Marital status of women			Total	
	unmarried	married	widowed	(5)	
(1)	(2)	(3)	(4)		
		HINDUS*			
0-14	420	1	-	421	(48.5)
15-24	45	77	1	123	(14.2)
25-34	1	97	6	104	(12.0)
35-44	1	82	20	103	(11.9)
45+	-	51	65	116	(13.4)
all ages	467	308	92	867	(100.0)
		MUSLIMS			
0-14	552	1	-	553	(53.3)
15-24	39	107	2	148	(14.3)
25-34	-	135	1	136	(13.1)
35-44	-	78	7	85	(8.2)
45+	-	55	58	115	(11.1)
all ages	593	376	68	1037	(100.0)
		CHRISTIANS			
0-14	67	-	-	67	(46.2)
15-24	8	13	-	21	(14.5)
25-34	1	12	-	13	(9.0)
35-44	-	21	2	23	(15.9)
45+	-	8	13	21	(14.4)
all ages	76	54	15	145	(100.0)

* 7 Hindu women with 'divorce' status not included

age-group	Distribution of married women by number of children (surviving)						
	0	1	2	3	4	5+	Total
			HINDUS				
0-14	0	1	0	0	0	0	1 (0.3)
15-24	33	15	14	10	5	0	77 (25.0)
25-34	7	5	11	33	19	24	99 (32.2)
35-44	2	5	11	12	16	35	81 (26.3)
45+	1	8	2	12	5	22	50 (16.2)
all ages	43	34	38	67	45	81	308
	14.0	11.0	12.3	21.8	14.6	26.3	(100.0)
			MUSLIMS				
0-14	1	0	0	0	0	0	1 (0.3)
15-24	29	29	17	20	9	3	107 (28.5)
25-34	3	11	14	30	31	46	135 (35.9)
35-44	4	4	5	8	12	45	78 (20.7)
45+	4	11	10	6	11	13	55 (14.6)
all ages	41	55	46	64	63	107	376
	10.9	14.6	12.2	17.0	16.8	28.5	(100.0)

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TOTAL HEALTH CARE PROJECT : 1974

Supplementary Notes to the INDEX REPORT (February 1975)

SOME ASPECT OF NATALITY BY SOCIAL GROUPS

In the villages and semi-urban settlements surveyed in Sonarpur P.S. the households were found to possess on average about 6 persons and the small (1 - 3 persons) and medium (4 - 6 persons) - sized households together accounted for 63 out of every 100 cases. On the other hand, in the total population the ever-married persons of both sexes explained 40% cases. The population size of these rural and semi-ruban habitats was, thus, very largely depended on the natality behaviour of these ever-marrieds. Currently the married couples formed not mor than 35 per cent and eventually they would continue to influence future population magnitude along with those who would commence new procreative families.

On the other hand, out of total 10252 females found in 3653 households of the given survey area we find that the married females alone (irrespective of age) stood for 36 percent. These married females were distributed in varying strength over the villages. Consequently, it is imperative that one should know the specific numerical strength of the married females in each village where any family welfare programme may be organised. Moreover, social group wise stratification of the married females has to be sifted out in giving effective service to the families concerned. From our survey-findings it is noticed in each of the villages Kumar khali and Hogalkhuria as well as in semi-urban Elachi the proportion of married females to the total female population was relatively highest (38%), where as in villages Ramchandrapur and Dingelpota

the married females explamied only 32% and 34% respectively of the total female population of individual village. In Kumarkhali village the Muslim families dominate, but in Hogalkuria it is the low caste Hindus who were the major Social Group. In Elachi the Hindus and the Muslims were present in matching strength. Under the circumstances, it is quite evident that family welfare programme meant for Kumarkhali has to be largely oriented to suit primarily the family building attitude and procreative behaviour of the Muslim couples, but the same has to be different for Hogalkuris or Elachi. Taking cue to these examples, some general and some particular family planning activities are required to be organised in time with the population characteristics of each habitat under question.

The second Socio-demographic indicator of natality performances of the couples concerned is immediately related to the magnitude of women who were in the child-bearing ages between 15 and 44 years. There might be some child-bearing women below 15 yrs or above 44 yrs, but their strength would not be decisive to influence the general fertility ratio (child-women ratio) in the given population. In many parts of the world where systems of registering births are either lacking or very inadequate the measure of general fertility ratio is especially useful to reflect on the nature and trend of fertility in the population concerned. In this respect two Tables A and B are appended below to indicate social group-wise general fertility ratio in each of the rural and semi-urban settlements under survey. The quantitative findings given in these two tables are expected to help the administrators of any family welfare planning programmes in fixing priority of work.

In general it is interestingly found that the general fertility ratio among the Hindus as a whole was relatively the lowest (54), but among the Muslims the same was very high (84). The christians came in between these communities. Now looking into the state of affair per sample village it would be evident that the child-woman ratio among the Hindu s only fluctuated very widely between the low of 24 (Jagannathpur) and the high of 76 (Hogulkuria). Naturally, the women of child-bearing ages in Hogalkuria village have to be accorded the first priority in making them understood the boon of smaller number of children per couple. This Hogalkuria is a village of low caste Hindus among whom the poor, illiterate families of Teor caste dominate most consipiciously. In this village only 137 women falling within 15-44 yrs were found among the Teors.

In contrast, number of children under 5 yrs per 100 women of child-bearing ages among the Muslims only varied between a low of 50 (Nischintapur) and a high of 92 (Kusumba). Eventually, the families residing in Kusumba village have to be given foremost attention to curb down the general fertility ratio. There were in Kusumba only 170 women in the given child-bearing age and they should immediately be contacted by the family planning workers. Another point of interest is that in each sample village where the Muslims formed a sizable group general fertility ratio was alwaysmuch higher than what was found for other communities. In this situation

general family planning education has first to be imparted to the Muslims before any particular action oriented programme may be envisaged.

The Christian families resided in villages Hogalkuria and Ban Hugli and among them general fertility ratio varied between 67 and 68. Since Hogalkuria encompasses only low caste teors and christians, they together presented child woman ratio on a little higher side (73).

In conjunction to what has been noted above it is recorded here that among the Hindus only the High caste women showed the minimum ratio (34) and the highest ratio (64) was registered by the low caste women. The middle caste women come in between them in showing ratio of 54. It is, thus, quite clear that the stress and strain of bigger load of children was relatively lowest among the high caste people. From the point of family welfare planning activities it is the low caste families who need topmost attention among the hindus. Among the low caste population under examination the general fertility ratio ranged betwen a low of 44 (Elachi) and a high of 117 (Nischintapur). In the middle caste people child-women ratio varied between a low of 25 (Kusumba) and a high of 92 (ELACHI), while in the high caste Hindus the ratio was between a low of 24 (Elachi as well as Jagaddal) and a high of 45 (Chauhati).

From the above picture of child-woman ration amonth each caste group of the Hindus and again among the Muslims it may be suggested that for the given sample habitants the priority of family welfare planning activities should be shared at the beginning as follows :

	LEVEL OF PRIORITY OF F.P.PROGRAMS IN SURVEY AREA	
Community/ Caste	High Priority for settlement of	Low Priority for settlement
I.THE HINDUS:		
a) High caste	Chauhati Ban Hugli	Elachi Jaggadal
b) Middle caste	Elachi Banhugli	Kusumba Jagaddal
c) Low caste	Nischingapur Hogalkuria	Elachi Jayenpur
II.THE MUSLIMS :	Chauhati Kusumba	Nischintapur

This schematic arrangement of the rural and semi-urban settlements under study does not mean that the other settlements should remain out side the focus of the general family planning education and/or action-oriented programmes. In Summary, it may be noted that as the first and foremost target group the women in the child bearing ages 15 to 44 Yrs. have to be roped in the fold of F.P. programmes that might be developed for the given households. Altogether 2652 women of the said child-being age-group were found among the Hindus only of these the Low caste women alone accounted for 56 percent,

while the middle caste women explained only 15 per cent. The rest 29 percent was for the High caste women. Since the Low caste (15-24 yrs.) were dominating among the Hindus, it is quite obvious that they would demand greater attention as well as higher resources from the Family Planning Welfare programmes as may be outlined for the given 13 rural and semi-urban settlements of Sonarpur p.s.

With respect to the total female population surveyed as good as 4135 (40 per cent) were found to be within the child-bearing ages 15 to 44 yrs. Of these strength (4135) the Hindu women and the Muslim women accounted for 65 percent and 32 percent respectively. They need to be given all care and education in favour of small family. The Muslim women do require a more organized plan in this respect since they evinced a very high child-women ratio.

Now, coming to the third aspect of the natality situation in the survey area it is to be noticed that among the Hindu women falling within the child-bearing ages (15-44) as good as 43 percent were in young ages (15-24 Yrs.) But the same aged women among the Muslims were found in 38% cases. Among the Christians the young aged women were ralatively dominating most (44 percent). Naturally, it is the Christian young women of child-bearing ages do need the most concentrated attention for imparting necessary F.P. education. In contrast, about the middle aged women

coming under the age-group 25-34 it may be noted that the Muslim women of this age group concentrated maximum (39%), the minimum being among the Christian women (26%). As far as the advanced aged women under the age-group of 35-44 Yrs are concerned, their strongest presence was among the Christians, while among the Hindus and the Muslims such Women were present almost in equal strength.

From this it may be suggested that F.P. programmes have to be pinpointed for the young aged women who constituted 41% of all the women in child-bearing ages. Since the Hindus formed the strongest social group in the area they would, of course, draw greater attention. In the Table C detailed distribution of the women of child-bearing ages by community/Caste affiliation as well as residential attachment has been shown. A careful study of the findings of this table is expected to give fruitful lead in the enactment of F.P. programmes in any village under study. As for example, in comparison to all the habitants in question Chauhati village presented the largest concentration of young aged women (50%) among all women of child-bearing ages. And hence, highest priority has been suggested for this village in the over-all out-lay of F.P. programmes that may be envisaged. Similar such judgement may be made after due checking of the magnitude of child-bearing women of different ages. In conjunction with this the social identity of the population of any village has to be taken up in order to mark efficient line of actions.

Table: A Child-Woman Ratio (no. of children under 5 years per 100 women 15 to 44 years old) among the Bengali castes found in 13 sample villages, Sonarpur p.s., 24 Parganas, 1974.

Bengali Hindu caste	No. of children under 5 years	No. of Women 15 to 44 yrs.old	No.of children per 100(Col.3)
(1)	(2)	(3)	(4)
	1. Nischintapur		
a) High caste	1	4	25
b) Middle caste	33	86	38
c) Low caste	7	6	117
All castes	41	96	43
	2. Ukhila		
a) High caste	0	2	0
b) Middle caste	3	6	50
c) Low caste	6	10	60
All castes	9	18	50
	3. Jagannathpur		
a) High caste	0	7	0
b) Middle caste	6	18	33
c) Low caste	-	-	-
All castes	6	25	24
	4. Kumarkhali		
a) High caste	31	98	32
b) Middle caste	17	28	61
c) Low caste	42	55	76
All castes	90	181	50
	5. Kismba		
a) High caste	18	62	29
b) Middle caste	3	12	25
c) Low caste	48	69	70
All castes	69	143	48
	6. Hogalkuria		
a) High caste	-	-	-
b) Middle caste	-	-	-
c) Low caste	104	137	76
All castes	104	137	76
	7. Jayenpur		
a) High caste	-	-	-
b) Middle caste	-	-	-
c) Low caste	42	76	55
All castes	42	76	55

Table: A (contd.)

(1)	(2)	(3)	(4)
		8. Ramchandrapur	
a) High caste	5	13	38
b) Middle caste	36	61	59
c) Low caste	70	89	79
All castes	111	163	68
		9. Elachi	
a) High caste	22	93	24
b) Middle caste	54	59	92
c) Low caste	53	120	44
All castes	129	272	47
		10. Dingelpota	
a) High caste	-	-	-
b) Middle caste	-	-	-
c) Low caste	98	155	63
All castes	98	155	63
		11. Jagaddal	
a) High caste	37	152	24
b) Middle caste	8	29	28
c) Low caste	125	222	56
All castes	170	403	42
		12. Chauhati	
a) High caste	143	320	45
b) Middle caste	31	63	49
c) Low caste	170	261	65
All castes	344	644	53
		13. Ban Hugli	
a) High caste	8	19	42
b) Middle caste	23	38	61
c) Low caste	182	282	65
All castes	213	339	63
		14. All Villages	
a) High caste	265	770	34
b) Middle caste	214	[illegible]	54
c) Low caste	947	1482	64
All castes	1426	2652	54

Table B: Child - Women Ratio (no. of children under 5 years. per 100 women 15 to 44 years old) in different communities found in 13 sample villages, Sonarpur p.s., 24 Parganas District, 1974

Community/ Caste	No. of children under 5 years	No. of women 15 to 44 yrs. old	No. of children per 100 women (col.3)
1	2	3	4
1. Nischintapur			
a) HINDU :			
i) Goala	33	86	38
ii) Others	8	10	80
All Hindus	41	96	43
b) MUSLIM :	2	4	50
Total (a + b)	43	100	43
2. Ukhila			
a) HINDU :			
All Hindus	10	19	53
b) MUSLIMS	152	227	67
Total (a + b)	162	246	66
3. Jagannathpur			
a) HINDU :			
i) Goala	5	15	33
ii) Others	5	10	10
All Hindus	6	25	24
b) MUSLIM :	158	196	81
Total (a + b)	164	221	74
4. Kumarkhali			
a) HINDU :			
i) Kayastha	21	74	28
ii) Others	74	113	65
All Hindus	95	187	51
b) MUSLIM :	173	216	80
Total (a + b)	268	403	66
5. Kusumba			
a) HINDU :			
i) Brahmin	10	34	29
ii) Others	61	110	55
All Hindus	71	144	49
b) MUSLIM :	157	170	92
Total (a + b)	228	314	73
6. Hogalkuria			
a) HINDU :			
All Hindus	104	137	76
b) Christian	41	61	67
Total (a + b)	145	198	73

1	2	3	4
7. Jayenpur			
a) HINDU :			
i) Paundra	33	57	58
ii) Others	9	19	47
All Hindus	42	76	55
b) MUSLIM :	19	27	70
Total (a + b)	61	103	59
8. Ramchandrapur			
a) HINDUS :			
i) Paundra	63	82	77
ii) Others	48	81	59
All Hindus	111	163	68
b) MUSLIM :	40	41	98
Total (a + b)	151	204	74
9. Elachi			
a) HINDUS :			
i) Paundra	39	60	65
ii) Others	96	221	43
All Hindus	135	281	48
b) MUSLIM	64	76	84
Total (a + b)	199	357	56
10. Dingelpota			
a) HINDUS :			
i) Paundra	70	115	61
ii) Others	28	40	70
All Hindus	98	155	63
11. Jagaddal			
a) HINDU :			
i) Paundra	50	86	58
ii) Brahmin	21	111	19
iii) Others	101	208	49
All Hindus	172	405	42
12. Chauhati			
a) HINDU :			
i) Kayastha	106	230	46
ii) Jugi	123	191	64
iii) Others	116	226	51
All Hindus	345	647	53
b) MUSLIM :	11	11	100
Total (a + b)	356	658	54
13. Ban Hugli			
a) HINDUS :			
i) Heor	157	250	63
ii) Others	56	89	63
All Hindus	213	339	63
b) MUSLIM :	356	373	95

1	2	3	4
13. Ban Hugli			
c) Christian	33	57	58
Total (a + b) + c	602	769	78
14 ALL VILLAGES			
a) HINDUS	1443	2674	54
b) MUSLIMS	1132	1341	84
c) CHRISTIANS	74	118	63
Total (a + b + c)	2649	4133	64

Table C : Distribution of women in child-bearing ages by community/caste over 13 sample villages, Sonarpur p.s., 24-Parganas District, 1974.

Community/ Caste	Women in child-bearing ages 15-24	25-34	35-44	Total	Total females in the habitat
(1)	(2)	(3)	(4)	(5)	(6)
			1. Nischintapur		
HINDU	39	33	24	96	228
MUSLIM	1	2	1	4	7
Total	40 (40.0)	35 (35.0)	25 (25.0)	100 (100.0)	235
			2. Ukhila		
HINDU	8	7	4	19	34
MUSLIM	80	96	51	227	585
Total	88 (35.8)	103 (41.9)	55 (22.3)	246 (100.0)	619
			3. Jagannathpur		
HINDU	13	8	4	25	50
MUSLIM	72	82	42	196	520
Total	85 (38.5)	90 (40.7)	46 (20.8)	221 (100.0)	570
			4. Kumarkheli		
HINDU	65	83	39	187	409
MUSLIM	70	91	54	215	596
Total	135 (33.6)	174 (43.3)	93 (23.1)	402 (100.0)	995
			5. Kusumba		
HINDU	54	58	32	144	318
MUSLIM	69	59	42	170	411
Total	123 (39.2)	117 (37.3)	74 (23.5)	314	729
			6. Hogalkuria		
HINDU	51	46	40	137	379
CHRISTIAN	27	18	16	61	147
Total	78 (39.4)	64 (32.3)	56 (28.3)	198 (100.0)	526

Table C :

7. Jayenpur					
HINDU	32	25	19	76	180
MUSLIM	10	10	7	27	75
CHRISTIAN	0	0	1	1	3
Total	42 (40.4)	35 (33.6)	27 (26.0)	104 (100.0)	258
8. Ramchandrapur					
HINDU	74	57	32	163	430
MUSLIM	19	11	11	41	110
Total	93 (45.6)	68 (33.3)	43 (21.1)	204 (100.0)	540
9. Elachi					
HINDU	122	113	46	281	614
MUSLIM	33	23	20	76	201
Total	155 (43.4)	136 (38.1)	66 (18.5)	357 (100.0)	815
10. Dingelpota					
HINDU	59	55	41	155	428
CHRISTIAN	0	0	0	0	2
Total	59	55	41	155 (100.0)	430
11. Jagaddal					
HINDU	184	122	99	405	896
MUSLIM	1	0	1	2	4
Total	185 (45.4)	122 (30.0)	90 (24.6)	407 (100.0)	
12. Chauhati					
HINDU	319	177	151	647	1547
MUSLIM	4	5	2	11	32
Total	323 (49.9)	182 (27.6)	153 (22.5)	658 (100.0)	1579
13. Ban Hugli					
HINDU	124	107	108	339	871
MUSLIM	147	139	87	373	1039
CHRISTIAN	22	13	22	57	146
Total	293 (38.1)	259 (33.7)	217 (28.2)	769 (100.0)	2056

Table C :

14. ALL VILLAGES

HINDUS	1144 (42.8)	891 (33.3)	639 (23.9)	2674 (100.0)	6384
MUSLIMS	506 (37.7)	518 (38.6)	318 (23.7)	1342 (100.0)	3570
CHRISTIANS	49 (44.1)	31 (26.0)	39 (29.9)	119 (100.0)	298
Total	1699 (41.1)	1458 (35.2)	996 (23.7)	4135 (100.0)	10252

Duplicate WH-138

TOTAL HEALTH CARE PROJECT : 1974

Supplementary Notes to the INDRA REPORT (February 1975)

SOME ASPECT OF MATALITY BY SOCIAL GROUPS

In the villages and semi-urban settlements surveyed in Sonarpur P.S. the households were found to possess on average about 6 persons and the small (1 - 3 persons) and medium (4 - 6 persons) - sized households together accounted for 63 out of every 100 cases. On the other hand, in the total population the over-married persons of both sexes explained 40 cases. The population size of these rural and semi-rubon habitats was, thus, very largely depended on the natality behaviour of these over-marrieds. Currently the married couples formed not mor than 35 per cent and eventually they would continue to influence future population magnitude along with those who would commence new procreative families.

On the other hand, out of total 10252 females found in 3653 households of the given survey area we find that the married females alone (irrespective of age) stood for 36 percent. These married females were distributed in varying strength over the villages. Consequently, it is imperative that one should know the specific numerical strength of the married females in each village where any family welfare programme may be organised. Moreover, any social group wise stratification of the married females has to be sifted out in giving effective service to the families concerned. From our survey-findings it is noticed in each of the villages Kumar Khali and Bogalkhuria as well as in semi-urban Khachi the proportion of married females to the total female population was relatively highest (38), where as in villages Raschandrapur and Dingelpota

the married females explained only 32% and 34% respectively of the total female population of individual village. In Kusarkhali village the Muslim families dominate, but in Hogal-kuria it is the low caste Hindus who were the major social Group. In Blachi the Hindus and the Muslims were present in matching strength. Under the circumstances, it is quite evident that family welfare programme meant for Kusarkhali has to be largely oriented to suit primarily the family building attitude and procreative behaviour of the Muslim couples, but the same has to be different for Hogalkuris or Blachi. Taking some cue to these examples, some general and some particular family planning activities are required to be organised in time with the population characteristics of each habitat under question.

The second Socio-demographic indicator of natality performances of the couples concerned is immediately related to the magnitude of women who were in the child-bearing ages between 15 and 44 years. There might be some child-bearing women below 15 yrs or above 44 yrs, but their strength would not be decisive to influence the general fertility ratio (child-women ratio) in the given population. In many parts of the world where systems of registering births are eit er lacking or very inadequate the measure of general fertility ratio is especially useful to reflect on the nature and trend of fertility in the population concerned. In this respect two Tables A and B are appended below to indicate social group-wise general fertility ratio in each of the rural and semi-urban settlements under survey. The quantitative findings given in these two tables are expected to help the administrators of any family welfare planning programmes in fixing priority of work.

In general it is interestingly found that the general fertility ratio among the Hindus as a whole was relatively the lowest (84), but among the Muslims the same was very high (84). The christians came in between these communities. Now looking into the state of affair per sample village it would be evident that the child-woman ratio among the Hindus only fluctuated very widely between the low of 24 (Jagannathpur) and the high of 76 (Mogulkuria). Naturally, the women of child-bearing ages in Mogalkuria village have to be accorded the first priority in making them understood the boon of smaller number of children per couple. This Mogalkuria is a village of low caste Hindus among whom the poor, illiterate families of Teor caste dominate most conspicicously. In this village only 137 women falling within 15-44 yrs were found among the Teors.

In contrast, number of children under 5 yrs per 100 women of child-bearing ages among the Muslims only varied between a low of 50 (Mischintapur) and a high of 92 (Musumba). Eventually, the families residing in Musumba village have to be given foremost attention to curb down the general fertility ratio. There were in Musumba only 170 women in the given child-bearing age and they should immediately be contacted by the family planning workers. Another point of interest is that in each sample village where the Muslims formed a sizable group general fertility ratio was alwaysmuch higher than what was found for other communities. In this situation

general family planning education has first to be imparted to the Muslims before any particular action oriented programme may be envisaged.

The Christian families resided in villages Bogalkuria and Ban Hugli and among them general fertility ratio varied between 67 and 68. Since Bogalkuria encompasses only low caste toors and christians, they together presented child woman ratio on a little higher side (73).

In conjunction to what has been noted above it is recorded here that among the Hindus only the High caste women showed the minimum ratio (34) and the highest ratio (64) was registered by the low caste women. The middle caste women come in between them in showing ratio of 54. It is, thus, quite clear that the stress and strain of bigger load of children was relatively lowest among the high caste people. From the point of family welfare planning activities it is the low caste families who need topmost attention among the Hindus. Among the low caste population under examination the general fertility ratio ranged between a low of 44 (Kachi) and a high of 117 (Nischintapur). In the middle caste people child-woman ratio varied between a low of 25 (Kusumba) and a high of 92 (KACHI), while in the high caste Hindus the ratio was between a low of 24 (Kachi as well as Jagaddal) and a high of 45 (Chaumti).

From the above picture of child-woman ration amonth each caste group of the Hindus and again among the Muslims it may be suggested that for the given sample habitants the priority of family welfare planning activities should be shared at the beginning as follows :

Community/ Caste	LEVEL OF PRIORITY OF F.P.PROGRAMS IN SURVEY AREA	
	High Priority for settlement of	Low Priority for settlement
I. THE HINDUS:		
a) High caste	Chauhati Kan Hugli	Klachi Jaggadal
b) Middle caste	Klachi Kanhugli	Kusumba Jagaddal
c) Low caste	Mischingapur Bogalkuria	Klachi Jayenpur
II. THE MUSLIMS :	Chauhati Kusumba	Mischintapur

This schematic arrangement of the rural and semi-urban settlements under study does not mean that the other settlements should remain out side the focus of the general family planning education and/or action-oriented programmes. In Summary, it may be noted that as the first and foremost target group the women in the child bearing ages 15 to 44 Yrs. have to be roped in the fold of F.P. programmes that might be developed for the given households. Altogether 2652 women of the said child-being age-group were found among the Hindus only of these the Low caste women alone accounted for 56 percent.

while the middle caste women explained only 15 per cent. The rest 79 percent was for the High caste women. Since the low caste (15-24 yrs.) were dominating among the Hindus, it is quite obvious that they would demand greater attention as well as higher resources from the Family Planning Welfare programmes as may be outlined for the given 13 rural and semi-urban settlements of Sonarpur p.s.

With respect to the total female population surveyed as good as 4135 (40 per cent) were found to be within the child-bearing ages 15 to 44 yrs. Of these strength (4135) the Hindu women and the Muslim women accounted for 65 percent and 32 percent respectively. They need to be given all care and education in favour of small family. The Muslim women do require a more organized plan in this respect since they evinced a very high child-women ratio.

Now, coming to the third aspect of the natality situation in the survey area it is to be noticed that among the Hindu women falling within the child-bearing ages (15-44) as good as 43 percent were in young ages (15-24 Yrs.) But the same aged women among the Muslims were found in 38% cases. Among the Christians the young aged women were relatively dominating most (44 percent). Naturally, it is the Christian young women of child-bearing ages do need the most concentrated attention for imparting necessary F.P. education. In contrast, about the middle aged women

coming under the age-group 25-34 it may be noted that the Muslim women of this age group concentrated maximum (39%), the minimum being among the Christian women (26%). As far as the advanced aged women under the age-group of 35-44 Yrs are concerned, their strongest presence was among the Christians, while among the Hindus and the Muslims such women were present almost in equal strength.

From this it may be suggested that F.P. programmes have to be pinpointed for the young aged women who constituted 41% of all the women in child-bearing ages. Since the Hindus formed the strongest social group in the area they would, of course, draw greater attention. In the Table C detailed distribution of the women of child-bearing ages by community/Caste affiliation as well as residential attachment has been shown. A careful study of the findings of this table is expected to give fruitful lead in the enactment of F.P. programmes in any village under study. As for example, in comparison to all the habitants in question Chauhati village presented the largest concentration of young aged women (50%) among all women of child-bearing ages. And hence, highest priority has been suggested for this village in the over-all out-lay of F.P. programmes that may be envisaged. Similar such judgement may be made after due checking of the magnitude of child-bearing women of different ages. In conjunction with this the social identity of the population of any village has to be taken up in order to mark efficient line of actions.

Table: A Child-Woman Ratio (no. of children under 5 years per 100 women 15 to 44 years old) among the Bengali castes found in 13 sample villages, Sonarpur p.s., 24 Parganas, 1974.

Bengali Hindu caste	No. of children under 5 years	No. of Women 15 to 44 yrs. old	No. of children per 100 (Col. 3)
(1)	(2)	(3)	(4)
	1. Nischintapur		
a) High caste	1	4	25
b) Middle caste	33	86	38
c) Low caste	7	6	117
All castes	41	96	43
	2. Ukhila		
a) High caste	0	2	0
b) Middle caste	3	6	50
c) Low caste	6	10	60
All castes	9	18	50
	3. Jagannathpur		
a) High caste	0	7	0
b) Middle caste	6	18	33
c) Low caste	-		
All castes	6	25	24
	4. Kumarkhali		
a) High caste	31	98	32
b) Middle caste	17	28	61
c) Low caste	42	55	76
All castes	90	181	50
	5. Kasunba		
a) High caste	18	62	29
b) Middle caste	3	12	25
c) Low caste	48	69	70
All castes	69	143	48
	6. Hogalkuria		
a) High caste	-	-	-
b) Middle caste	-	-	-
c) Low caste¢	104	137	76
All castes	104	137	76
	7. Jayenpur		
a) High caste	-	-	-
b) Middle caste	-	-	-
c) Low caste	42	76	55
All castes	42	76	55

Table B: Child - Women Ratio (no. of children under 5 years. per 100 women 15 to 44 years old) in different communities found in 13 sample villages, Sonarpur P.S., 24 Parganas District, 1974

Community/ Caste	No. of children under 5 years	No. of women 15 to 44 yrs. old	No. of children per 100 women (col.3)
1	2	3	4
1. Nischintapur			
a) HINDU :			
i) Goala	33	86	38
ii) Others	8	10	80
All Hindus	41	96	43
b) MUSLIM :	2	4	50
Total (a + b)	43	100	43
2. Ukhila			
a) HINDU :			
All Hindus	10	19	53
b) MUSLIMS	152	227	67
Total (a + b)	162	246	66
3. Jagannathpur			
a) HINDU :			
i) Goala	5	15	33
ii) Others	5	10	10
All Hindus	6	25	24
b) MUSLIM :	158	196	81
Total (a + b)	164	221	74
4. Kumarkhali			
a) HINDU :			
i) Kayastha	21	74	28
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All Hindus	95	187	51
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5. Kusumba			
a) HINDU :			
i) Brahmin	10	34	29
ii) Others	61	110	55
All Hindus	71	144	49
b) MUSLIM :	157	170	92
Total (a + b)	228	314	73
6. Hogalkuria			
a) HINDU :			
All Hindus	104	137	76
b) Christian	41	61	67
Total (a + b)	145	198	73

1	2	3	4
7. Jayenpur			
a) HINDU :			
i) Paundra	33	57	58
ii) Others	9	19	47
All Hindus	42	76	55
b) MUSLIM :	19	27	70
Total (a + b)	61	103	59
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i) Paundra	63	82	77
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All Hindus	111	163	68
b) MUSLIM :	40	41	98
Total (a + b)	151	204	74
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a) HINDUS :			
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a) HINDU :			
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Total (a + b)	356	658	54
13. Ban Hugli			
a) HINDUS :			
i) Keor	157	250	63
ii) Others	56	89	63
All Hindus	213	339	63
b) MUSLIM :	356	373	95

1	2	3	4
13. Ban Nugli			
c) Christian	33	57	58
Total (a + b) + c	602	769	78
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a) HINDUS	1443	2674	54
b) MUSLIMS	1132	1341	84
c) CHRISTIANS	74	118	63
Total (a + b + c)	2649	4133	64

NHY/13-9

TOTAL HEALTH CARE PROJECT : 1974

Additional Notes to the REPORT ON SOME ASPECT OF NATALITY BY SOCIAL GROUPS (March 1975)

BIOSOCIAL PROFILE OF SMALL FAMILIES

A little over than one-third of all females (10252) found in 3653 households which were surveyed in 11 rural and 2 semi-urban settlements falling under Sonarpur p.s. of 24-Parganas district, were married. Irrspective of age, these married women concentrated in varying strength within different social groups namely the Hindus, Muslims or Christians. Their concentrations varied also highly between the settlements in question. In addition to these married females the widowed (9.7%) and divorced women were present in 10 percent cases only. Thus, the ever-married women as a whole were responsible to account for not more than 46 percents of total 10252 females enumerated in the survey.

These evermarried women presented differential natality behaviour depending on their individual age and social group affiliation Net outcome of this behaviour was reflected in the very size of progenies per mother. Here an attempt has been made to examine the distribution of married women only by number of children (surviving) in each village. Since number of married women differed greatly in magnitude between the Hindus, the Muslims and the Christians, first consideration was laid upon the dominant, more populous social group of a village and then among that dominant group the distribution of married women by number of children was exmined over different age-group of the mothers concerned.

Primary purpose of this study is to locate the trend in the formation of small families (with not more than 3 children) by the couples under survey. To what extent, social group wise variations in the formation of small families were in existence in the local society? In which village the small families were dominant or vice versa? To sustain small families which social group of any village demand, immediate Family Planning welfare

measures? The ~~xxxxxxx~~ quantitative findings of the present empircial study are expected to provide with the Basic <u>reference-frame</u> of the above problems. With this frame in mind appropriate Family Planning measures may be tried in tune ~~x~~ with the prevailing social/cultural values of the social group concerned. Village wise concentrations of small families have been studied hereafter in terms of the dominant social group of the rural society.

1. In <u>Nischintapur</u> village 86 out of total 235 females were married and the <u>Hindus formed the dominant group.</u> Among the Hindus the middle castes constituted the basic stratum. Thus, the natality behaviour of the Hindu couples as observed in this village was very largely influenced by middle caste households. Among the married women those who were 25 to 34 in age formed the single major group and about one-half of them were already enjoying small family. This age-group (25-34) needs foremost Family Planning attention, since they were still reproductively protent enough to add more children to augment population pressure. In general, in the village in every 49 out of 100 cases the married women were found to report already 4 and more children. It is noted further that as 22 percent of total married women of the village ~~xx~~ had meanwhile entered the age group 45+ years they can be left outside the perview of any family planning programme.

2. In the village <u>Ukhila</u> 225 out of total 619 females were reported to be married. In this settlement the <u>Muslims were the dominant social group</u>. Accordingly fertility behaviour of married women of the village was shaped strongly by this social group. There were 592 Muslim women and 36 percent of them were married. The married women falling under the age-group 25-34 accounted for the single major group (43%). Within this age-group the married women having 5 and more children were most conspicous. In general , in every 100 cases only 41 ~~xxx~~ were observed to maintain small family with 1-3 children. Thus, in Ukhila it is conspicuons that the married muslim women were ~~possessing higher number~~

possessing higher number of children (4+) and under the circumstances, Ukhila requires intensive family planning education to impress upon the boon of small family per couple.

3.X. In Jagannathpur village the dominance of Muslim households was again found. Out of the total 570 women of the village 199 were married and again, of this 199 the Hindu women shared a small portion (15 souls only). Here again, the muslim married women of the age group 25-34 constituted the single major block (45%), but among them the women having 1-3 children were conspicuous. Ingeneral, in this village presence of small families was shown by a little more than one-half of all Muslim married females. But as these women were still in reproductive ages they should be imparted with family Planning education and appliances to resist further expansion of the agerage family size, In their natality behaviour the Jagannathpur Muslim married women showed a difference from their counterparts living in Ukhila.

4. Village Kumarkhali presented the Hindus and the Muslims in matching strength, though the Muslims were numerically larger. Thus, in this settlement natality behaviour vis-a-vis formation of small family had to be evaluated separately for the social group in question. Among the Hindus the High caste Households dominated on the other hand. Of the total 409 Hindu women recorded in the settlement 43 percent were married, where as among 587 Muslim women only 34 per cent were married. Among both the Hindus and the Muslims the married women of the age group 25-34 formed the single major group. But among the Hindus the married women of this particular agegroup showed higher incidence of small families. Among the Muslims the married women of 25-34 age-group presented families with higher number of children (4+) in majority cases. Ingeneral, the Hindu married women had in 58.5% cases small families inconstrast to their Muslim counterparts who possessed larger sized (4 and more children) families in 49.8% cases. Thus, in this village the Hindus are to be greatly motivated to sustain small families through Family Planning activities,

While through family planning ~~education~~

While the Muslims are to be imparted with intensive family planning education so as to make them biosocially oriented towards small family.

5. Village Kusumba is another settlement were the Hindus and the Muslims were quite numerous. Again, among the Hindus the low caste households wer predominant. 36 percent of total Hindu women and 35 per cent of total Muslim women were found to be married. Among the Hindus the married females of the agee group 25-34 explanied almost half of the total married women. But among the Muslims though the married females of 25-34 age-group shared 36 percent of total married women, the married females of 15-24 age-group were not insufficient in number. Younger married women falling between 15-34 yrs. accounted for as high as 67 percent of all married women among the Muslims. Such a dominant occurrence of younger married women is an indicator of the future fertility load among the Muslims of the village. The majority of the Hindu married women (25.34)yrs reported to possess 1 to 3 children , where as the majority of the muslim married women (25-34 yrs) was observed to possess 4+ children. In general, small families were dominant among the Hindus (54%), but among the Muslims larger sized families were more frequent (43%).

6. In Hogalkuria village Low Caste Hindus and the Christians were the occupants, through the former was numerically stronger. Of the total 526 females of the village the majority (379) belonged to Hindu social group. Of these Hindu females 38 percent were married, while among the Christian females 36 percent were married. Among the Hindus the married women (25-34yrs) formed the single major group (30%) and within them both small and large families were distributed equally. In general, irrespective of age, the Hindu married women were found to possess 1 to 3 children in matching strength to 4+ children. But, among the Christians the married women showed in general, irrespective of age, 4+ children in greater proportion (53%). Thus, for this village the christian families are required to be given greater amount of

of family planning welfare measures.

7. Jayenpur village was predominantly inhabited by the Low Caste Hindus and they were associated with Muslims. Of the total females (258) the Low Caste females account for major portion (180), while only 75 Muslim females were there, Inspite of differential population size the Hindus and the Muslims had similar load of married women (37%). In general, among the Hindus the married women possessed, irrespective of age, 1-3 children in majority cases (49%) and within this married group those belonged to the age-group 25-34 formed the single majority (37%), though married women of younger ages (15-24) were quite conspicuous (30%). Under the circumstances, the Low Caste families of Jayenpur village should be exposed under a more intensive family planning programme.

8. Ramchandrapur is a village where the Hindus were a dominant social group (79%), but the muslims were present not freely. Among the Hindus Low Caste families concentrated most. Of all the females (540) of the village 80 percent were accounted by the Hindu. Of these Hindu females 32 percent were only married. The Hindu married women of the age group (25-34) formed the single major block and among them 4+ children occurred in greater proportion. In general, among the Hindu married women, irrespective of age, 1-3 children were reported in majority cases (45 percent), but 4+ children were found in as good as 42 percent cases. Eventually, immediate family planning care has to be taken to motivate the couples towards small family to arrest further population increase.

9. In the semi-urban settlement of Elachi the Hindus were the most dominant social group (74%) and among them families belonging to different caste group were not insignificant. Besides the Hindus, presence of the Muslims was marked by noticable. Within the Hindus 38.5% of total 613 females were found to be married, while within the Muslims their counterparts explained 37.6%. Among the Hindu married women those who belonged

to the age group 25-34 were very conspicuous (43%) and they were observed to possess 1-3 children in majority cases. On the other hand, among the Muslim married women those were in the age-group 15-24 constituted the single majority block and they were found to possess again 1-3 children in majority cases. In general, among the Hindu married women, irrespective of age, smaller family (1-3 children) was more frequent (58%), while among the muslim married women larger family (4+ children) was dominant, In this situation, the Hindu families have to be encouraged to sustain the trend of small family through family planning methods, while the muslim families need through family planning education to achieve small family per couple.

10. Dingelpota village is a Low Caste village. Here the Hindus belonging to different low castes dominated as a single social group 428 females were recorded among them and only 34% of them were married. Here again, among the married females those who were between 25 and 34 in age formed the single majority having 4+ children in greater number of cases. In general, among the Hindus the married women were found to possess 4+ children in 51 percent cases. This shows how they were maintaing their natality behaviour. They require immediate family planning education to modify the prevailing natality attitude and behaviour which favoured more children per couple.

11. Jagaddal is the semi-urban settlement where the Hindus were the sole occupants. Among them the Low Caste families concentrated maximum, through the High caste families were not insufficient in number, of the total Hindu females of the settlement 35 per cent were married and among them those who were in the agegroup 25-34 formed the single majority block and they showed 1-3 children in majority cases. In general, among the Hindu married women 52 percent presented, irrespective of age, small families. Naturally, the couples of this settlement have to be educated in such manner that they can sustain this trend of small family

through family planning education.

12. Village Chowhati is fairly populous and the Hindus, especially the Low Caste Hindus, formed the most dominant social group. Among the Hindus, 37 percent of all females were married and those married women who belonged to age-group 25-34 were present in majority cases (30%). But the younger married women of the age group (15-24) wer not insignificantly found. In general, the Hindu married women with 1-3 children were found in greater proportion (52%) and the contribution made by younger mothers ((15-24) in this aspect was extremely married. Thus, family planning activities have to be intensifiew among this younger mothers in preventing further rise in the size of the families concerned.

13. Village Bonhoogly was inhabited by the Hindus, muslims and christians in varying strength. The muslims accounted for one-half of total village population. The Hindus were explained 43 per cent of the population. This village is highly populated. In all 2056 females were recorded. Among the muslim females 36 per cent were married, while among their Hindu counterparts 35 percent were married. But, relatively speaking among the chirstans married females were present in greater proportion. Among the muslin married women those who were between 25 and 34 yers in age concentrated maximum (36%), where as within the Hindus married women of such age-group were found in 32% cases In general, the Hindu married women presented 1-3 children in majority cases (45%), while their counterparts among the muslims showed small families in 44% cases. Thus, in forming small families the Hinuds and the Muslims showed not much difference. As such, in this settlement family planning activities in favour of small family can be initiated for both the Hindus and the muslims with equal emphasis. Only point is to be noted here that Low Caste families dominated within the social group of Hindus.

SUMMARY OBSERVATION

Reviewing the nature and magnitude of small families over the given 11 rural and 2 Semi-urban settlements surveyed in Sonarpur p.s. 24-parganas district (1974) the following observations may be made: (vide Summary Table)

1. In 6 out 13 settlements presence of small families were shown by more than 50 percent of the married women belonging to specific social group. In this respect the Hnidus of village Kumarkhali and of the Semi-urban settlement of Elachi possessed relatively the highest magnitude of small families (58%). Next was the position of the Hindus (53%) of the village Kusumba. The Hindus of village Chowhati and of semi-urban settlement of Jagaddal came after the above Hindus in possessing small families in 52% cases. Along with the last named settlement came the village Jagannathpur where the Muslims married women showed 1-3 children in 51% cases. Thus, in these villages primary objective of any family planning welfare measures should be to motivate the couples concerned in keeping the currently occuring trend of small sized families undisturbed.

II. In 2 rural and 1 semi-urban settlements the married women belonging to specific social group presented larger families (with more than 3 children) in 50 percent or more cases. In this respect the christians of Hogalkuria village draw immediate attention since 53 percent of married women among this social group reported 4+ children. Next come the Hindus of Dingelpota village the Muslims of Elachi and the Muslims of Kumarkhali village. The Hindus of Nischintapur village showed district tendency towards larger sized families. Under the circumstances, the couples, concerned of these settlements have to be aided with adequate supply of family planning methods and appliances in order to check further addition of children per couple. As a matter of fact, intensive family planning education appears to be sine qua non for the couples concerned of these five settlements.

III. In general it has been found that the maximum concentration of married women coming under the age-group 25-34 had occurred, irrespective of social group wise affiliation, in most of the settlements under study. They should be the primary target group in the overall family planning programme envisaged for the population of the local society. They are to be sufficiently motivated to achieve as well as sustain small family.

SUMMARY TABLE

Distribution of married women with number of children (surviving) by social group per village.

Village	Dominant social group	p.c.of married women with not more than 3 children	more than 3 children
(1)	(2)	(3)	(4)
1. MISCHINTAPUR	Hindu	38.6	49.4
2. UKHILA	Muslim	41.0	46.1
3. JAGANNATHPUR	muslim	51.2	43.2
4. KUMARKHALI	Hindu	58.5	29.6
	muslim	39.8	49.8
5.KUSUMBA	Hindu	53.9	39.1
	muslim	48.7	43.0
6.HOGALKURIA	Hindu	40.7	41.4
	Christian	39.6	52.8
7. JAIKHPUR	Hindu	49.3	32.8
8. RAMCHANDRATUR	Hindu	45.2	42.4
9. BLACHI	Hindu	58.1	30.9
	Muslim	41,9	50.0
10. DINGELPOTA	Hindu	40.0	51.0
11. JAGADDAL	Hindu	51.8	39.0
12. CHOWHATI	Hindu	51.7	38.4
13. BONHOGLY	Hindu	45.1	40.9
	Muslim	43.8	45.3

Table. 1. Distribution of women by marital status and age
Village: NISCHINTAPUR

age-group	marital status of the women x				
	Unmarried	married	Widowed	Total	
(1)	(2)	(3)	(4)	(5)	
		HINDUS			
0 - 14	98	13	6	98	(43.0)
15 -24	26	13	-	39	(17.1)
25 -34	-	31	1	32	(14.0)
35-44	-	21	4	25	(11.0)
45+	-	18	16	34	(14.9)
All ages	124	83	21	228	%
	54.4	36.4	9.2	(100.0)	
		MUSLIMS			
0-14	3	-	-	3	
15-24	-	1	-	1	
25-34	-	1	-	1	
35-44	-	1	-	1	
45+	-	-	1	1	
all	3	3	1	7	
				(100.0)	

Distribution of married women (Hindus)
by number of children (surviving)

	0	1	2	3	4	5+	Total	
15-24	5	3	3	-	2	-	13	(15.7)
25-34	5	4	8	3	6	5	31	(37.3)
35-44	-	1	1	3	3	13	21	(25.3)
45+	-	3	2	1	4	8	18	(21.7)
all ages	10	11	14	7	15	26	83	
	12.0	13.3	16.9	8.4	18.1	31.3	(100.0)	

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Table: 2 Distribution of women by marital status and age

Village: UKHILA

age group	marital status of woman unmarried	married	widowed	Total	
(1)	(2)	(3)	(4)	(5)	
		HINDUS			
0-14	11	-	-	11	(32.3)
15-24	5	3	-	8	(23.5)
25-34	-	7	-	7	(20.6)
35-44	-	3	1	4	(11.8)
45+	-	2	2	4	(11.8)
all ages	15 44.1	15 44.1	3 1.2	34 (100.0)	
		MUSLIMS			
0-14	281	-	-	281	(48.3)
15-24	32	46	1	79	(13.6)
25-34	-	90	6	96	(16.5)
35-44	-	39	11	50	(8.6)
45+	-	35	41	76	(13.0)
all ages	313 53.8	210 36.1	59 10.1	582*	

* 3 women with "divorce" status was not included

age group	Distribution of married women (Muslim) by number of children (surviving)						
	0	1	2	3	4	5+	TOtal
15-24	18	14	9	3	2	0	46(21.9)
25-34	5	9	9	13	24	30	90 (42.8)
35-44	3	4	3	3	8	18	39(18.6)
45+	1	5	6	8	3	12	35 (16.7)
all ages	27 12.9	32 15.2	27 12.9	27 12.9	37 17.6	60 28.5	210 (100.0)

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Table: 3 Distribution of women by marital status and age

Village: GAGANNATHPUR

age group (1)	marital status of women unmarried (2)	married (3)	widowed (4)	Total (5)
		MUSLIMS*		
0-14	251	-	-	251 (48.5)
15-24	26	46	-	72 (13.9)
25-34	-	77	3	80 (15.4)
35-44	-	35	7	42 (8.1)
45+	-	26	47	73 (14.1)
all	277	184	57	518
ages	53.5	35.5	11.0	(100.0)
		HINDUS		
0-14	19	-	-	19 (38.0)
15-24	10	3	-	13 (26.0)
25-34	2	6	-	8 (16.0)
35-44	-	4	-	4 (8.0)
45+	-	2	4	6 (12.0)
all	31	15	4	50
ages	62.0	30.0	8.00	(100.0)

* 2 Muslim women with 'divorce' status not included

age group	Distribution of married women (Muslim) by member of children (surviving)						
	0	1	2	3	4	5+	Total
15-24	5	12	13	3	1	1	35 (21.6)
25-34	1	7	13	22	13	17	73 (45.1)
35-44	2	1	0	1	11	16	31 (19.1)
45+	1	4	4	3	4	7	23 (14.2)
all	9	24	30	29	29	41	162*
ages	5.6	14.8	18.5	17.9	17.9	25.3	(100.0)

* No.of children of each one of 22 Muslim woman could not be precisely ascertained.

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Table:4. Distribution of women by marital status and age

Village: KUMARKHALI

age group (1)	marital status of women unmarried (2)	married (3)	widowed (4)	Total (5)	
		HINDUS			
0-14	159	-	-	159	(38.9)
15-24	34	32	-	66	(16.1)
25-34	3	80	1	84	(20.5)
35-44	1	33	3	37	(9.1)
45+	-	31	32	63	(15.4)
all	197	176	36	409	
ages	48.2	43.0	8.8	(100.0)	
		MUSLIMS*			
0-14	301	-	6	301	(51.3)
15-24	27	41	1	69	(11.7)
25-34	-	85	1	86	(14.7)
35-44	-	49	4	53	(9.0)
45+	-	26	52	78	(13.3)
all	328	201	58	587	
ages	55.9	34.2	9.9	(100.0)	

* 1 woman with 'divorce' status not included

Age group	Distribution of married women by number of children (surviving)							
	0	1	2	3	4	5+	Total	
			HINDUS					
15-24	11	15	5	1	0	0	32	(18.2)
25-34	7	19	22	15	9	8	80	(45.4)
35-44	1	3	2	6	6	15	33	(18.8)
45+	2	7	2	6	4	10	31	(17.6)
all	21	44	31	28	19	33	176	
ages	11.9	25.0	17.6	15.9	10.8	18.8	(100.0)	
			MUSLIMS					
15-24	12	13	10	4	2	0	41	(20.4)
25-34	6	6	7	15	28	23	85	(42,3)
35-44	2	1	5	9	7	25	49	(24.4)
45+	1	2	7	1	4	11	26	(12.9)
all	21	22	29	29	41	59	201	
ages	10.4	11.0	14.4	14.4	20.4	29.4	(100.0)	

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Table: 5. Distribution of women by merital status ad age

Village: KUSUMBA

age group	Marital satus of women Unmarriad	married	widowed	Total	
(1)	(2)	(3)	(4)	(5)	
		HINDUS			
0-14	128	-	-	128	(40.2)
15-24	38	14	-	52	(16.4)
25-34	2	57	1	60	(18.9)
35-44	-	23	6	29	(9.1)
45+	-	21	28	49	(15.4)
all	168	115	35	318	
ages	52.8	26.2	11.0	(100.0)	
		MUSLIMS*			
0-14	215	-	-	215	(52.6)
15-24	10	45	-	55	(13.4)
25-34	-	52	3	55	(13.4)
35-44	-	35	7	42	(10.3)
45+	-	12	30	42	(10.3)
all	225	144	40	409	
ages	55.0	35.2	9.8	(100.0)	

* 2 women with 'divoce'status not included

age group	Distribution of married women by number of children (survising)							
	0	1	2	3	4	5	Total	
			HINDUS					
15-24	6	3	2	3	0	0	14	(12.2)
25-34	1	8	16	14	11	7	57	(49.5)
35-44	0	0	3	3	3	14	23	(20.0)
45+	1	5	2	3	2	8	21	(18.3)
all	8	16	23	23	16	29	115	
ages	7.9	13.9	20.0	20.0	13.9	25.2	(100.0)	
			MUSLIMS					
15-24	10	12	13	7	1	2	45	(31.3)
25-34	2	7	6	7	14	16	52	(36.1)
35-44	0	5	2	5	3	20	35	(24.3)
45+	0	2	2	2	0	6	12	(8.3)
all	12	26	23	21	18	44	144	
ages	8.3	18.1	16.0	14.6	12.5	30.5	(100.0)	

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Table 6: Distribution of women by marital status and age

Village: HOGALKURLA

age group	marital status of women			Total	
	unmarried	married	widowed		
(1)	(2)	(3)	(4)	(5)	
		HINDUS			
0-14	188	1	-	189	(49.9)
15-24	15	36	-	51	(13.4)
25-34	-	42	4	46	(12.1)
35-44	-	37	5	42	(11.1)
45+	-	29	22	51	(13.5)
all	203	145	31	379	
ages	53.6	38.2	8.2	(100.0)	
		CHRISTIANS			
0-14	71	-	-	71	(48.3)
15-24	16	11	-	27	(18.4)
25-34	1	17	-	18	(12.2)
35-44	-	16	-	16	(10.9)
45+	-	9	6	15	(10.2)
all	88	53	6	147	
ages	59.9	36.0	4.1	(100.0)	

age group	Distribution of married women by number of children (surviving)							
	0	1	2	3	4	5+	Total	
		HINDUS						
0-14	0	1	0	0	0	0	1	(0.7)
15-24	16	12	4	3	1	0	36	(24.8)
25-34	3	3	4	13	10	10	43	(29.7)
35-44	1	0	5	2	13	14	35	(24.1)
45+	6	6	4	2	3	9	30	(20.7)
all	26	22	17	20	27	33	145	
ages	17.9	15.2	11.7	13.8	18.6	22.8	(100.0)	
		CHRISTIANS						
15-24	4	2	1	1	2	0	10	(18.9
25-34	0	1	2	6	5	4	18	(33.9
35-44	0	1	1	0	6	7	15	(28.3
45+	0	2	1	3	2	2	10	(18.9
all	4	6	5	10	15	13	53	
ages	7.6	11.3	9.4	18.9	28.3	24.5	(100.0)	

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Table: 7 Distribution of women by marital status and age

Village: JAYENPUR

age group (1)	marital status of women unmarried (2)	married (3)	widowed (4)	Total (5)	
	HINDUS				
0-14	79	-	-	79	(43.9)
15-24	9	20	-	29	(16.1)
25-34	-	26	-	26	(14.4)
35-44	-	16	2	18	(10.0)
45+	-	5	23	28	(15.6)
all ages	88	67	25	180	
	48.9	37.2	13.9	(100.0)	
	MUSLIMS				
0-14	37	-	-	37	(49.4)
15-24	3	7	-	10	(13.3)
25-34	-	10	-	10	(13.3)
35-44	-	4	3	7	(9.3)
45+	-	7	4	11	(14.7)
all ages	40	28	7	75	
	53.3	37.3	9.4	(100.0)	

Note: 3 Christian women were also found in the village

age Group	Distribution of married women (Hindu) by number of children (servining)							
	0	1	2	3	4	5+	Total	
15-24	11	3	4	2	0	0	20	(29.8)
25-34	1	1	6	6	6	5	25	(37.3)
35-44	0	2	2	4	4	5	17	(25.4)
45+	0	2	0	1	2	0	5	(7.5)
all ages	12	8	12	13	12	10	67	
	17.9	12.0	17.9	19.4	17.9	14.9	(100.0)	

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Table : 8. Distribution of women by marital status and age

Village: RAMCHANDRAPUR

age group (1)	marital status of women unmarried (2)	married (3)	widowed (4)	Total (5)	
		HINDUS*			
0-14	212	-	-	212	(49.4)
15-24	36	37	1	74	(17.2)
25-34	1	48	4	53	(12.4)
35-44	-	27	7	34	(7.9)
45+	-	25	31	56	(13.1)
all ages	249	137	43	429	
	58.1	31.9	10.0	(100.0)	
		MUSLIMS			
0-14	56	-	-	56	(50.9)
15-24	7	12	-	19	(17.3)
25-34	-	11	-	11	(10.0)
35-44	-	7	4	11	(10.0)
45+	-	7	6	13	(11.8)
all ages	63	37	10	110	
	57.3	33.6	9.1	(100.0)	

* 1 Hindu woman with 'divorce'status not included

age group	Distribution of married women (Hindu) by number of children (surviving)							
	0	1	2	3	4	5+	Total	
0-14	1	-	-	-	-	-	1	(0.7)
15-24	11	10	8	7	0	0	36	(26.3)
25-34	2	4	5	12	12	13	48	(35.0)
35-44	0	1	1	3	4	18	27	(19.7)
45+	3	2	3	6	2	9	25	(18.3)
all ages	17	17	17	28	18	40	137	
	12.4	12.4	12.4	20.4	13.2	29.2	(100.0)	

pa:

Table:9. Distribution of women by maritalm status agd age
Village: ELACHI

age group (1)	marital status of woman unmarried (2)	married (3)	widowed (4)	Total (5)	
		HINDUS*			
0-14	235	-	-	235	(38.3)
15-24	67	54	-	121	(19.7)
25-34	5	100	7	112	(18.3)
35-44	1	38	7	46	(7.5)
45+	1	44	54	99	(16.2)
all	309	236	68	613	
ages	50.4	38.5	11.1	(100.0)	
		MUSLIMS*			
0-14	105	-	-	105	(53.3)
15-24	4	28	-	32	(16.2)
25-34	-	21	-	21	(10.7)
35-44	-	15	5	20	(10.1)
45+	-	10	9	19	(9.7)
all	109	74	14	197	
ages	55.3	37.6	7.1	(100.0)	

* 1 Hindu woman and 4 muslim women with 'divorce'status not included

age group	Distribution of married women by number of children (surviving) 0	1	2	3	4	5+	Total	
			HINDUS					
15-24	11	24	9	6	1	2	53	(22.4)
25-34	10	27	23	15	11	15	101	(42.8)
35-44	2	3	2	7	9	15	38	(16.1)
45+	3	10	6	5	5	15	44	(18.7)
all	26	64	40	33	26	47	236	
ages	11.0	27.1	17.0	14.0	11.0	19.9	(100.0)	
			MUSLIMS					
15-24	5	10	8	2	1	2	28	(37.8)
25-34	1	0	3	4	7	6	21	(28.4)
35-44	0	1	2	0	2	10	15	(20.3)
45+	0	0	1	0	1	8	10	(13.5)
all	6	11	14	6	11	26	74	
ages	8.1	14.9	18.9	8.1	14.9	35.1	(100.0)	

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Table: 10. Distribution of women by marital status and age

Village: DINGELPOTA

age-group	marital status of women			Total	
	unmarried	married	wieowed		
(1)	(2)	(3)	(4)	(5)	
		HINDUS*			
0-14	200	-	-	200	(14.0)
15-24	27	31	-	58	(13.6)
25-34	-	53	3	56	(13.1)
35-44	-	34	8	42	(9.9)
45+	-	27	43	70	(16.4)
all	227	145	54	426	
ages	53.3	34.0	12.7	(100.0)	

* 2 Hindu women with 'divorce' status not included

Note: 2 christian women were recorded in the village.

Age-group	Distribution of married women (hindu) by number of children (surviving)							
	0	1	2	3	4	5+	Total	
15-24	10	12	3	4	2	0	31	(21.4)
25-34	2	4	11	7	10	19	53	(36.6)
35-44	0	2	2	4	9	17	34	(23.4)
45+	1	2	4	3	4	13	27	(18.6)
all	13	20	20	18	25	49	145	
ages	9.0	13.8	13.8	12.4	17.2	33.8	(100.0)	

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Table 11: Distribution of women by marital status and age

Village; JAGADDAL

age-group (1)	marital status of women: unmarried (2)	married (3)	widowed (4)	Total (5)	
		HINDUS			
0-14	358	1	-	359	(40.1)
15-24	121	65	-	186	(20.7)
25-34	15	103	1	119	(13.3)
35-44	1	90	7	98	(10.9)
45+	-	56	78	134	(15.0)
all ages	495	315	86	896	
	55.2	35.2	9.6	(100.0)	

Note: 4 Muslim women were recorded in the village.

age-group	Distribution of married women (Hindu) by number of children (surviving)							
	0	1	2	3	4	5+	Total	
0-14	1	0	0	0	0	0	1	(0.3)
15-24	18	23	17	6	0	0	64	(20.3)
25-34	7	13	17	33	17	19	106	(33.6)
35-44	2	8	3	19	16	42	90	(28.6)
45+	1	7	7	10	7	22	54	(17.2)
all ages	29	51	44	68	40	83	315	
	9.2	16.2	14.0	21.6	12.7	26.3	(100.0)	

pa:

Table: 12. Disrribution of women by marital status and age

Village: GHOWHATI

age-group (1)	marital status of women unmarried (2)	married (3)	widowed (4)	Total (5)	
		HINDUS			
0-14	650	-	-	650	(42.1)
15-24	165	149	4	315	(20.4)
25-34	3	166	-	169	(11.0)
35-44	-	132	12	144	(9.3)
45+	2	120	143	265	(17.2)
all	820	567	156	1543*	
ages	53.1	36.8	10.1	(100.0)	

* 4 Hindu women with 'divorce'status not included

	MUSLIMS				
0-14	17	-	-	17	(53.1)
15-24	-	3	1	4	(12.5)
25-34	-	5	-	5	(15.6)
35-44	-	1	1	2	(6.3)
45+	-	1	3	4	(12.5)
all	17	10	5	32	
ages	53.1	31.2	15.7	(100.0)	

age-group	Distribution of married women (Hindu) by number of children (surviving)							
	0	1	2	3	4	5+	Total	
15-24	35	69	33	12	4	1	154	(27.2)
25-34	9	16	33	39	38	34	169	(29.8)
35-44	4	7	11	24	27	51	124	(21.9)
45+	8	15	20	14	26	37	120	(21.1)
all	56	107	97	89	95	123	567	
ages	9.9	18.9	17.7	15.7	16.7	21.7	(100.0)	

pa:

Table 8 : Distribution of women in child-bearing ages by community/caste over 13 sample villages, Sonarpur P.S., 24-Parganas District, 1974.

Community/ Caste	Women in child-bearing ages 15-24	25-34	35-44	Total	Total females in the habitat
(1)	(2)	(3)	(4)	(5)	(6)
			1. Kischintapur		
HINDU	39	33	24	96	226
MUSLIM	1	2	1	4	7
Total	40 (40.0)	35 (35.0)	25 (25.0)	100 (100.0)	235
			2. Ukhila		
HINDU	8	7	4	19	34
MUSLIM	80	96	51	227	585
Total	88 (35.8)	103 (41.9)	55 (22.3)	246 (100.0)	619
			3. Jagannathpur		
HINDU	13	8	4	25	50
MUSLIM	72	82	42	196	520
Total	85 (38.5)	90 (40.7)	46 (20.8)	221 (100.0)	570
			4. Kumarkhali		
HINDU	65	83	39	187	409
MUSLIM	70	91	54	215	586
Total	135 (33.6)	174 (43.3)	93 (23.1)	402 (100.0)	995
			5. Kusumba		
HINDU	54	58	32	144	318
MUSLIM	69	59	42	170	411
Total	123 (39.2)	117 (37.3)	74 (23.5)	314	729
			6. Mondalkuria		
HINDU	51	46	40	137	379
CHRISTIAN	27	18	16	61	147
Total	78 (39.4)	64 (32.3)	56 (28.3)	198 (100.0)	526

Table C :

		7. Jayenpur			
HINDU	32	25	19	76	180
MUSLIM	10	10	7	27	75
CHRISTIAN	0	0	1	1	3
Total	42 (40.4)	35 (33.6)	27 (26.0)	104 (100.0)	258
		8. Ramchandrapur			
HINDU	74	57	32	163	430
MUSLIM	19	11	11	41	110
Total	93 (45.6)	68 (33.3)	43 (21.1)	204 (100.0)	540
		9. Kiachi			
HINDU	122	113	46	281	614
MUSLIM	33	23	20	76	201
Total	155 (43.4)	136 (38.1)	66 (18.5)	357 (100.0)	815
		10. Hingelpota			
HINDU	59	55	41	155	428
CHRISTIAN	0	0	0	0	2
Total	59	55	41	155 (100.0)	430
		11. Jayaddal			
HINDU	184	122	99	405	896
MUSLIM	1	0	1	2	4
Total	185 (45.4)	122 (30.0)	90 (24.6)	407 (100.0)	
		12. Chauhati			
HINDU	319	177	151	647	1547
MUSLIM	4	5	2	11	32
Total	323 (49.9)	182 (27.6)	153 (22.5)	658 (100.0)	1579
		13. Ban Hugli			
HINDU	124	107	108	339	871
MUSLIM	147	139	87	373	1039
CHRISTIAN	22	13	22	57	146
Total	293 (38.1)	259 (33.7)	217 (28.2)	769 (100.0)	2056

(1A)

WH-13.10

TOTAL HEALTH CARE PROJECT, 1974-75

Report on Socio-demographic Survey

Carried out in 13 villages and Semi-urban x
Settlements of Sonarpur P.S., 24- Parganas,
West Bengal, 1974.

INDEX REPORT :

(February 1975)

[Second Copy]

PREAMBLE :

1. Bio-Social interest in the study of fertility and its immediate impact on rapid population increases is growing faster. But for the staggering 'additions' to the population-reservoir of the country each year the peoples at large are being exposed to rising stress and strain both within and without family and/ or community life. On the other hand, immediate concern for poor health, poverty and mortality (especially that of infants) is also parallely mounting up in the society. As the general welfare of the population and the socio-economic conditions under which it lives cannot be considered independently one has to pay increasing attention to both quantitative and qualitative characteristics of population. This is more true with respect to various social groups constituting a population in any locality. Thus problems of fertility and population growth should not be examined without any reference to the state of health of the people under examination. The importance of health as a medico-demographic variable is obvious and it has to be accepted as an important element in all other basic population functions, including reproduction, survival, agricultural and industrial production, and the achievement of cultural and social goal.

To keep the continuity of the family line, the responsible couples have to procreate and in this respect social codes of conduct governing family - building attitude and and actions cannot easily be neglected by the couples concerned. Naturally, the issues of fertility and its control have to be examined in tune with the prevailing social codes of conduct governing Family living in any community under consideration. On the other hand, poverty, malnutrition and

impaired health reign high in general amidst population of the country. Hopelessly poverty is making people imprudent and reckless to burden themselves with a family and again, the same poverty is causing ill-health and diseases. With no or little education and family wealth the couples at large are forced to adjust continuingly with the fortunes and miseries of daily life and living. In the very process of adjustment their total behaviour - pattern -cultural, economic and psychological- gets naturally entangled in the volutions caused by various forms of social interactions. The very way of life with which the people are accustomed for generations becomes gradually exposed under what is known as 'modernization complex' of the time.

Lately it has been increasingly felt by the social scientists, medical health workers, family planning welfare administrations that family planning activities should not be pursued as an independent issue. Rather , family planning activities have to be dovetailed with health planning measures in reaping the better divided. More family oriented health care measures would be flowing among the people, more they would become cousious as well as active in paying heed to the need for family planning welfare developments. It has been assumed that with better health and lesser physical impairments the utter ~~indifference~~ in-difference of the couples towards various birth planning measures would tend to diminish.

Rural health centres and hospitals are coming up steadily in many areas where common medical facilities are lacking miserably. Local people are slowly being attracted by these centers for medical dispension and they are being exposed by degrees to expert advices, social cooperation, economic benefits and most importantly, to a new pattern of interactions. From a narrower, parochial bound of world view the rural peoples are more and more drawn nearer to a wider social context through these health centres and hospitals.

It may reasonably be expected that they are becoming gradually not only health conscious but also welfare conscious while interacting with the physicions, para medical personnel and other fellow rural-bred visitors of the Centres.

THE PROJECT UNDERTAKEN

Keeping the above propositions in mind an attempt was made to examine the following issues among the local people residing in and around Rajpur town of Sonarpur police station, 24-Parganas district. This town is the only urban settlement of the given police station and it possess three hospitals and health centres. One of the hospitals is located right in one of eight sections of the town, namely, Elachi. Basing Elachi as the starting point, a comprehensive survey-plan was envisaged to collect relevant facts and figures pertaining to the given issues on the basis of family-information:

a) To what extent the people are taking basic health services from the local hospital?

b) For what particular kind of diseases or physical ailments the people are prompted to seek. hospital service?

c) What is the prevailing concept about occurence of a disease?

d) Do the people seek hospital treatment invariably?

e) In what environmental sanitation condition the people are used to live?

f) What form of treatment to care a disease is generally pursued by the people?

g) What kind of family planning measures is followed by the couples?

h) If, tubectomy and vasectomy are at all accepted by the couples?

Necessary family-based information is being collected by canvassing a specific Family Schedule: "Family Schedule for Basic Health Services"

To precede the work with 'Family Schedule for Basic Health Services', endeavour had been made to collect basic socio-demographic particulars of the families subjected to the present study. For this a detailed schedule entitled "Preliminary Census" had been put into operation. In this schedule the following items of information have been collected from each and every family residing in the rural or semi-urban settlements chosen for study:

i) composition of family by sex, age. Year of birth, relation with head of household

ii) Civil condition of members

iii) Occupational status of members

iv) Main and subsidiary means of livelihood of members

v) Caste/Community affiliation of family

vi) Indentification-particulars of each village by name, municipal/panchayat affiliation, police station and District.

Information received through the schedule of "Preliminary Census" is imperative to identify the families by its (a) Type (b) social affiliation, (c) religion affiliation (d) occupational affiliation and (e) educational achievement. More over, from this schedule the basic ~~socio-econo~~ Socioeconomic information about the people under study is obtained and such information is sin qua non for understanding the core social structure of the people. Since society and population are interwoven, primary socio-cultural characteristics of the people under study is essential in reflecting upon the behaviour of each population-aggregate classified by caste/community (religion), occupation, education, or family composition with respect to physical health care as well as family planning activity or both together.

3. OBJECTIVES OF THE STUDY:

The objectives with which the present project has been undertaken are as follows:

I. To study the interconnectedness between general health care measures. ~~mm~~ and family planning activities among rural families of West Bengal.

II. To examine the nature and extent of traditional concept of disease and its treatment in the immediate back ground of modern medical facilities available from a hospital.

III. To consider the relationship between level of family health, family size and socioeconomic status:

4. SELECTION OF VILLAGES:

As said earlier, Elachi, a component of the muncipality town of Rajpur, serves as the base of the field survey undertaken. Taking Elachi as centre which is accommodating Amiya devi charitable Hospital since mid- 1960s' selection of villages and semi-urban villages had been made from within 5 miles. These human settlements were so chosen that they would form a compact but continuous block and again, they were within easy reach of the Hospital. Strictly speaking, selection of villages was not random in nature and statistically these villages do not stand to represent the general characteristics of the local residents of 24-parganas district as a whole. Selection procedure was, in fact, purposeful to satisfy the pilot study envisaged. The villages which were chosen for the purpose of the present endeavour and which were completely enumerated have hereafter been described in details in the next Section2. . This much is stated here that in total 13 rural and semi-urban habitats situated in close distance from Elachi were enumerated. All these settlements are located near the

fringe of the small town of Rajpur. Moreover, considering time, field cost and local facilities available for any survey the present method in the choice of the villages had to be followed. Since the study is pilot in character no attempt was immediately made to go for a proper statistical design in chosing the villages concerned. The present study would really represent a type study which has hardly been undertaken in the State. Nevertheless, the findings of the survey are expected to bring out such information as would be useful to offer a frame for future research in this line in the given locality.

Section :2

INTRODUCING THE SURVEY AREA :

The Survey was conducted in 13 villages located in Sonarpur Police Station under Sadar Sub-divison of 24-Parganas district. Sonarpur is one of fourteen police stations which delineate the boundaries of the Sadar Sub-division. Sonarpur police station with 98 inhabited villages covers 65.9 sq. miles and of this area the rural part explains as good as 57.8 sq. miles. In 1961 Census total population under Sonarpur P.S. was recorded to be 133, 324 (rural population being 108, 512). The urban part falling in this police station is accounted only by Rajpur town which extends over 8.1 sq.miles.

Rajpur town is situated on the road from Calcutta to Kulpi, 11 miles south of Calcutta. The town constitutes a municipality with eight sections namely, (i) Rajpur, (ii) Harinavi (J.L.No. 56) (iii) Kodalia (J.L. 55), (iv) Changripota, (v) Malancha (J.L. 78), (vi) Mahinagar (j.L.79), (vii) Elachi (J.L.70) and (viii) Jagadal (J.L. 71). Taking Elachi as the starting centre the present survey ~~we~~ were carried out in 1974 by six investigators in the following villages:

1. Kumarkhali (J.L. 48) - The village covers 378.34 ~~acres~~ acres and was inhabited by 2143 persons (1961) census). This habitat is provided with electricity and it is, in fact, a semi - urban settlement. The 1961 census shows that this settlement encompassed 280 houses with 213 households. Total population was 2143 (males: 1245/females: 898/ sex ratio: 138·6). Of these persons only 659 were literates (males: 531) and total workers were 1039 (~~5~~) In 1951 Census count population of this village was 1727.

2. Kusumba (J.L. 50) - The village extends over 359.31 acres with 1708 persons (1961). In 1951 census population of the village was shown to be only 943. In the village 245 houses and 245 households were found in 1961 Census. Out of total 1708 persons the males were 982 and sexratio was 135.3 and the number of literates were 445 (males: 355). In the total population 699 persons were returned as workers (males:590).

3. Jagannathpur(J.L. 51): Spreding over 202.1 acres area the village had 880 persons in 1961, but in 1951 census population of the village was only 441. Within a decade the village registered a stagerring population growth. It became almost doubled. Such high order of population increase within only ten years is, indeed, extremely striking. Of the total 880 persons the males explained as good as 487 soules, the sexratio being 123.9. The village was constituted by 129 occupied residential houses with the same number of households in 1961. Total literates were 156 (males: 127) in the population, where as total number of workers of all cotegories was 347 in the last 1961 census count.

4. Nischintapur(J.L. 53.) This is one of the small villages of the local area encompassing only 120.1 acres. Population of the village was 357 in 1961 census count, while in 1951 census the same was 329. Of the total 357 persons the males accounted for 191 (sexratio: 115.1). The village had in 1961 seventy eight occupied residential houses with 62 households. In the total population the number of literates was 73 (males: 59) and the number of workers was 78 (males:77). No primary school was recorded in the village in 1961 census.

5. Ukhila Paikpara (J.L. 56): Extending over 458.3 acres this village was constituted by 1512 persons in 1961 and 613 persons in 1951. In the census decode of 1951-61 the population did increase significantly. Population gorwth was more than double in the village. This feature has its own importance in explaining the nature of increasing density in the village. In 1961 census this semi-urban settlement was shown to possess a primary school , a post office and electricity. In possessing these institutions offering 'modern' facilities Ukhila stands uniquely distinguished from the neighbouring rural settlements. Of the total 1512 persons of this semi-urban habital the males alone accounted for 1124 souls, the sexratio being 289.7. In the present settlement 158 occupied houses with 187 households were noted in 1961 census. Total literates and workers were 904 and 407 respectively in the population.

The above 3 villages and 2 semi-urban settlements are situated on the northern margin of Rajpur town and they form a continuous compact area. Villages Jagannathpur and Nischintapur and the Semi - urban settlement of Ukhila Paikpara are just on the immediate fringe of northern boundary of the town, while villages Kumarkhali and Kasumba are contiguous with northern limits of Jagannathpur and Ukhila. The said compact block of villages and semi-urban settlements covers 1518 acres and 6600 persons. This geographical block of habitats stands separated from the second continuous compact block of villages and urban segments of Rajpur town by a distinct spatial gap. The undernoted villages and urban segments are situated in west and south of the marches of the town. Urban habitat of Rajpur comes in between the said two compact blocks of human settlements under survey.

All the villages, semi - Urban villages and urban segments which were investigated are, thus, within immediate focus of Rajpur town, the only urban area of Sonarpur police station.

6. Ramchandrapur (J.L. 58): This village covers an area of 398.33 acres. In 1961 census the settlement was reported to have 100 occupied residential houses and 128 households. Population was 705, the males being 358. Sex ratio was 103'2. In the decade of 1951-61 the rural habitat experienced a sizable increase in population, since in 1951 census only 481 persons were shown. The village possessed a primary school and the number of literates was 243 in 1961. Total number of workers was 204. Male literates and male workers were 179 and 181 respectively. Geographically this habitat is just on the western marches of Rajpur municipality town. Its eastern boundary marches with the urban boundary and there by it is within closest influence of Rajpur town. Along with Dingelpota village (J.L. 69) the village demarcates the western margin of the town.

7. Bon Hugli (J.L. 65): This settlement is one of largest habitats of Sonarpur police station. But among the villages, and semi-urban villages under survey Bon Hugli happens to be the largest one with 948.47 acres in area. This particular habitat possessed a primary school as well as a post office in 1961. It is situated in the near west of Rajpur town. Population of this large settlement was recorded to be 3851 in 1961 and 2630 in 1951 census. Of the total population of 3851 the males were 2018 in number, sexratio being 110·1 in 1961. Total number of literates and workers was 808 and 1101 respectively. Male literates were 646 and male workers numbered 990. In the village 696 occupied residential houses with 664 households were found in 1961 census count.

8. Jayenpur (J.L. 66): This village is just on the eastern side of Ban Hugli and is separated from Rajpur town by Dingelpota village. It covers 252.2. ~~acres~~ acres and prosessed only 425 persons in 1961. In 1951 census population of the habitat was 316 only. Of the total 425 persons the males were 212 in number (sexratio was 99·5). In the village only 75 occupied residential houses with 66 households were found in 1961 census. Number of literates and workers was 95 and 100 ~~xxkx~~ respectively. Among the literates male persons were 75, but not a ~~single~~ female workers was recorded in 1961 census count.

9. Hagolkuria (J.L. 67): This village with 277-4 ~~acres~~ acres in area had 118 occupied houses and 156 households in 1961. Population was counted to be 905 which showed definite increases over the figure of 626 recorded in 1951 census. This settlement is located in the west of Rajpur town and is ~~xxxx~~ separated from the urban area by two other adjoining villages. Of the total population of 905 the males accounted for 466 ~~sqls~~ souls, sexratio being 106·2 . In the village only 92 literates (males: 84) were found in 1961 census. Total number of workers was 240 and of this only 3 female workers were noted.

10. Dingelpota (J.L. 69:) This village lies just on the western marches of Rajpur town. Geographically it is contiguous with the urban settlement. It has 220.9 ~~acres~~ acres in area with 112 occupied houses and ~~22~~ 112 households. In 1961 census population of the habitat was found to be 633 the males being 321 in number. Sexratio was thus 1079. In 1951 census population was only 495. Number of literates and workers was 160 (males: 133) and 153 (males: 149) respectively in the village. A primary school was reported for the village in 1961 census.

11.Chauhati (J.L. 76): This is the second largest village among all the surveyed habitats with 355.0 ~~acres~~ acres in area. It is situated just on southern side of Rajpur town and is spatially continuous with the said urban settlement. The village was reported to possess three primary schools and a post office, but no electricity in 1961 census. The village had 740 occupied residential houses and 552 households. In 1961 population was 2979, the males being 1534 in number. Sexratio was thus 106.2 . But in 1951 census population was enumerated to be 2022. Within a decade a sizable addition to the village population is noticed. Number of literates in the habitat was 1372 (males: 873): Number of workers was 726 (males: 577). Chauhati is a ~~family~~ fairly populated settlement having close link with Rajpur town.

12. Elachi(J.L. 70): Some years back this was a rural settlement having a J.L. number. Both in 1951 and 1961 census counts this settlement was recorded as an "uninhabited" area. In fact this settlement had already been included as an integral section of the urban settlement of Rajpur municipality town. Its population had been counted along with the urban population of Rajpur in 1961. Separate information on any socioeconomic items is, thus, not available. Rural characteristics of Elachi do not exist any longer . Rather, being a part of urban area of Rajpur, Elachi has now turned to be a non-rural habitat. In the total area of Rajpur town (8.1 sq. mile) the section of Elachi ~~xxxxxx~~ contributes only 445.14 ~~acres~~ acres. In the present survey Elachi served as the centre of field operation. Demographic and socioeconomic information about the residents of Elachi have been collected separately to compare with the rest.By census definition Elachi is an urban settlement, but in the present survey Elachi was treated as a semi-urban Village.

13. Jagaddal (J.L. 71:) In 1951 census this settlement was shown to be a rural one having 3030 persons over 583.22 ~~acres~~. In 1961 census Jagaddal was shwon to be an integral portion of Rajpur town. As one of eight sections of Rajpur municipality this settlement had lost its rural affiliation Eventually separate information of any demographic or socio-economic items was note recorded in 1961 census Charactistics of the residents of Jagaddal had been merged with those of the urban dwellers of Rajpur town. But for the present survey Jagaddal had been examined as a semi-urban village, the residents of which were identificed on the other day with rural population of Sonarpur police station.

The above five villages (serial no. 6 to 10) form the second compact and continuous block. This block of rural settlements lie in the west of Rajpur town. This block is separated from the first block of five villages (serial no. 1 to 5) (that is in the north of the town) by a metalled road connecting Rajpur with Tollygunge police station (outside Calcutta city) of the same Sadar sub-division. In contrast with these two compact blocks of villages, a third block is the/to encompass village Chanhati. semi-urban settlement of Elachi and semi-urban settlement of Jagaddal. Village Chanhati lies just in south of Rajpur town, while Elachi and Jagaddal are right within the municipality area of Rajpur. Thus, we have schematically three distinct blocks of villages and semi-urban settlements in and around the only urban area of Sonarpur police station, namely, Rajpur town. The second block of western villages as a whole cover an area of 2097.2 acres and possessed 5519 persons in 1961. The first block of northern villages as a whole cover, as shown earlier, a lesser area (1518 acres) than that of the second one, ~~left~~ but encompassed a little higher number of persons (6600). Thus, with respect to (a)

(a) spatial coverage and (b) population strength the two blocks of villages and semi-urban settlements in question are found not to very much. For the third block comprising souther village of choutati, Elachi and Jagaddal sections of Rajpur town this much can be said that they together cover only 1384.2 acres, in area. Except for Chauhati's population figure nothing specific about total persons inhabitation Elachi or Jagaddal is known from 1961 census. But in the present survey population count for both Elachi and Jagaddal has been made separately.

This keeping Rajpur town in the centre the schematic pattern of three blocks of villages and semi urban villages which have been surveyed in 1974 is outlined below.

A) BLOCK I: NORTHERN VILLAGES: 1. Kumarkhali, 2.Kusumba, 3.Jagannathpur, 4. Nischintapur and 5. Ukhila Paikpara.

B) BLOCK II: WESTERN VILLAGES: 1. Ramchandrapur, 2. Bannugli, 3. Jagannpur, 4. Hogalkuria, and 5. Dingelpota.

C) BLOCK III: SOUTHERN VILLAGES and URBAN SECTIONS:
1. Chauhati village, 2. Elachi section of Rajpur town and 3. Jagaddal section of Rajpur town.

This is to be particulary noted here that the present survey operation was conducted with Elachi as the focal point. As a matter of fact, Elachi serves a vital role in the locality of Rajpur and its neighbouring villages in possessing a hospital (Amiya Devi Charitable Hospital). Medical and social services rendered by this hospital are reaching the ruralites and urbanites of Sonarpur police station in a significant way. In order to find out the extent and magnitude of their impact of such services the present Total Health care project has been undertaken. At the very outset attempt has been made to know the bio-social characteristics of the local people through house to house enquiry. In the second attempt household survey has been started

to assess the level of health and family planning consciousness of the local villagers and urban dwellers. Sociodemographic Survey of the given villages and semi- urban settlements had already been completed. Preliminary analysis have been carried out to sift out biosocial characteristics of the dwellers of each of 13 villages and semi-urban ~~in~~ villages. These analyses help significantly to learn in what way and how the people under survey vary among themselves from one settlement to another. The findings of analysis which have been discussed hereafter help build a reference frame of the people of the locality. With this frame in mind newer enquiry may be undertaken to probe into any particular problems of the villagers of lower West Bengal.

It should be noted that the present study is a pilot one and this tries to protrayl the basic biosocial make-up of the villagers who are day in and day out exposed to urban influences. Rajpur town is only 11 miles from Calcutta and eventually it is not at all free from urban exposures.

Section : 3

THE VILLAGES AND THE PEOPLE : A SOCIO-DEMOGRAPHIC PROFILE

In the present survey in all 21504 persons were enumerated from the given 13 villges and semi-urban settlements of Sonarpur p.s. of this population as good as 52 percent were explained by the males only. Dominance of the males is quite district. This feature is no new development in the context of the country as a whole where in 1971 census the sex ratio (females per 1000 males) turns out to be 930. In 1961 census Sonarpur P.S. was shown to possess 57530 males against 50982 females. Excess of males in the state or 24-parganas district or even in the police station is continuing still. Its reflection is evident in the present data.

Taking individual village's figure it is immediately noticed that the villages of Nischintapur, Kumarkhali and Elach, Dingelpota possessed respectively higher proportion of the males than the over-all average of 52 per cent. In contrast, the village Ramchandrapur showed less dominance of the males (49%). This is the only village under survey where the females were in excess. For the remaining villages and semi-urban settlements the proportions of males were found to be more or less same to that of the general average. Elachi is though a part of urban Rajpur its population is not characterised by any extraordinary male excess.

On average 5.9 persons (males: 3.1) are found per household. Out of the given settlements the following show higher average number of persons per household: (1) Nischintapur (6.5), (2) Jagannathpur (6.2), (3) Jagaddal (6.3), (4) Hogolkuria (6.0), (5) Ramchandrapur (6.0), and (6) Ban Hugli (6.0). Of these six villages and semi-urban village Nischintapur stands urique. Only 78 households were found here and these together contributed the highest average number of persons per household .

In contrast, Ukhila which has been treated as a semi-urban settlement presented the lowest average number of persons per house hold (5.4). Elachi was found to possess on average 5.7 persons per household. Such variation in average number of persons per household between the given habitats is a ready indicator of the state of development in population of the area. The above features would be more clearly understood from the Table A.

Now a look into the age. structure of the persons under study reveals clearly that the infants (0-4) years) and the children (5-14 years) together accounted for as high as 44. per cent of total population. Such a high figure for unproducti segment of the population evokes immediate interest. In 1971 census the infants and children group together explained 42.55 percent of total population of India. In this context, the given population of Sonarpur police station has not of course differed much from all -India estimate in having a higher load of uneconomic dependents in 1974. Table B indicates the detailed pattern of distribution of the enumerated population by age and sex.

In this context attention is drawn to village Mogalkuria and Ban Mugli. In the former village the infants and children constituted 48.3 percent of total population, while in the latter one the same explained 47.5 percent. In any village where the infants and children happen to acount for a little less than half of total inhabitants, the demograp ic situation seems to be alarming. Elachi was found was to have 42 infants and children out of every 100 persons. In contrast Jageddal, the second integral part of Rajpur town happened to show only 38 infants and children out of every 100 persons. This Jageddal settlement registered the minimum concentration of 'unproductive' population and for this single feature it stands distinguished from the rest.

Now as for as only the infant population (0-5 years:) is concerned, village Kusumba registered the highest

concentration (15 per 100 persons) among all. Next to this village comes village Ramchandrapur (14.3 %), Bonhugli (14.0%). It appears that the couples of these settlements have a fertility behaviour which differ from those of the rest, especially of village Mischintapur (8.5%) or Jagaddal (9.3%). Strength of infant population in the total population of Khachi was in the order of 11.5%. only, but in Jaggadal the same was still lower (9.3%).

In total population among only the infants 10-5 years) the sex ratio is 101.2 and and this is not on high side. But in Khachi sexratio among the infant population only is found to be 128.8 while in Jagaddal the same is 111.9. In village Kusumba sexratio comes to 101.8, where as in village Mischintapur the same happens to be 115.0. In spite of noticable differences in the concentration of the males in total population or of the infants and children per 100 persons among the surveyed villages and semi-urban settlements, it is interestingly found from Table 8 that as good as 43 out of every 100 households had the medium size having 4 to 6 persons of all ages and sexes. Small households (1-3 persons) concentrated in little less than one-fifth cases. Very large households having 10 and more persons accounted for 9% only. The modal size of the households under survey is, thus, explained not more than 6 persons.

This general characteristic of household size is certainly not uniform over the given settlements. Immediate attention is drawn by the village Ukhila in possessing relatively highest concentration (27% 27.5%). of small families (1-3 persons). This proportion is 8 points above the general average (19.4%). On the other extreme Mischintapur village marked relatively the lowest concentration of small families (12.8%). This proportion is about 7 points below the general average. Khachi had a fairly good concentration of small families (22.0%) , where as in Jaggadal the concentration of the same sized households is still

still lower (13.8%). As far as the concentration of only medium sized households is concerned it is found that the village Jayenpur topped the list in possessing 54% and next to it comes village Kusumba (50.0%). But in village Dingelpota the same sized households were formed relatively in the lowest strength (39.1%). On the other hand, village Mischintapur showed the highest concentration of very large households (12.9%), but in contrast village Kusumba had relatively the lowest concentration (6.2%) In this respect village Umila (6.3%). comes very near to Kusumba.

This much can be stated that among the population under survey the medium sized households (4-6 persons) were singularly conspicuous and this was evident in 8 out of 13 villages and semi urban settlements. Concentration of only the small sized household (1-3 persons) was very distinct in 7 out of all the given habitats. Formation of only the very large sized households (10+persons) was relatively more than the general average in 6 out all the settlements in question. As far as large sized households (7-9 persons) are concerned they were found in 28 out 100 cases. Dingelpota village showed relatively the highest concetration of such households (34.0%), whereas village Jayenpur marked the lowest concentration (17.5%). The villages under reference are multi-caste and multi-community in character. Hindus of middle and low castes are scattered over the villages in varying strength. Of the total Hindus population (21504) the low caste people form the most dominant group (7058 persons) and then comes the High caste people (3452 persons). But as a single social group the Muslims form the biggest cluster with 7465 persons. The strength of the Christians is relatively very low (62). There were 27 non-bengali families with 88 persons in the survey area. Detailed distribution of persons by caste or community affiliation in individual settlement is shown in the Table D.

In all 601 households belonging to High caste Hindus were found to contain on average 5.7 persons per household. Among the middle caste Hindu households (471) the average size was 6.0 and the same size was prevailing among the Low caste Hindu houshholds numbering 1185. On the other hand among 1261 Muslim households average number of persons per household happened to be 5.9. This figure is little higher than what was found for the High caste Hindus only. In comparison with the Hindus as a whole the muslims had the same average householdsize. Among the Christians the average size was 5.8. Christan households were found to be only 108 in the surveyed villages. Hindu high caste people were found to have better concentration in Kumarkhali, kusumba, Machi, Jagaddal and particularly in Chauhati. As a matter of fact, of all the Hindu high caste people a very little less than half was enumerated in chauhati village alone (1514 perosns) In contrast, the Hindus of middle caste group were concentrating better in Mischintapur, Hogalkuria, Ramchandrapur, Machi, Chautati and Ban Hugli Highest concentration of the middle caste Hindus was in Hogalkuria village (798 persons) and this village was peopled only by the middle caste Hindus side by side of the christians (309 persons).

Special mention has to be made to village Jayenpur and Lingelpota since they did not show a single household belonging to either high or middle caste, In those two village onle the low caste households were dominating over smaller number of Muslim or Christian households. Village Hogalkuria had no High or low caste households. Village Jagannathpur possessed not a single low caste household.

The Muslim households (1261 in number) were most dominant in several villages. In this respect village Bonhugli

deserves first attention since a very little less them half of total population of the village (4290) were formed by the Muslims only (2131 persons). Next come the villages Kumarkhali and Ukhila, In the former village out of total 2134 persons the muslims alone stood for 1241 persons, while in the latter village, the muslims explained as high as 1208 persons out of total 1296 persons of the habitat. As matter of fact, Ukhila may be described as the muslim village. Similarly, Jagannathpur is also a muslim village as out of total village population of 1191 they numbered as high as 1091. On the other hand, Kusumba village possessed 677 Hindus against 878 muslims Sizable concentration of the muslims is observed in Ramchandra pur (224 persons), and Elachi (442 persons).

The christians were found to have concentrated in villages Hogalkuria (309 out of total 1097 persons) and Ban Hugli (308 out of total 4290 persons).

Education is generally considered as an important social inuicator of progressive development of any population. In the country as a whole the number of literates was definitely low, the literacy rate (excluding 0-4 aged inuiviouals) being 45.3 in 1971 census. But in rural India the same was only 39. This state of affair has its immediate reflection in the rural population under study. In very 100 persons (including 0-4 aged infants) as good as 52 were noted to be illiterate in the ~~at one time or other~~ present population. But those who had passed a written examination in a formal educational institutions accounted for 37 percent. This is, indeed, an encouraging development. In 1961 census the prevalence of literates in rural Sonarpur p,s. and rural 24-Parganas district was shown to be 31.8% and 23.5% respectively .

In the present survey of the rural people of 13 villages and semi-urban settlements the percentage of literates happened to be as high as 48%. With respect to the district as a whole Sonarpur p.s, registered distinctly higher concentration of the literates among the ruralites in 1961. And this tradition is well maintained by the people under study.

Apart from Elachi and Jaggaddal, the two segments of urban Rajpur settlements the villages Bongugli, Chauhati Ramchandrapur and Ukhila were reported in 1961 to possess primary schools. As a matter of fact, Chauhati maintained 3 primary schools. It is quite possible that because of these schools the facilities for formal education were not difficult to exploit by the local inhabitants. This question is well attested by the fact that in every 100 persons under examination as good as 35 had school level of education (primary and above). In addition, 3 percent of total 21540 persons reported to manitain college level of education.

Considering the state of affair related to educational development in individual village under study, Jagaddal, one of the sections of Rajpur town, evinced relatively the highest concentration of individuals having school level of education (39.6%). It is quite encouraging to see that half of the total population of this semi-urban settlement (1879) persons possessed school level of formal education and in the same settlement 5.4 per cent reported to have college level of education. Next comes the village Chauhati where 46 out of every 100 persons had only school level of education and another 4 percent possessed college level of education. In Elachi, another section of Rajpur town, 42 percent of total residents had school level of education, but the concentration of persons having college level of education,

~~of persons having college of education~~ was relatively the highest (10.2 percent) in this particular settlement. (Table E)

On the other side, the village Hogalkuria portrays a distressing development in having the illiterates in as high ~~as~~ 80 percent cases. Next we see the position of the village Jagenpur where in 69 out of 100 persons the illiterates dominated. In this regard, Benhugli and Jagannath pur accounted 65 percent and 64 percent respectively for the illiterates only. Dingelpota village presented the illiterates in 63 percent cases. In short,6 out of 13 villages under study possessed individually illiterate persons in lesser strength than that of the general average for the same. They are Nischintapur, Kumarkhali, Kusumba, Lachi, Jargadal and Chamhati. In the remaining 7 villages dominance of illiterate persons has to be immediately taken into notice with reference to the question of the prevailing socio-economic developmental activities in the area.

In the survey area in question we have ~~formed~~ found that out of total 21540 persons as good as 50% were in the age group 15-59 years, That is one half of the population were comprising the total labour force, But, those who were found gainfully employed during surveyg period constituted only 27 percent of total population. Among these gainfully employed persons (5825) only 26 were below the age 15 and 492 were 60 years and above in age. Total working force in the age-group 15-34 was formed by 2700 persons, whereas in ~~the~~ age-group 35-59 the same was accounted by 2507 persons. In the ~~Table~~ Table F detailed distribution of total labour force and total gainfully employed persons by age has been presented for each village and semi-urban settlement. Further discussion on the gainfully employed persons will follow next and hence nothing more is added here except the remark that the economically active people were really

meggre in number in the surgey area. This indicates, on the other handk the state of economic situation of the people. To spellout definitely, out of 10799 persons falling within 15-59 ages, only. 5207 of the same ages were found gainfully employed (48.2%). More than half of the available labour force under reference had no gainful pursuits in 1974. This general feature is more or less applicable for any one habitat under study. In Alachi 52 percent of the available labour force (15-59 years) were found to be gainfully employed. From the Table G the distribution of persons by sex and marita status over the given settlements it isobserved that in every 100 persons as good as 60 were never-married and 34.5 percent were married. In 1961 census for Sonnrpur p.s as awhole the unmarrieds and the marrieds were shown in 53 ~~percent~~ percent and 40 percent cases respectively. From the present survey it is noted that the strength of the unmarrieds was in higher side, but the marrieds were in lower order. in comparision to what is obtained for entire population of Sonarpur p.s., in 1961.

Among the unmarrieds the dominance of the males was evident in the villages and semi-urban villages under study. Sex-balance among the marrieds was disturbed a little. But among the widowed persons dominance of the females was extraordimary. Sex- ratio (number of males per 100 females) reveal the nature of sex-balance more pointedly in each of the marrital status group as foll ws: (1) Never-married: 133.4; (2) Married: 100.4 and (3) widowed: 14.8 In this regard we remember that general sex-ratio in the population was found to be 109.7 in 1974.

Prepondemacne of the never-married persons was noticed in almost all the villages and semi-urban settlements, the relative highest concentration was found in the villages of Nischintapur and Kusumba and Ramchandrapur.

In each of this village 61 out of every 100 persons were unmarried. The proportions of the married varied not too much over the habitats, the maximum being 36.2 (Hogalkuria village) and the minimum being 32.5 (Ramchandrapur and Dingelpota villages). Relatively speaking, greatest concentration of the widowed persons was observed in Dingelpota village (6.6%), the range of variations between the village being from a low of 3.9% (Hogalkuria) to a high of 6.6%. Number of divorced persons was negligible (0.2%) in the given population.

1. In Nischintapur village population the general sexratio was 114.9 and among the never marrieds the same was 142.5 The married persons evinced a near balance, but among the widowed the females outnumbered the males.

2. In Ukhila village general population sexratio was 109.4. Among the unmarrieds the males dominated clearly, but the females were in higher strength among the widowed persons. Near balance among the marrieds was again noticed.

3. In Jagannathpur village general sexratio happened to be 108.9. The never married group evinced sexratio in the order of 134.7. Near balance in the married group was obtained and again, the widowed females concentrated most conspicuously.

4. In the population of Kumarkhali village sexratio was 114.5. Hereagain, the males out numbered the females in unmarried group, while the females in widowed group. Near sex-balance in the married group was noticed.

5. Kusumba gillage showed sexratio of 113.0. In the unmarried group the sexratio was 141.2. Perfect sex-balance (100.00) was noticed among the marrieds. Among the widowed the sexratio was 14.7 only.

6. In the population of Hogalkuria the sexratio was obtained to be 108.6, but in the never married group only the same happened to be 125.8 Near balance in the married group but disbalance in the widowed group was again observed in the village

7. In Jayenpur population sexratio was 108.5. Dominance of the males in the never married group and dominance of the females in the widowed group is quite clearly observed. The married group enjoyed a near sex-balance.

8. Ramchandrapur is the village where the females were more in number than the males in the total population. Hence the sexratio turned out to be 96.3 only. But in the unmarried group the males were dominating to result the sexratio of 107.1 Among the widowed group the sexratio was 24.5

9. In Elachi general sexratio in the population was 112-14. In the unmarried group the sexratio turned out to be 141.9. Near sexbalance in the married group and disbalance in the widowed group was also repeated in this urban segment of Rajpur town.

10. Dingelpota evinced population sexratio to be 112.3. Among the unmarrieds the males out numbered the females. In the married group sexratio happened to be 104.8. The widowed females were most remarkable.

11. In Jagaddal, another segment of Rajpur town, population sexratio was 108.8. Among the unmarrieds sexratio happened to be 129.3. The males were slightly more in number in the married group, while in the widowed group the females were dominant.

12. In Chanhati village population sexratio turned out to be 109.9. The males out numbered the females in the never married group . But the females were concentrating more in the widowed group.

13. Ban Hugli village presented population sexratio in the order of 108.7. Among the unmarried group the sexratio was 129.2. Balance of sex in the married group was found. Here again, the females dominated over the males in the widowed group.

High sexratio in the unmarried group in almost all the villages is very remarkable. Similarly low sexratio in the widowed group over the villages attracts immediate attention. In the survey as good as 3653 households were surveyed and the essential characteristics of these households with respect to sex distribution, age distribution, size etc. have been shown earlier. now considering the kinship affiliation of the members of each household the family organizational types have been sifted out in the Table H. Those members who did not show any genealogically tracable kinship relation with the Head of the household have been excluded in identifying the family type concerned. At the second stage, those members who were kins but not consonguineous to the Head of household have been treated as patri/ matri-kins. For description purpose these patri/matri kins have been shown as 'complex'. In general, the core of the family structure has been determined and if there was any kin member who should not be long to the core by virtue of the prevailing marriage custom he or she was taken as 'complex' element adhered to the family concerned. Those who were found living alone by themselves without any kin have been marked as single member unit. The nuclear family consists of the parents / parent with only the unmarried children. The rest of the kin-aggregates except the married couples is included within Joint (extended) family. Principally there are 4 major types of family aggregate under study Total single member units had been found in only 4 percent cases, this signifies the fact that the people under surveyx were almost fully family-members. Total married couple units having no children were also very slender in strength(3.4%). It is the type of nuclear(simple) family which dominates the scene. In as high al 64 out of every 100 kin-aggregates nuclear families were formed. In the remaining 28 percent

cases Joint(extended) families having varied kin composition were organized. Thus, it can safely be stated that in the given survey area the people are more oriented towards simple family organization,

Taking the position of individual village and semi-urban settlement it is observed that the village Kusumba had relatively the highest concentration of simple, nuclear families of all types (71.4 percent), the lowest concentration being in the village Chaghati (57%). The range of variation in the given human settlements was, of course, not very marked. As far as the concentration of joing family organizations is concerned, it is noticed that the village Nischintapur had relatively the highest concentration (33.3%). where as the lowest concentration was found in two villages, namely, Kusumba (23%) and Hogalkuria (23%). It is remarked here that in 14 out of 100 family types in question 'complex' elements were present, the maximum(10%) being with joint families of the survey area. In the Table I detailed distribution of the gainfully employed persons over the villages by broad occupation group affiliation is shown. It is remarkeble that as agriculturists only a very minor fraction (0.8%) among total 5825 gainfully employed persons was met with in the survey. The largest magnitude of the economically active force was represented by those who were working as labourer. These labourers were either agricultural or day labourer (51%). A sizable portion of the working force was attached to some sort of trade and commence (15%). About one-third of total economically active people were affiliated with service. type of avocation.

With respect to the villages and semi-urban settlemnets it is stated that in Kalachi(segment of Rajpur town) the single

dominant group of the ecominomically active people was connected with services (57 3%). In tune with its semi-urban character Elachi presented definitely in as good as 70 per cent cases non-agricultural labour force. But in Jagaddal (another segment of Rajpur town) service-affiliated labour force explained only 50.3%, but here economically active persons linked with business were quite dominant (21.3%). Jagaddal also manitains its semi-urban character in having definitely in as high as 72 percent cases non-agricultural earres. In both Elachi and Jagaddal the majority of the households dependened on non-agricultural occupations.

In contrast village Hogalkuria showed that 91% of the local labour force were related to labour type of avocations. The households of the habitat were extemely dependent on those who gave mannal labour for earning family subsistence. Next in this context come the villages of Jayenpur (74%). Jagannathpur (73%). Dingelpota (73%) and Ban Hugli (72%). In these villages non-agricultural households were distinctly weaker in concentration.

Relatively speaking, one-half of all the ganifully employed persons of Chauhati village were affiliated with service- type occupations. Next Comes the village Kukarkhali where in 45 out of 100 economically active people were in one or other type of service. Kusumba does not lag much behind Kumarkhali in having sercice affiliated labour force in 42% cases. These is marked variation in the relative concentration of persons engaged in service type of occupations over the settlements under study, the maximum and the minimum being 57% (Elachi) and 6% (Hogalkuria).

As far as the persons engaged in business, the highest concentration is comparatively obtained in Mischintapur village (28%). Then come Jagaddal (21%) and Kusumba (21%).

Range of variation in the relative concentration of the ganifully employed persons in business over the given human settlements is found to be between a high of 28 % (Nischintapur) and a low of 4% (Hogalkuria).

With respect to general averge (57.1%) of labour-affiliated economically active persons, in 7 out of 13 villages and semi-urban set tlements the concentration of the same people was definitely lower. Similarly, with reference to general agerage (15%) of business- affiliated bread-earners, in 6 out of 13 settlements occurrence of such earrers was lower.

Earlier the Table D has been discussed to show the distribution of the enumerated persons by caste and community affiliation. Now we go a step further to examine the people by caste, community and sex for each human settlement under study Table J Here only the Bengali speking residents of the villages have been considered excluding 27 non-Bengali households and their 88 members. Among 21416 Bengalis 37 percent belonged to low castes. In total 21 low cstes were found in the survey area. Of these low castes the Paundras dominated over the rest having 464 households with 2758 persons. The were found in varying strength in all the villges except Akhila, Jagannathpur and Hogalkuria. Their best concentration was in both Jaggadal and Ramchandrapur. Their next best concentration was in Elachi. Apart from the Paundras, the low caste of Teor formed the second best concentration, with 405 household and 2411 persons. They were, of course, limited to only three villages of Hogalkuria, Jayenpur and Ban Hugli, the last village Bon Hugli had the highest number of Teors (1326 persons in 224 households.) The Jugis were found in 196 households having 1202 persons and they were restricted to only 2 villages of Chanhati and Jaggadal . Maximum concentration was, of course, in

Chauhati village (174 households with 1043 persons). Of the total 7846 low caste persons of the survey area the above three castes together accounted for as high as 6371 (81.2 percent). Naturally, the population characteristics shown by the low caste Hindus of the survey area were certainly influenced mostly by these three social groups, ~~xxxxx influenced mostly by these three social groups,~~ namely Paundra, Teors and Jugis.

The middle caste Hindus were in all 2024 in number and they constituted 15% of the Bengali Hindus, but 9.5% of all Bengali speaking inhabitants of the area under surgey. Altogether 10 different castes belonging to the Middle caste category were met with in the settlements . Of these ten castes Goalas (Ghose) and Mahisyas were dominant group . The Goalas happened to form the strongest group with 167 households and 1026 persons. They were found scattered in 8 villages, the maximum ~~xxxxxxxxxxxx~~ concentration being in the village Ramchandrapur (24 households with 134 persons). The Mahisyas formed 50 households and numbered 267. They were living in 6 out of the given 13 settlements. Their best concentration was found in Elachi segment of Rajpur town.

Among the High Caste group 3452 persons are found. They explained 26 percent of the Bengali Hindus examined here, but 16 percent of total Bengali-speaking people in question. Only 3 caste groups belonging to the High caste category were observed. The Kayasthas formed the dominant social group having 332 households and 1902 persons. Except the villages of Hogalkuria, Jayenpur and Dingelpota, the remaining rural and semi-urban settlements possessed the Kayasthas. But their best concentration was in the village Chauhati where 187 Kayastha households with 1118 persons were enumerated.

The Brahmins constituted the second influential group having 215 households and 1465 persons. They were found in all rural and semi-urban settlements under study, except Mogalkuria, Jagenpur and Dingelpota (they didnot show any Kayasth households also). Best concentration of the Brahmins was noticed in Jagadal, the segment of Rajpur town. Here 70 Brahmin households with 441 persons were counted. Thus, the Kayas-thas and the Brahmins stand together for all socioeconomic and demographic characteristics which might be sifted out for the High caste Hindus of the locality. Sexratio among the Hindus was 109.0.

The Muslims as a community stand as a solid population group with 7465 persons (35%) among the total Bengali-Speking inhabitants surveyed. Among them sex ratio is found to be 109.0 .They were found in all the given rural and semi-urban settlements, except in Mogalkuria and Dingolpota villages. Their highest concentration was, of course, found in the village Ban Hugli (2131 persons in 348 households). As a matter of fact, the Muslim households constituted 49 percent of all households (711) surveyed in Ban Hugli. Their second beat concentration is observed in Kumarkhali village (1241) persons in 207 households). In this village of all the households (372) the muslim households accounted for as high as 56 per cent. They were found fairly concentrated also in the villages Jagannath pur (1091 percent) aand Kusumba (878) persons.

The Christians were found principally in two villages, namely, Mogalkuria (309 persons in 52 households) and Ban Hugli (308 persons in 54 households). The Christions explanied only 2.9 percent of the total Bengali speaking inhabitants under examination.

Sex ratio among them was found to be 111.1 In this respect the Christians show greater dominance of the males in their population than what is observed for either the Hindus or the Muslims.

Thus, in the population under examination the Low caste Hindus formed the single major group and next to their came the muslims. They together formed 71.5 percent of the total population of the given 13 rural and semi-urban settlements.

In Elachi proper 1700 Bengali speaking persons were counted in 1974 survey. Of these persons the low caste Hindus alone stood for 30.5 per cent. Next came the muslims having 26.0 per cent share of Elachi population. The High and middle caste Hindus were present almost in equal strength. On the other hand, in Jaggadal proper 1870 persons were found in the present survey. Of this population the Low caste Hindus alone accounted for 58.9 percent. Next came the High caste Hindus with 33.7 percent share of the local semi-urban inhabitants. In Jaggaddl the muslims were very meagre in number (only 9 persons). Thus, in the given two urban segments of Rajpur town we find a variation in the concentration of the caste Hindus and the Muslims. But in both areas the Low caste Hindus formed the single major group, while in Jagaddal the Low caste Hindus were the most dominant social group.

The socio- demographic profile of the villages and semi-urban settlements under examination is, thus, presented in such manner that would help readily to sift the required population characteristics for any one settlement or for any clusters of settlements. In any case, it is clear that the characteristics evinced by the semi-urban inhabitants of Elachi and Jagaddal do not vary sharply from those presented by the rural dwellers of the frinze villages of Rajpur town.

SECTION:@4

TENTATIVE CONCLUSIONS WITH RECOMMENDATORY OBSERVATIONS

The population characteristics which have been discussed in the previous section need to be assessed in the historical background of the District 24-parganas, 1961 Census showed that the total population had increased by 40.8 percent over that of 1951. The increase during 1951-61 had surpassed all the records of decennial increase during 1901-51. There was a sharp distinction between the growth in rural sector and that in urban sector. The rural areas of the district claimed an increase of 32.05 per cent, while in the urban areas had registered 64.29 per cent increase during the decade 1951-61.

As a matter of fact, the growth of population in the district in each census year was higher than that in the State. There were 11 police station where the increase during 1951-61 varied between 30 and 39.9 percent and Sonarpur p.s. was one of them. Sonarpur showed actually 33.7 per cent increase in population during the decade 1951-61. Again, among 14 police stations of the Sadar subdivition Sonarpur evinced the second highest increase in population. Percentage variations of population during 1941-51 and 1951-61 were 7.8% and 33.7% respectively in Sonarpur p.s. In the context of the above demographic developments the significance of the biosocial features of the population under reference has to be evaluated. It is quite clear that when the district of 24-Parganas as a whole was experiencing 'staggering' population increase, especially druing the decde 1951-61, any village of any police station of the district can not remain to totally unaffected. Moreover, Sonarpur p.s. as a whole is a geographical tract where the

thrust
~~trust~~ of higher population increase was quite remarkable. Naturally, each and every village of Sonarpur p.s. is highly expected to face the stress and strain of such high population growth. On the otherhand, the urban settlements of the district had experienced greater impact of population ~~pudda~~ boad. Being an urban area Rajpur town cannot he, thus, expected to remain unaffected. In this town Elachi and Jagaddal are located and consequently all the good and bad effects of fastly swelling urban population of the District or the police Stations have to be borne by them.

Social developmental measures including family welfare activities which have already been initiated in the District have its universal appeal for ~~each~~ each settlement -urban or rural - of 24-parganas. No settlement can be isolated from the focal point of these Developmental measures. But the population of each settlement requires to be examined by their social make up. It is better to treat the social groups in tune with their prevailing cultural assests. The Hindus and the Muslims are ~~xxxxxxx~~ never governed by the same family- building attitudes and activities and as such family welfare programmes have to be tailored such that their traditional way of living and acting is not unduly disturbed. Moreover, among the Hindus the high caste people should not be equated with either the middle or low caste people. As a Hindu they have a common ground for social inter-actions, but in the arena of marriage, mate selection and family interactions they have their own societal choices and preferences.

In implementing any social welfare programmes, particularly programmes of health care and family planning serious attention should not lack in giving due weightage to the said

social choices and preferences. To give specific examples, it is noted that the villages of Ukhila, Jagannathpur, Kumarkhali, Kusumba and Ban Hugli have to be treated especially as Muslim village and in consonance with their ideas and actions related to family and fertility the social welfare programmes of family planning have to be organized as a special task. High natality and social defence for the same in the Muslim World as a whole are welknown and it would be advisable to develop due social consciousness in dealing with the question of family limitation programme among them. Though they suffer the same socio-economic hardles in maintaining distressing load of children per family like the Hindus, yet they have their own logic for and against the exigency of birth control. More progressively this logic is understood. better would be the prospect of family welfare programme.

Among the Hindus the low caste people are the worst social sufferers and they continue to hear the stigma of Hindu social rules and regulations. They have their own dharma in shaping their family and usually the higher cates pay scant respect to this dharma. In the area of present survey the law caste people are the dominant segment of the population. Naturally, they deserve foremost attention of those who are socio-culturally placed in a more advantageous position. To encourage these peoples the High castes are to set examples. Traditionally in societal matter the low castes are given leadership by the High castes. Under the circumstances, the villages like Kumarkhali, Kusumba, Chanhati should be the best experimental ground to push forward family welfare programmes. These are the settlements where the High caste and low caste people are residing in matching strength . It is expected that once the High Caste families of these settlements, are sufficiently motivated

Co-villagers of Low caste group would find enough fillip to get themselves convinced about the efficacy and dire need of family welfare activites. If the Low caste people are approached independently, desired responses from among them may not be available to one's satisfaction. In this process, the middle caste families can not obviously remain apathetic, since their social interactions with the High caste families are legion.

Above all, the people of Elachi and Jagaddal have to be treated at per with the remaining urban residents of Raipur town Here family welfare programmes would get better scope for their intensive application. Along with Elachi and Jaggadal it is suggested that Kumarkhali and Ukhila may be bracketed. Families of Kumarkhali and Ukhila have already started enjoying 'modern ' facilities engendered by the service of electricity and it is expected that the people of these two semi-urban villages would show lesser resistance in paying heed to family welfare programmes. The remaining villagefolk should be approached more than once in getting them 'hooked' in the wider plan of family welfare activities by phases.

13.2.75

13.2.75

Table : A: Distribution of Household by no. of persons and average no. of persons per family in 10 out of 13 villages surveyed in Sonarpur p.s., 24 parganas, 1974.

(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)
Village	no.of family	no.of person male	female	total	Average no.of person per household male	female	total
1. Nischintapur	78	270 53.47	235 46.53	505 100.00	3.5	3.0	6.5
2. Ukhila	240	677 52.24	619 47.76	1296 100.00	2.8	2.6	5.4
3. Jagannath pur	193	621 52.14	570 47.86	1191 100.00	3.2	3.0	6.2
4. Kumarkhali	372	1139 53.37	995 46.63	2134 100.00	3.1	2.6	5.7
5. Kusumba	276	826 53.12	729 46.88	1555 100.00	3.0	2.6	5.6
6. Bogolkuria	183	571 52.14	526 47.86	1097 100.00	3.1	2.9	6.00
7. Jayenpur	97	280 52.04	258 47.96	538 100.00	2.9	2.7	5.6
8. Raychandrapur	176	520 49.06	540 50.94	1060 100.00	3.0	3.0	6.0
9. Nischi	304	916 52.92	815 47.08	1731 100.00	3.0	2.7	5.7
10. Bingolpota	156	483 52.90	430 47.10	913 100.00	3.1	2.8	5.9
11. Jagaddal	298	979 52.10	900 47.90	1879 100.00	3.3	3.0	6.3
12. Chauhati	569	1736 52.37	1579 47.63	3315 100.00	3.0	2.8	5.8
13. Bonhogli	711	2234 52.07	2056 47.93	4290 100.00	3.1	2.9	6.0
ALL VILLAGES	3653	11252 52.33	10252 47.67	21504 100.00	3.1	2.8	5.9

Table 1: Family Incidence Rate* of different Disease-groups for the families surveyed in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, West Bengal, 1974-75

Disease-group (WHO catagories)	Rural area (name of the villages): Bon-hooghly	Chow-hati	Ding-alpota	Hogal-kuria	Jagan-nath-pur	Jayen-pur	Kuma-rkhali	Kus-umba	Nisc-hinta-pur	Ram-chan-drapur	Ukh-ila	All Rural areas	Semi-Urban area: ELA-CHI	JAGA-DDAL	All semi-Urban areas
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
I. IPD	44.8	26.0	48.7	37.4	97.4	53.1	89.8	100.0	72.7	82.3	99.1	60.1	67.6	50.7	59.2
II N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III ENMD	1.9	1.3	0.6	0	0	0	0	0	0	2.3	0	0.9	1.4	2.1	1.7
IV. DBBO	1.7	0.9	0	0	0	1.0	0	0	0	0	0	0.6	0.3	0.4	0.4
V. MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VI. DNS	1.4	1.4	3.2	0	0	13.5	0	0	0	4.7	0	1.5	2.4	1.7	2.1
VII. DCS	2.9	2.1	0.6	3.3	0	4.2	0	0	0	4.7	0	6.2	7.5	4.5	6.0
VIII.DRS	31.9	33.8	28.8	27.7	63.2	20.8	35.1	29.0	49.3	15.9	35.4	29.2	41.6	36.9	39.3
IX.DDS	4.7	4.5	4.5	2.8	0	3.1	0	15.3	0	5.3	0	3.5	9.5	7.6	8.6
X. DUGS	1.7	0.7	1.9	0	0	2.1	0	0	0	0.6	0	0.8	1.0	0.7	0.9
XI. CPCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XII.DST	14.1	17.3	12.8	33.5	3.1	27.1	40.1	30.6	37.7	27.0	29.7	22.2	22.2	22.8	22.5
XIII.DMCT	1.4	4.6	3.2	0	0	0	0	0	0	9.4	0	2.0	5.8	3.8	4.8
XIV. CA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XV. DPNM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XVI.SILC	92.1	83.7	94.2	85.5	45.6	94.8	88.1	86.3	100.0	83.5	99.6	86.8	100.0	88.3	94.2
XVII. ACV	0.3	1.4	0	0	0	1.0	0	0	0	1.2	0	0.4	1.7	1.0	1.4
No. of Families surveyed	708	562	156	179	193	96	362	124	77	170	229	2856	293	290	583

Disease-groups:
I.IPD: Infective and Parasitic Diseases (code 000-136)
II. N: Neoplasms (140-239)
III. ENMD: Endocrine, Nutritional, and Metabolic Diseases (240-279)

continued..

Continued:-..

Table 1:

Disease-groups:

IV: DBBO : Diseases of Blood and Blood forming organs (280-289)

V. MD : Mental Disorders (290-315)

VI. DNS : Diseases of Nervous system and Sense Organs (320 - 389)

VII. DCS : Diseases of Circulatory System (390 - 458)

VIII. DRS : Diseases of Respiratory System (460 - 519)

IX. DDS : Diseases of Digestive System (520 - 577)

X. DU GS : Diseases of Urino - Genital System (580 - 629)

XI. CPCP : Complications of Pregnancy, child birth & the Puerperium (630 - 678)

XII. DST : Diseases of Skin and sub cutaneous tissues (680 -709)

XIII. DMCT : Diseases of the Musculo - skeletal System & connective tissues (710 - 738)

XIV. CA : Congenital Anomalies (740 - 759)

XV. DPMM : Certain Diseases of peri-natal morbidity & Mortality (760 - 779)

XVI. SILC : Symptoms & Ill-definied conditions (780 - 796)

XVII. ACV : Accidents, poisimings, and Violence (800 - 999)

* Family Incidence Rate = $\frac{100 \times \text{number of families affected by the particular disease-group}}{\text{Total number of families.}}$

pa:

Table 2:

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, W.Bengal, 1974-75

Rural (R)/Semi-urban (U) area	Family Incidence Rate of Infective and Parasitic disease-Group (I)	Rate of most frequently reported disease of the Group I	
		Dysentery	Diarrhoea
(1)	(2)	(3)	(4)
1. Bonhoogly (R) (No. of families: 708)	44.8	15.1	-
2. Chowhati (R) (no. of families :562)	26.0	13.2	-
3. Dingalpota (R) (No. of families: 156)	48.7	20.0	-
4. Hogalkuria (R) (no. of families:179)	37.4	-	11.7
5. Jagannathpur (R) (no. of families: 193)	97.4	47.1	-
6. Jayenpur (R) (no. of families: 96)	53.1	32.3	-
7. Kumarkhali (R) (no. of families: 362)	89.8	-	57.4
8. Kusumba (R) (no. of families;124)	100.0	-	66.1
9. Mischintapur (R) (no. of families: 77)	72.7	44.1	-
10. Ramchandrapur (R) (no. of families: 170)	82.3	53.5	-
11. Ukhila (R) (no. of families: 229)	99.1	-	47.2
ALL RURAL AREAS (no. of Families: 2856)	60.1	16.4	14.7
1. Elachi (U) (no. of families:293)	67.6	15.2	-
2. Jagaddal (U) (no. of families: 290)	50.7	23.2	-
ALL Semi-URBAN AREAS (no. of Families: 583)	59.2	19.2	-
ALL AREAS (Rural + Semi-Urban) (no. of Families. 3439	59.9	16.9	12.2

pa:

A. Table 3:

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease group in villages and semi-urban areas of Sonarpur P.S.,24-Parganas, W.Bengal, 1974 - 75

Rural / semi-Urban area	Family Incidence Rate of Diseases of Respiratory system (VIII)	Most frequently reported disease of the Group VIII Cold	Flu
(1)	(2)	(3)	(4)
1. Bonhoogly	31.9	26.8	
2. Chowhati	33.8	31.8	-
3. Dingalpota	28.8	26.3	-
4. Hogalkuria	27.4	23.5	-
5. Jagannathpur	63.2	-	62.7
6. Jayenpur	20.8	7.3	-
7. Kumarkhali	35.1	-	32.6
8. Kusumba	29.0	-	26.6
9. Mischintapur	49.3	-	48.0
10. Ramchandrapur	15.9	12.9	-
11. Ukhila	35.4	-	34.9
ALL RURAL AREAS	29.2	16.8	13.6
1. Elachi	41.6	29.7	-
2. Jagaddal	36.9	33.4	-
ALL semi-URBAN AREAS	39.3	31.6	-
ALL AREAS	30.9	19.3	11.3

pa.

Table 4:

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, W. Bengal, 1974 - 75

Rural/ Semi-urban area	Family Incidence Rate of Diseases of Skin and sub-cutaneous Tissues (XII)	Most frequently reported disease of the Group XII	
		Itch	SK.disease dermatitis
(1)	(2)	(3)	(4)
1. Bonhoogly	14.1	5.6	-
2. Chowhati	17.3	10.5	-
3. Dingolpota	12.8	10.9	-
4. Hogalkuria	33.5	27.4	-
5. Jagannathpur	3.1	2.6	-
6. Jayenpur	27.1	22.9	-
7. Kumarkhali	40.1	40.0	-
8. Kusumba	30.6	27.4	-
9. Nischintapur	37.7	32.5	-
10. Ramchandrapur	27.0	-	12.9
11. Ukhila	29.7	29.7	-
ALL RURAL AREAS	22.2	16.2	0.8
1. Elachi	22.2*	-	-
2. Jagaddal	22.8	11.4	-
ALL Semi URBAN AREAS	22.5	11.4	-
ALL AREAS	22.3	14.4	0.6

* In Elachi Skin disease of 'Abscess' was reported most frequently (Fam. Inc, Rate: 3.4)

Table: 5:

Family Incidence Rate of One of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, W. Bengal, 1974 - 75

Rural/ semi-urban area	Family Incidence Rate of		
	Symptoms and Ill-defined conditions(XVI)	Most frequently reported disease of the Group XVI	
		Cough	Fever
(1)	(2)	(3)	(4)
1. Bongoogly	92.1	-	90.7
2. Chowhati	83.7	-	80.1
3. Dingolpota	94.2	46.8	-
4. Hogalkuria	85.5	-	75.4
5. Hagannathpur	45.6	-	27.5
6. Jayenpur	94.8	-	66.7
7. Kumarkhali	88.1	75.4	-
8. Kusumba	86.3	6.4	-
9. Nischintapur	100.0	71.4	-
10. Ramchandrapur	83.5	-	74.7
11. Ukhila	99.6	93.0	-
ALL RURAL AREAS	86.8	24.3	51.5
1. Elachi	100.0	-	65.5
2. Jagaddal	88.3	-	77.6
All Semi URBAN AREAS	94.2	-	71.5
ALL AREAS	88.1	18.9	54.9

Table 6:

Social group (community)-wise Family Incidence Rate of different Disease-groups for the families surveyed in villages and semi-urban areas, W.Bengal 1974

Social group (community) (1)	Disease-group (WHO categories) I	III	IV	VI	VII/VIII	IX	X	XII	XIII	XVI	XVII	Total families (3)
					1. Village BOMHOOGLY							
					(2)							
Hindu	40.3	1.6	1.3	1.0	3.6	29.8	5.3	1.6	14.1	0.3	91.2	0.7	305 (100.0)
Muslim	49.7	2.0	2.3	1.4	2.6	35.6	4.3	1.4	14.4	2.3	93.1	0	348 (100.0)
Christian	38.6	2.3	4.1	0	2.3	20.4	4.1	4.1	13.2	2.3	91.3	0	55 (100.0)
All groups	44.8	1.9	1.7	1.4	2.9	31.9	4.7	1.7	14.1	1.4	92.1	0.3	708 (100.0)
					2. Village CHOWHATI							
Hindu	25.2	1.3	0.9	1.5	2.2	34.3	4.6	0.7	16.6	4.8	84.7	1.4	549 (100.0)
Muslim	61.5	0	0	0	0	15.4	0	0	46.1	0	84.6	0	13 (100.0)
All groups	26.0	1.3	0.9	1.4	2.1	33.8	4.5	0.7	17.3	4.6	83.7	1.4	562 (100.0)
					3. Village DINGALPOTA							
Hindu	48.7	0.6	0	3.2	0.6	28.8	4.5	1.9	12.8	3.2	94.2	0	155* (100.0)
* 1 Christian family was also found in the village													
					4. Village MOGALKURIA							
Hindu	39.8	0	0	0	3.1	28.9	2.3	0	34.4	0	85.1	0	128 (100.0)
Christian	31.5	0	0	0	4.1	23.7	4.1	0	31.5	0	86.4	0	51 (100.0)
All groups	37.4	0	0	0	3.3	27.4	2.8	0	33.5	0	85.5	0	179 (100.0)
					5. Village JAGANNATHPUR							
Hindu	66.7	0	0	0	0	53.3	0	0	6.7	0	100.0	0	15 (100.0)
Muslim	100.0	0	0	0	0	64.0	0	0	2.8	0	41.0	0	178 (100.0)
All groups	97.4	0	0	0	0	63.2	0	0	3.1	0	45.6	0	193 (100.0)

Table:6 Continued...

Social group (community)	Disease-group (WHO categories) i	iii	iv	vi	vii	viii	ix	x	xii	xiii	xvi	xvii	Total families
(1)						(2)							(3)
6. Village JAYANPUR													
Hindu	49.5	0	1.7	4.7	6.2	28.6	4.7	0	28.6	0	95.7	1.7	67 (100.0)
Muslim	64.3	0	0	35.7	0	0	0	3.6	25.0	0	96.4	0	28 (100.0)
Christian		0	0	0	0	100.0	0	100.0	0	0	0	0	1 (100.0)
All groups	53.1	0	1.0	13.5	4.2	20.8	3.1	2.1	27.1	0	94.8	1.0	96 (100.0)
7. Village KUMARMALLI													
Hindu	88.6	0	0	0	0	35.4	0	0	25.9	0	88.6	0	158 (100.0)
Muslim	90.7	0	0	0	0	34.8	0	0	51.0	0	87.7	0	204 (100.0)
All groups	89.8	0	0	0	0	35.1	0	0	40.1	0	88.1	0	362 (100.0)
8. Village KUSUMBA													
Hindu	100.0	0	0	0	0	50.0	16.7	0	0	0	100.0	0	6 (100.0)
Muslim	100.0	0	0	0	0	28.0	15.2	0	32.2	[illegible]	85.6		118 (100.0)
All groups	100.0	0	0	0	0	29.0	15.3	0	30.6	0	86.3	0	124 (100.0)
9. Village MISCHINTAPUR													
Hindu	73.3	0	0	0	0	49.3	0	0	36.0	0	100.0	0	75 (100.0)
Muslim	50.0	0	0	0	0	50.0	0	0	100.0	0	100.0	0	2 (100.0)
All groups	72.7	0	0	0	0	49.3	0	0	37.7	0	100.0	0	77 (100.0)
10. Village RAMCHANDRAPUR													
Hindu	83.2	2.1	0	2.1	2.8	10.5	5.6	0.7	26.6	9.1	84.6	0	143 (100.0)
Muslim	78.0	3.9	0	18.7	15.0	44.6	3.9	0	29.8	11.3	78.0	7.6	27 (100.0)
All groups	82.3	2.3	0	4.7	4.7	15.9	5.3	0.6	27.0	9.4	83.5	1.2	170 (100.0)

Table 6: (~~continued~~continued)

Social group (community)	Disease-group (WHO categories) i	iii	iv	vi	vii	viii	ix	x	xii	xiii	xvi	xvii	Total families
(1)						(2)							(3)
11. Village UKHILA													
Hindu	87.5	0	0	0	0	12.5	0	0	0	0	100.0	0	8 (100.0)
Muslim	99.5	.0	0	0	0	36.2	0	0	30.8	0	99.5	0	221 (100.0)
All groups	99.1	0	0	0	0	35.4	0	0	29.7	0	99.6	0	229 (100.0)
ALL VILLAGES (RURAL)													
HINDU	47.1	0.4	0.6	1.4	2.2	31.1	3.9	0.8	20.1	2.8	88.7	0.7	1609 (100.0)
MUSLIM	80.9	0.7	0.7	1.7	1.1	38.4	3.0	0.5	25.3	1.0	84.1	0.4	1139 (100.0)
CHRISTIAN	54.3	0.9	0	1.8	2.8	13.0	3.7	2.8	21.3	0.9	88.0	0	108 (100.0)
All GROUPS	60.1	0.9	0.6	1.5	6.2	29.2	3.5	0.8	22.2	2.0	86.8	0.4	2856 (100.0)
12. Semi-urban JAGADDAL													
Hindu	51.2	2.1	0.4	1.7	4.5	37.0	7.6	0.7	22.8	3.8	88.2	1.0	289* (100.0)
13. Semi-urban BLACHI													
Hindu	66.0	1.3	0.5	1.8	8.9	43.3	10.3	0.9	16.5	6.3	100.0	1.8	224 (100.0)
Muslim	72.5	1.4	0	4.3	2.9	36.2	7.2	1.4	40.6	4.3	100.0	1.7	69 (100.0)
All groups	67.6	1.4	0.3	2.4	7.5	41.6	9.6	1.0	22.2	5.8	100.0	1.7	293 (100.0)
ALL SEMI-URBAN AREAS (URBAN)													
HINDU	57.7	1.8	0.4	1.7	6.4	39.8	8.8	0.8	20.1	4.9	93.4	1.4	513 (100.0)
MUSLIM	71.4	1.4	0	4.3	2.8	35.7	7.1	1.4	40.0	4.3	100.0	1.4	70 (100.0)
All groups	59.2	1.7	0.4	2.1	6.0	39.3	8.6	0.9	22.5	4.8	94.2	1.4	583 (100.0)

* 1 Muslim family was also found

TABLE 6 (contd.) DISEASE-GROUP (WHO CATEGORIES)

Social Group (community)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
(1)						(2)							(3)
						6. Village Jayenpur							
Hindu	49.5	0	1.7	4.7	6.2	28.6	4.7	0	28.6	0	95.7	1.7	67 (100.0)
Muslim	64.3	0	0	35.7	0	0	0	3.6	25.0	0	96.4	0	28 (100.0)
Christian		0	0	0	0	100.0	0	100.0	0	0	0	0	1 (100.0)
All Groups	53.1	0	1.0	13.5	4.2	20.8	3.1	2.1	27.1	0	94.8	1.0	96 (100.0)
						7. Village Kumarkhali							
Hindu	88.6	0	0	0	0	35.4	0	0	25.9	0	88.6	0	158 (100.0)
Muslim	90.7	0	0	0	0	34.8	0	0	51.0	0	87.7	0	204 (100.0)
All Groups	89.8	0	0	0	0	35.1	0	0	40.1	0	88.1	0	362 (100.0)
						8. Village Kusumba							
Hindu	100.0	0	0	0	0	50.0	16.7	0	0	0	100.0	0	6 (100.0)
Muslim	100.0	0	0	0	0	28.0	15.2	0	32.2	0	85.6	0	118 (100.0)
All Groups	100.0	0	0	0	0	29.0	15.3	0	30.6	0	86.3	0	124 (100.0)
						9. Village Nischintapur							
Hindu	73.3	0	0	0	0	49.3	0	0	36.0	0	100.0	0	75 (100.0)
Muslim	50.0	0	0	0	0	50.0	0	0	100.0	0	100.0	0	2 (100.0)
All Groups	72.7	0	0	0	0	49.3	0	0	37.7	0	100.0	0	77 (100.0)
						10. Village Ramchandrapur							
Hindu	83.2	2.1	0	2.1	2.8	10.5	5.6	0.7	26.6	9.1	84.6	0	143 (100.0)
Muslim	78.0	3.9	0	18.7	15.0	44.6	3.9	0	29.8	11.3	78.0	7.6	27 (100.0)
All Groups	82.3	2.3	0	4.7	4.7	15.9	5.3	0.6	27.0	9.4	83.5	1.2	170 (100.0)

TABLE 6 (contd.) DISEASE-GROUP (WHO CATEGORIES)

Social Group (community)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
(1)						(2)							(3)
6. Village Jayenpur													
Hindu	49.5	0	1.7	4.7	6.2	28.6	4.7	0	28.6	0	95.7	1.7	67 (100.0)
Muslim	64.3	0	0	35.7	0	0	0	3.6	25.0	0	96.4	0	28 (100.0)
Christian		0	0	0	0	100.0	0	100.0	0	0	0	0	1 (100.0)
All Groups	53.1	0	1.0	13.5	4.2	20.8	3.1	2.1	27.1	0	94.8	1.0	96 (100.0)
7. Village Kumarkhali													
Hindu	88.6	0	0	0	0	35.4	0	0	25.9	0	88.6	0	158 (100.0)
Muslim	90.7	0	0	0	0	34.8	0	0	51.0	0	87.7	0	204 (100.0)
All Groups	89.8	0	0	0	0	35.1	0	0	40.1	0	88.1	0	362 (100.0)
8. Village Kusumba													
Hindu	100.0	0	0	0	0	50.0	16.7	0	0	0	100.0	0	6 (100.0)
Muslim	100.0	0	0	0	0	28.0	15.2	0	32.2	0	85.6	0	118 (100.0)
All Groups	100.0	0	0	0	0	29.0	15.3	0	30.6	0	86.3	0	124 (100.0)
9. Village Nischintapur													
Hindu	73.3	0	0	0	0	49.3	0	0	36.0	0	100.0	0	75 (100.0)
Muslim	50.0	0	0	0	0	50.0	0	0	100.0	0	100.0	0	2 (100.0)
All Groups	72.7	0	0	0	0	49.3	0	0	37.7	0	100.0	0	77 (100.0)
10. Village Ramchandrapur													
Hindu	83.2	2.1	0	2.1	2.8	10.5	5.6	0.7	26.6	9.1	84.6	0	143 (100.0)
Muslim	78.0	3.9	0	18.7	15.0	44.6	3.9	0	29.8	11.3	78.0	7.6	27 (100.0)
All groups	82.3	2.3	0	4.7	4.7	15.9	5.3	0.6	27.0	9.4	83.5	1.2	170 (100.0)

TABLE 6 (contd.)

DISEASE-GROUP (WHO CATEGORIES)

C

Social Group (community (1)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families (3)	
11. Village Ukaila														
Hindu	87.5	.0	0	0	0	12.5	0	0	0	0	100.0	0	8	(100.0)
Muslim	99.5	0	0	0	0	36.2	0	0	30.0	0	99.0	0	221	(100.0)
All Groups	99.1	0	0	0	0	35.4	0	0	29.7	0	99.6	0	229	(100.0)
All Villages (Rural)														
Hindu	47.1	0.4	0.6	1.4	2.2	31.1	3.9	0.8	20.1	2.8	88.7	0.7	1609	(100.0)
Muslim	80.9	0.7	0.7	1.7	1.1	38.4	3.0	0.5	25.3	1.0	84.1	0.4	1139	(100.0)
Christian	34.3	0.9	0	1.8	2.8	13.0	3.7	2.8	21.3	0.9	88.0	0	108	(100.0)
All Groups	60.1	0,9	0.6	1.5	6.2	29.2	3.5	0.8	22.2	2.0	86.8	0.4	2856	(100.0)
12. Semi-urban Jawaddal														
Hindu	51.2	2.1	0.4	1.7	4.5	37.0	7.6	0.7	22.8	3.8	88.2	1.0	289*	(100.0)
*1 Muslim family was also found														
13. Semi-urban Bhachi														
Hindu	66.0	1.3	0,5	1.8	8.9	43.3	10.3	0.9	16.5	6.3	100.0	1.8	224	(100.0)
Muslim	72.5	1.4	0	4.3	2.9	36.2	7.2	1.4	40.6	4.3	100.0	1.7	69	(100.0)
All Groups	67.6	1.4	0.3	2.4	7.5	41.6	9.6	1.0	22.2	5.6	100.0	1.7	293	(100.0)
All Semi-urban areas (Urban)														
Hindu	57.7	1.8	0.4	1.7	6.4	39.8	8.8	0.8	20.1	4.9	93.4	1.4	513	(100.0)
Muslim	71.4	1.4	0	4.3	2.8	35.7	7.1	1.4	40.0	4.3	100.0	1.4	70	(100.0)
All Groups	59.2	1.7	0.4	2.1	6.0	39.3	8.6	0.9	22.5	4.8	94.2	1.4	583	(100.0)

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TABLE 6

Socila Group (community)-wise Family Incidence Rate of different Disease-groups for the families surveyed in villages and semi-urban areas, W. Bengal 1974

Social group (community)	DISEASE-GROUP (WHO CATAEGORIES) I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
1.						(2)							(3)
1. Village Bonhoogly													
Hindu	40.3	1.6	1.3	1.0	3.6	29.8	5.3	1.6	14.1	0.3	91.2	0.7	305 (100.0)
Muslim	49.7	2.0	2.3	1.4	2.6	35.6	4.3	1.4	14.4	2.3	93.1	.0	348 (100.0)
Christian	38.6	2.3	4.1Ø	4.Ø	2.3	20.4	4.1	4.1	13.2	2.3	91.3	.0	55 (100.0)
All Groups	44.8	1.9	1.7	1.42	.9	31.9	4.7	1.7	14.1	1.4	92.1	0.3	708 (100.0)
2. Village Chowhati													
Hindu	25.2	1.3	0.9	1.5	2.2	34.3	4.6	0.7	16.6	4.8	84.7	1.4	549 (100.0)
Muslim	61.5	0	0	0	0	15.4	0	0	46.1	0	84.6	0	13 (100.0)
All Groups	26.0	1.3	0.9	1.4	2.1	33.8	4.5	0.7	17.3	4.6	83.7	1.4	562 (100.0)
3. Village Dingalpota													
Hindu	48.7	0.6	0	3.2	0.6	28.8	4.5	1.9	12.8	3.2	94.2	0	155*(100.0)
* 1 Christian family was also found in the village													
4. Village Hogalkuria													
Hindu	39.8	0	0	0	3.1	28.9	2.3	0	34.4	0	83.1	0	128 (100.0)
Christian	31.5	0	0	0	4.1	23.7	4.1	0	31.5	0	86.4	0	51(100.0)
All Groups	37.4	0	0	0	3.3	27.4	2.8	0	33.5	0	85.5	0	179 (100.0)
5. Village Jagannathpur													
Hindu	66.7	0	0	0	0	53.3	0	0	6.7	0	100.0	0	15 (100.0)
Muslim	100.0	0	0	0	0	64.0	0	0	2.8	0	41.0	0	178 (100.0)
All Groups	97.4	0	0	0	0	63.2	0	0	3.1	0	45.6	0	193 (100.0)

TABLE 6

Socila Group (community)-wise Family Incidence Rate of different Disease-groups for the families surveyed in villages and semi-urban areas, W. Bengal 1974

Social group (community)	DISEASE-GROUP (WHO CATAEGORIES) I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
1.						(2)							(3)
						1. Village Bonhoogly							
Hindu	40.3	1.6	1.3	1.0	3.6	29.8	5.3	1.6	14.1	0.3	91.2	0.7	305 (100.0)
Muslim	43.7	2.0	2.3	1.4	2.6	35.6	4.3	1.4	14.4	2.3	93.1	.0	348 (100.0)
Christian	38.6	2.3	4.1Ø	7.0	2.3	20.4	4.1	4.1	13.2	2.3	91.3	.0	55 (100.0)
All Groups	44.8	1.9	1.7%	1.42	.9	31.9	4.7	1.7	14.1	1.4	92.1	0.3	708 (100.0)
						2. Village Chowhati							
Hindu	25.2	1.3	0.9	1.5	2.2	34.3	4.6	0.7	16.6	4.8	84.7	1.4	549 (100.0)
Muslim	61.5	0	0	0	0	15.4	0	0	46.1	0	84.6	0	13 (100.0)
All Groups	26.0	1.3	0.9	1.4	2.1	33.8	4.5	0.7	17.3	4.6	83.7	1.4	562 (100.0)
						3. Village Dingalpota							
Hindu	48.7	0.6	0	3.2	0.6	28.8	4.5	1.9	12.8	3.2	94.2	0	155*(100.0)
	* 1 Christian family was also found in the village												
						4. Village Hogalkuria							
Hindu	39.8	0	0	0	3.1	28.9	2.3	0	34.4	0	83.1	0	128 (100.0)
Christian	31.5	0	0	0	4.1	23.7	4.1	0	31.5	0	86.4	0	51(100.0)
All Groups	37.4	0	0	0	3.3	27.4	2.8	0	33.5	0	85.5	0	179 (100.0)
						5. Village Jagannathpur							
Hindu	66.7	0	0	0	0	53.3	0	0	6.7	0	100.0	0	15 (100.0)
Muslim	100.0	0	0	0	0	64.0	0	0	2.8	0	41.0	0	178 (100.0)
All Groups	97.4	0	0	0	0	63.2	0	0	3.1	0	45.6	0	193 (100.0)

TABLE 6

Socila Group (community)-wise Family Incidence Rate of different Disease-groups for the families surveyed in villages and semi-urban areas, W. Bengal 1974

Social group (community)	DISEASE-GROUP (WHO CATAEGORIES) I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
1.						1. Village Bonhoogly (2)							(3)
Hindu	40.3	1.6	1.3	1.0	3.6	29.8	5.3	1.6	14.1	0.3	91.2	0.7	305 (100.0)
Muslim	49.7	2.0	2.3	1.4	2.6	35.6	4.3	1.4	14.4	2.3	93.1	.0	348 (100.0)
Christian	38.6	2.3	4.1	1.8	2.3	20.4	4.1	4.1	13.2	2.3	91.3	.0	55 (100.0)
All Groups	44.8	1.9	1.7	1.42	.9	31.9	4.7	1.7	14.1	1.4	92.1	0.3	708 (100.0)
						2. Village Chowhati							
Hindu	25.2	1.3	0.9	1.5	2.2	34.3	4.6	0.7	16.6	4.8	84.7	1.4	549 (100.0)
Muslim	61.5	0	0	0	0	15.4	0	0	46.1	0	84.6	0	13 (100.0)
All Groups	26.0	1.3	0.9	1.4	2.1	33.8	4.5	0.7	17.3	4.6	83.7	1.4	562 (100.0)
						3. Village Dingalpota							
Hindu	48.7	0.6	0	3.2	0.6	28.8	4.5	1.9	12.8	3.2	94.2	0	155*(100.0)
	* 1 Christian family was also found in the village												
						4. Village Hogalkuria							
Hindu	39.8	0	0	0	3.1	28.9	2.3	0	34.4	0	83.1	0	128 (100.0)
Christian	31.5	0	0	0	4.1	23.7	4.1	0	31.5	0	86.4	0	51(100.0)
All Groups	37.4	0	0	0	3.3	27.4	2.8	0	33.5	0	85.5	0	179 (100.0)
						5. Village Jagannathpur							
Hindu	66.7	0	0	0	0	53.3	0	0	6.7	0	100.0	0	15 (100.0)
Muslim	100.0	0	0	0	0	64.0	0	0	2.8	0	41.0	0	178 (100.0)
All Groups	97.4	0	0	0	0	63.2	0	0	3.1	0	45.6	0	193 (100.0)

TABLE 6 (contd.) DISEASE-GROUP (WHO CATEGORIES)

Social Group (community)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families
(1)						(2)							(3)
6. Village Jayenpur													
Hindu	49.5	0	1.7	4.7	6.2	28.6	4.7	0	28.6	0	95.7	1.7	67 (100.0)
Muslim	64.3	0	0	35.7	0	0	0	3.6	25.0	0	96.4	0	28 (100.0)
Christian		0	0	0	0	100.0	0	100.0	0	0	0	0	1 (100.0)
All Groups	53.1	0	1.0	13.5	4.2	20.8	3.1	2.1	27.1	0	94.8	1.0	96 (100.0)
7. Village Kumarkhali													
Hindu	88.6	0	0	0	0	35.4	0	0	25.9	0	88.6	0	158 (100.0)
Muslim	90.7	0	0	0	0	34.8	0	0	51.0	0	87.7	0	204 (100.0)
All Groups	89.8	0	0	0	0	35.1	0	0	40.1	0	88.1	0	362 (100.0)
8. Village Kusumba													
Hindu	100.0	0	0	0	0	50.0	16.7	0	0	0	100.0	0	6 (100.0)
Muslim	100.0	0	0	0	0	28.0	15.2	0	32.2	0	85.6	0	118 (100.0)
All Groups	100.0	0	0	0	0	29.0	15.3	0	30.6	0	86.3	0	124 (100.0)
9. Village Nischintapur													
Hindu	73.3	0	0	0	0	49.3	0	0	36.0	0	100.0	0	75 (100.0)
Muslim	50.0	0	0	0	0	50.0	0	0	100.0	0	100.0	0	2 (100.0)
All Groups	72.7	0	0	0	0	49.3	0	0	37.7	0	100.0	0	77 (100.0)
10. Village Ramchandrapur													
Hindu	83.2	2.1	0	2.1	2.8	10.5	5.6	0.7	26.6	9.1	84.6	0	143 (100.0)
Muslim	78.0	3.9	0	18.7	15.0	44.6	3.9	0	29.8	11.3	78.0	7.6	27 (100.0)
All groups	82.3	2.3	0	4.7	4.7	15.9	5.3	0.6	27.7	9.4	83.5	1.2	170 (100.0)

TABLE 6 (contd.) DISEASE-GROUP (WHO CATEGORIES) C

Social Group (community (1)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families (3)	
11. Village Ukhila (2)														
Hindu	87.5	.0	0	0	0	12.5	0	0	0	0	100.0	0	8	(100.0)
Muslim	99.5	0	0	0	0	36.2	0	0	30.0	0	99.0	0	221	(100.0)
All Groups	99.1	0	0	0	0	35.4	0	0	29.7	0	99.6	0	229	(100.0)
All Villages (Rural)														
Hindu	47.1	0.4	0.6	1.4	2.2	31.1	3.9	0.8	20.1	2.8	88.7	0.7	1609	(100.0)
Muslim	80.9	0.7	0.7	1.7	1.1	38.4	3.0	0.5	25.3	1.0	84.1	0.4	1139	(100.0)
Christian	34.3	0.9	0	1.8	2.8	13.0	3.7	2.8	21.3	0.9	88.0	0	108	(100.0)
All Groups	60.1	0.6	0.6	1.5	6.2	29.2	3.5	0.8	22.2	2.0	86.8	0.4	2856	(100.0)
12. Semi-urban Jagaddal														
Hindu	51.2	2.1	0.4	1.7	4.5	37.0	7.6	0.7	22.8	3.8	88.2	1.0	289*	(100.0)
*1 Muslim family was also found														
13. Semi-urban Elachi														
Hindu	66.0	1.3	0.5	1.8	8.9	43.3	10.3	0.9	16.5	6.3	100.0	1.8	224	(100.0)
Muslim	72.5	1.4	0	4.3	2.9	36.2	7.2	1.4	40.6	4.3	100.0	1.7	69	(100.0)
All Groups	67.6	1.4	0.3	2.4	7.5	41.6	9.6	1.0	22.2	5.8	100.0	1.7	293	(100.0)
All Semi-urban areas (urban)														
Hindu	57.7	1.8	0.4	1.7	6.4	39.8	8.8	0.8	20.1	4.9	93.4	1.4	513	(100.0)
Muslim	71.4	1.4	0	4.3	2.8	35.7	7.1	1.4	40.0	4.3	100.0	1.4	70	(100.0)
All Groups	59.2	1.7	0.4	2.1	6.0	39.3	8.6	0.9	22.5	4.8	94.2	1.4	583	(100.0)

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TABLE 1 Family Incidence Rate* of different Disease-groups for the Families surveyed in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, West Bengal, 1974-75

Disease-group(WHO catagories)	Rural area (name of the Village)											All Rural areas	Semi-Urban area		All Semi-Urban areas
	Sonhoogly	Chowhati	Dingalpota	Hogalkuria	Jagannathpur	Jayenpur	Kumarkhali	Kusumba	Nischintapur	Ramchandrapur	Ukhila		ELA - CHI	BAGA - DDAL	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
I. IPD	44.8	26.0	48.7	37.4	97.4	53.1	89.8	100.0	72.7	82.3	99.1	60.1	67.6	50.7	59.2
II N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
III.END	1.9	1.3	0.6	0	0	0	0	0	0	2.3	0	0.9	1.4	2.1	1.7
IV DBBO	1.7	0.9	0	0	0	1.0	0	0	0	0	0	0	0	0	0.4
V MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VI DVS	1.4	1.4	3.2	0	0	13.5	0	0	0	4.7	0	1.5	2.4	1.7	2.1
VII.CS	2.9	2.1	0.6	3.3	0	4.2	0	0	0	4.7	0	6.2	7.5	4.5	6.0
VIII.MS	31.9	33.8	28.8	27.7	63.2	20.8	35.1	29.0	49.3	15.9	35.4	29.2	41.6	36.9	39.3
IX DDS	4.7	4.5	4.5	2.8	0	3.1	0	15.3	0	5.3	0	3.5	9.5	7.6	8.6
X DUGS	1.7	0.7	1.9	0	0	2.1	0	0	0	0.6	0	0.8	1.0	0.7	0.9
XI CPCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XII.DST	14.1	17.3	12.8	33.5	3.1	27.1	40.1	30.6	37.7	27.0	29.7	22.2	22.2	22.8	22.5
XIII.NCT	1.4	4.6	3.2	0	0	0	0	0	0	9.4	0	2.0	5.8	3.8	4.8
XIV CA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XV DPMI	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XVI.SILC	92.1	83.7	94.2	85.5	45.6	94.8	88.1	86.5	100.0	83.5	99.6	86.8	100.0	89.3	94.2
XVII.ACV	0.3	1.4	0	0	0	1.0	0	0	0	1.2	0	0.4	1.7	1.0	1.4
No. of Families surveyed	708	562	156	179	193	96	362	124	77	170	229	2856	293	290	583

Disease-groups:

I.IPD: Infective and Parasitic Diseases (code 000-136)
II.N: Neoplasms (140-239)

III.END: Endocrine, Nutritional, and Metabolic Diseases (240-279)

TABLE 1 Family Incidence Rate* of different Disease-Groups for the Families surveyed in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, West Bengal, 1974-75

Disease-group(WHO catagories)	Rural area (name of the Village)											All Rural areas	Semi-Urban area		All Semi-Urban areas
	Bon-hooghly	Chow-hati	Ding-alpota	Hogal-kuria	Jagan-nath-pur	Joyen-pur	Kuma-rkhali	Kus-umba	Nisc-hintg-pur	Ram-chan-drapur	Ukh-ila		ELA - CHI	BAGA - DDAL	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
I. IPD	44.8	26.0	48.7	37.4	97.4	53.1	89.8	100.0	72.7	82.3	99.1	60.1	67.6	50.7	59.2
II N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IIIENED	1.9	1.3	0.6	0	0	0	0	0	0	2.3	0	0.9	1.4	2.1	1.7
IV DRBO	1.7	0.9	0	0	0	1.0	0	0	0	0	0	0	0	0	0.4
V MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VI DVS	1.4	1.4	3.2	0	0	13.5	0	0	0	4.7	0	1.5	2.4	1.7	2.1
VIIECS	2.9	2.1	0.6	3.3	0	4.2	0	0	0	4.7	0	6.2	7.5	4.5	6.0
VIIIDMS	31.9	33.8	28.8	27.7	63.2	20.8	35.1	29.0	49.3	15.9	35.4	29.2	41.6	36.9	39.3
IX DDS	4.7	4.5	4.5	2.8	0	3.1	0	15.3	0	5.3	0	3.5	9.5	7.6	8.6
X DUGS	1.7	0.7	1.9	0	0	2.1	0	0	0	0.6	0	0.8	1.0	0.7	0.9
XI CPCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XIIDST	14.1	17.3	12.8	33.5	3.1	27.1	48.1	30.6	37.7	27.0	29.7	22.2	22.2	22.8	22.5
XIIIDMCT	1.4	4.6	3.2	0	0	0	0	0	0	9.4	0	2.0	5.6	3.8	4.8
XIV CA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XV DPPM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XVISILC	92.1	83.7	94.2	85.5	45.6	94.8	88.1	86.5	100.0	83.5	99.6	86.8	100.0	88.3	94.2
XVIIACV	0.3	1.4	0	0	0	1.0	0	0	0	1.2	0	0.4	1.7	1.0	1.4
No. of Families surveyed	708	562	156	179	193	96	362	124	77	170	229	2856	293	290	583

Disease-groups:

I.IPD: Infective and Parasitic Diseases (code 000-136)
II.N: Neoplasms (140-239)

III.EMND: Endocrine, Nutritional, and Metabolic Diseases (240-279)

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Table 1. DISEASE - GROUPS

IV. DBBO : Diseases of Blood and Blood forming organs (280-289)

V. MD : Mental Disorders (290-315)

VI. DNS : Diseases of Nervous System and Sense Organs (320-389)

VII. DCS : Diseases of Circulatory System (390-458)

VIII. DRS : Diseases of Respiratory System (460-519)

IX. DDS : Diseases of Digestive System (520-577)

X. DUGS : Diseases of Urino-Genital System (580-629)

XI. CPCP : Complications of Pregnancy, Child birth and the Puerperium (630-687)

XII. DST : Diseases of Skin and sub-cutaneous tissues (680-709)

XIII. DMCT : Diseases of the Musculo-skeletal System and connective tissues (710-738)

XIV. CA : Congenital Anomalies (740-759)

XV. DPNM : Certain Diseases of peri-natal morbidity and Mortality (760-779)

XVI. SIIC : Symptoms and Ill-defined conditions (780-796)

XVII. ACV : Accidents, poisinings and viloence (800-999)

* Family Incidence Rate = $\frac{100X \text{ number of families affected by the particular disease group}}{\text{Total number of families}}$

Table 1. DISEASE - GROUPS

IV.	DBBO	: Diseases of Blood and Blood forming organs (280-289)
V.	MD	: Mental Disorders (290-315)
VI.	DNS	: Diseases of Nervous System and Sense Organs (320-389)
VII.	DCS	: Diseases of Circulatory System (390-458)
VIII.	DRS	: Diseases of Respiratory System (460-519)
IX.	DDS	: Diseases of Digestive System (520-577)
X.	DUGS	: Diseases of Urino-Genital System (580-629)
XI.	CPCP	: Complications of Pregnancy, Child birth and the Puerperium (630-687)
XII.	DST	: Diseases of Skin and sub-cutaneous tissues (680-709)
XIII.	DMCT	: Diseases of the Musculo-skeletal System and connective tissues (710-738)
XIV.	CA	: Congenital Anomalies (740-759)
XV.	DPRM	: Certain Diseases of peri-natal morbidity and Mortality (760-779)
XVI.	SILC	: Symptoms and Ill-defined conditions (780-796)
XVII.	ACV	: Accidents, poisinings and viloence (800-999)

* Family Incidence Rate = $\frac{\text{100X number of families affected by the particular disease group}}{\text{Total number of families}}$

TABLE 2

Family Incidence Rate of one of Four Cominant Disease-groups and the most frequently reported diseased per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Paraneas, West Bengal, 1974-1975

Rural (R) Semi-Urban (U) area	Rate of Family Incidence Infective and Parasitic diseases-Group I	Most frequently reported diseases of the Group I	
1.	(2)	Dysentery	Diarrhoea
(1)	(2)	(3)	(4)
1. Bonhoogly (R) (No. of families: 708)	44.8	15.1	-
2. Chowhati (R) (No of families: 562)	26.0	13.2	-
3. Dingalpota (R) (No. of familes 156)	48.7	20.0	-
4. Hogalkuria (R) (No of families 179)	37.4	-	11.7
5. Jagannathpur (R) (No of families: 193)	97.4	47.1	-
6. Jayenpur (R) (No. of families: 96)	53.1	32.3	-
7. Kumarkhali (R) (No. of families: 362)	89.8	-	57.4
8. Kusumba (R) (No. of families: 124)	100.0	-	66.1
9. Nischintapur (R) (No. of families: 77)	72.7	44.1	-
10. Ramchandrapur (R) (No. of Families: 170)	82.3	53.5	-
11. Ukhila (R) No. of families: 229)	99.1	-	47.2
All Rural Areas (No. of Families:(2856)	60.1	16.4	14.7
1. Elachi (U) No. of Families: (293)	67.6	15.2	-
2. Jagaddal (U) No. of Families: (290)	50.7	23.2	-
All Semi-Urban Areas No. of Families: (583)	59.2	19.2	-
All Areas (Rural + Semi-Urban) No. of Families: (3439)	59.9	16.9	12.2

TABLE 3

Family Incidence Rate of one Four Dominant Disease - groups and the most frequently reported diseased per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Parangas, West Bengal, 1974-1975

Rural/ Semi-Urban area	Fa Family Incidence Rate of Diseases of Respiratory system (VIII)	Most frequently reported disease of the Group VIII	
		Cold	Flu
(1)	(2)	(3)	(4)
1. Bohoogly	31.9	26.8	-
2. Chowhati	33.8	31.8	-
3. Dingalpota	28.8	26.3	-
4. Hogalkuria	27.4	23.5	-
5. Jagannathpur	63.2	-	62.7
6. Jayenpur	20.8	7.3	-
7. Kumarkhali	35.1	-	32.6
8. Kusumba	29.0	-	26.6
9. Nischintapur	49.3	-	48.0
10. Ramchandrapur	15.9	12.9	-
11. Ukilia	35.4	-	34.9
ALL RURAL AREAS	29.2	16.8	13.6
1. Elachi	41.6	29.7	-
2. Jagaddal	36.9	33.4	-
ALL SEMI-URBAN AREAS	39.3	31.6	-
ALL AREAS	30.9	19.3	11.3

Family Incidence Rate of

TABLE 3

Family Incidence Rate of one Four Dominant Disease - groups and the most frequently reported diseased per disease-group in villages and semi-urban areas of Sonarpur P.S., 24-Parangas, West Bengal, 1974-1975

Rural/ Semi-Urban area	Fa Family Incidence Rate of Diseases of Respiratory system (VIII)	Most frequently reported disease of the Group VIII	
		Cold	Flu
(1)	(2)	(3)	(4)
1. Bohoogly	31.9	26.8	-
2. Chowhati	33.8	31.8	-
3. Dingalpota	28.8	26.3	-
4. Hogalkuria	27.4	23.5	-
5. Jagannathpur	63.2	-	62.7
6. Jayenpur	20.8	7.3	-
7. Kumarkhali	35.1	-	32.6
8. Kusumba	29.0	-	26.6
9. Nischintapur	49.3	-	48.0
10. Ramchandrapur	15.9	12.9	-
11. Ukilia	35.4	-	34.9
ALL RURAL AREAS	29.2	16.8	13.6
1. Elachi	41.6	29.7	-
2. Jagaddal	36.9	33.4	-
ALL SEMI-URBAN AREAS	39.3	31.6	-
ALL AREAS	30.9	19.3	11.3

TABLE 4

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S.; 24-Parganas, W. Bengal 1974-1975

Rural/ Semi-urban area	Family Incidence Rate of Diseases of Skin and sub cutaneous Tissues (XII)	Family Incidence Rate of Most frequently reported disease of the Group XII	
		Itch	SK.disease of dermatitis
(1)	(2)	(3)	(4)
1. Bonhoogly	14.1	5.6	-
2. Chowhati	17.3	10.5	-
3. Dingolpota	12.8	10.9	-
4. Gogalkuria	33.5	27.4	-
5. Jagannathpur	3.1	2.6	-
6. Jayenpur	27.1	27.1	-
7. Kukurkhali	40.1	40.0	-
8. Kusumba	30.6	27.4	-
9. Nischintapur	37.7	32.5	-
10. Ramchandrapur	27.0	27.0	12.9
11. Ukhila	29.7	29.7	?
ALL RURAL AREAS	22.2	16.2	0.8
1. Elachi	22.2*	-	-
2. Jagaddal	22.8	11.4	-
ALL SEMI URBAN AREAS	22.3	14.4	0.6

* In Elachi Skin disease of Abscess was reported most frequently. (Fam. Inc. Rate: 3.4)

TABLE 4

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S.; 24-Parganas, W. Bengal 1974-1975

Rural/ Semi-urban area	Family Incidence Rate of Diseases of Skin and sub cutaneous Tissues (XII)	Family Incidence Rate of Most frequently reported disease of the Group XII	
		Itch	Sk. disease of dermatitis
(1)	(2)	(3)	(4)
1. Bonhoogly	14.1	5.6	-
2. Chowhati	17.3	10.5	-
3. Dingolpota	12.8	10.9	-
4. Hogalkuria	33.5	27.4	-
5. Jagannathpur	3.1	2.6	-
6. Jayenpur	27.1	27.1	-
7. Kukurkhali	40.1	40.0	-
8. Kusumdo	30.6	27.4	-
9. Mischintapur	37.7	32.5	-
10. Ramchandrapur	27.0	27.0	12.9
11. Ukhila	29.7	29.7	?
ALL RURAL AREAS	22.2	16.2	0.8
1. Elachi	22.2*	-	-
2. Jagaddal	22.8	11.4	-
ALL SEMI URBAN AREAS	22.3	14.4	0.6

* In Elachi Skin disease of Abscess was reported most frequently. (Fam. Inc, Rate: 3.4)

TABLE 5

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S.; 24-Pargana, W.Bengal, 1974-1975

Rural semi-urban area	Family Incidence Rate of Symptoms and ill-defined conditions(XVI)	Most frequently reported disease of the Group XVI Cough	Fever
(1)	(2)	(3)	(4)
1. Bonhoogly	92.1	-	90.7
2. Chownati	83.7	-	80.1
3. Dingolpota	94.2	46.8	-
4. Hogalkuria	85.5	-	75.4
5. Haganathpur	45.6	-	27.5
6. Jayenpur	94.8	-	66.7
7. Kumarkhali	88.1	75.4	-
8. Kusumba	86.3	6.4	-
9. Nischintapur	100.0	71.4	-
10. Ramachandrapur	83.5	-	-
11. Ukhila	99.6	93.0	-
ALL RURAL AREAS	86.8	24.3	51.5
1. Elachi	100.0	-	65.5
2. Jagaddal	88.3	-	77.6
ALL SEMI URBAN AREAS	94.2	-	71.5
ALL AREAS	88.1	18.9	54.9

TABLE 5

Family Incidence Rate of one of Four Dominant Disease-groups and the most frequently reported disease per disease-group in villages and semi-urban areas of Sonarpur P.S.; 24-Pargana, W.Bengal, 1974-1975

Rural semi-urban area	Family Incidence Rate of Symptoms and Ill-defined conditions(XVI)	Most frequently reported disease of the Group XVI Cough	Fever
(1)	(2)	(3)	(4)
1. Bonhoogly	92.1	-	90.7
2. Chowhati	83.7	-	80.1
3. Dingolpota	94.2	46.8	-
4. Hogalkuria	85.5	-	75.4
5. Haganathpur	45.6	-	27.5
6. Jayenpur	94.8	-	66.7
7. Kumarkhali	88.1	75.4	-
8. Kusumba	86.3	6.4	-
9. Nischintapur	100.0	71.4	-
10. Ramachandrapur	83.5	-	-
11. Ukhila	99.6	93.0	-
ALL RURAL AREAS	86.8	24.3	51.5
1. Elachi	100.0	-	65.5
2. Jagaddal	88.3	-	77.6
ALL SEMI URBAN AREAS	94.2	-	71.5
ALL AREAS	88.1	18.9	54.9

TABLE 6 (contd.) DISEASE-GROUP (WHO CATEGORIES) C

Social Group (community (1)	I	III	IV	VI	VII	VIII	IX	X	XII	XIII	XVI	XVII	TOTAL Families (3)	
11. Village Ukhila (2)														
Hindu	87.5	.0	0	0	0	12.5	0	0	0	0	100.0	0	8	(100.0)
Muslim	99.5	0	0	0	0	36.2	0	0	30.0	0	99.0	0	221	(100.0)
All Groups	99.1	0	0	0	0	35.4	0	0	29.7	0	99.6	0	229	(100.0)
All Villages (Rural)														
Hindu	47.1	0.4	0.6	1.4	2.2	31.1	3.9	0.8	20.1	2.8	88.7	0.7	1609	(100.0)
Muslim	80.9	0.7	0.7	1.7	1.1	38.4	3.0	0.5	25.3	1.0	84.1	0.4	1139	(100.0)
Christian	34.3	0.9	0	1.8	2.8	13.0	3.7	2.8	21.3	0.9	88.0	0	108	(100.0)
All Groups	60.1	0.9	0.6	1.5	6.2	29.2	3.5	0.8	22.2	2.0	86.8	0.4	2856	(100.0)
12. Semi-urban Jagaddal														
Hindu	51.2	2.1	0.4	1.7	4.5	37.0	7.6	0.7	22.8	3.8	88.2	1.0	289*	(100.0)
*1 Muslim family was also found														
13. Semi-urban Elachi														
Hindu	66.0	1.3	0,5	1.8	8.9	43.3	10.3	0.9	16.5	6.3	100.0	1.8	224	(100.0)
Muslim	72.5	1.4	0	4.3	2.9	36.2	7.2	1.4	40.6	4.3	100.0	1.7	69	(100.0)
All Groups	67.6	1.4	0.3	2.4	7.5	41.6	9.6	1.0	22.2	5.8	100.0	1.7	293	(100.0)
All Semi-urban areas (urban)														
Hindu	57.7	1.8	0.4	1.7	6.4	39.8	8.8	0.8	20.1	4.9	93.4	1.4	513	(100.0)
Muslim	71.4	1.4	0	4.3	2.8	35.7	7.1	1.4	40.0	4.3	100.0	1.4	70	(100.0)
All Groups	59.2	1.7	0.4	2.1	6.0	39.3	8.6	0.9	22.5	4.8	94.2	1.4	583	(100.0)

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TOTAL HEALTH CARE PROJECT 1974-1975

REPORT ON

FAMILY HEALTH PROBLEMS IN A RURAL SOCIETY OF WEST BENGAL

1. Introduction

On national level social welfare planning measures are currently manifold and with respect to the same serious attention is being laid more and more increasingly upon various health problems of the people at large. Though search for reliable information about national health is continuing from long past (particularly since the publication of the momentous Report of Bhore Committee in 1946), a new approach has lately been emphasised to tackle health problems of the country. This approach urges that the family as a whole should be the focus of attention in the matter of health and family welfare services and moreover, health activities must also adopt a family rather than an individual approach.

Importance of this approach is, of course, not unknown to those who are professionally concerned with the conditions and processes of both health and disease. That 'family' has to be taken as a 'functional unit' in making the facts about the disease more intelligible and its course more manageable has already been strongly pointed out in the international circles of medical profession. As a matter of fact, it has been claimed that better progress in health field depends upon 'clearer conceptions of the identifiable functional units' which would provide greater knowledge and better control. Since the 'family' happens to be the smallest but certainly not the least important social unit for coping with disease, one cannot miss to concentrate on family-based health information in understanding the nature and magnitude of health problems in general.

There is now emerging within the medical profession a more systematic concern for the personal and social factors in illness and eventually, the need for exploration of some sociological variables in health and disease is becoming urgent. Study of Family-based incidences of disease by social group (community) is expected to provide insights into health problems of the stratified rural society at large. With this objective in view the present report has been written.

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Precisely speaking, the report attempts to reveal the following issues:

(a) the nature and magnitude of incidences of diseases among the rural as well as semi-urban families residing in a rural society,

(b) the differential incidences of family morbidity among different communities (social groups) of a rural society in contrast to those of a semi-urban society,

(c) the dominant disease-groups which create widely diffused health problems on family level in rural or semi-urban society,

(d) the Family Incidence Rates of the most frequently reported diseases among different rural as well as semi-urban communities (social groups).

2. Material and Method

A comprehensive survey on "Basic Health Services" was carried out in 1974-1975 in eleven villages and two semi-urban areas (sections of Rajpur municipal town) of Sonarpur P.S. 24-Paraganas, West Bengal.

Selection of villages and semi-urban areas was not at random. Rather, selection of the survey area was made with certain purposes. As A.D. Charitable Hospital which is located at Elachi, (a semi-urban section of municipal town of Rajpur,) has been catering medical and hospital needs of the local people since mid-1960 it was felt that a household to household enquiry should be attempted to know the impact area of the Hospital. To what extent the local inhabitants had taken health services from A.D. Hospital? Who were the people who had taken relatively more medical help from the Hospital? What was the morbidity condition in the locale of the Hospital? What forms of treatment the local people lately followed usually to cure diseases? To what level the rural people were conscious to go for modern medicines in tackling health hazards? These are some of the thoughts which prompted the household enquiry in question. Satisfactory evidences were hardly found to meet the initial queries and eventually a pilot but exploratory study to probe into the queries was brought into a resolution. But for such exploratory study eleven villages which are situated within 5 miles radial distance from Elachi (urban section of Rajpur town) and again, which form a compact but continuous area of habitation around Elachi, were chosen. As these villages were within easy reach of A.D. Hospital of Elachi, it was expected that relevant information which would be available from the rural people would be quite helpful to offer due answers to the initial queries

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and again, such information would help to plan better action-programmes of health services in complete agreement with local health condition and medical needs. In addition, residents of Elachi and those of another semi-urban section of Rajpur town, namely, Jaggadal were also chosen for making a comparative study with rural residents. Health and disease aspects of local society were to be examined in general and accordingly the given sample of rural and semi-urban settlements of Sonarpur P.S. were selected to constitute the area of survey-operation. Selection of villages and semi-urban habitats was purposeful to accomplish the proposed pilot survey. Under the circumstances, it is needless to say that the residents of the selected habitats do not stand to represent the general characteristics of the local residents of 24-Parganas district as a whole.

The survey attempted to make complete enumeration of all households of each village or semi-urban area by canvassing a 'Family Schedule For Basic Health Services'. In this schedule requisite information about the following items was sought from each household, the head of the household being taken generally as reference-point:

1) Identification particulars of each area of survey and again, of each household;

2) Demographic particulars of each constituent member of a household, with special reference to religion, marital status, education status, occupation and vaccination records;

3) Illness suffered by each member of a household within one year prior to the date of enquiry;

4) Concept about occurrence of disease in family,

5) Mode of treatment for each disease of each affected family member;

6) Type of Hospital services taken by the family, with particular reference to A.D. Charitable Hospital (located in Elachi section of Rajpur town);

7) Particulars of environmental sanitation with specific reference to source of water supply, sullage disposal, disposal of refuse and latrine-facility; and

8) Family Planning activities.

Total number of households which did ultimately furnish satisfactory information about the desired items of query in

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the areas of survey was 3439. The distribution of sample families by community (social groups) over the sample villages and semi-urban areas of Sonarpur P.S. has been shown in Table A. These 3439 families comprise the basic source of the core materials of all cases of physical sickness. Out of the total families the Hindus stood for 62 per cent. The Muslims explained for 35 per cent cases, the rest being the Christians.

Head and/or a senior member of the Household was asked to enumerate those diseases - minor or major - from which any member might have suffered during last twelve months from the date of enquiry. Names of the diseases and the affected persons were recorded immediately and subsequently ancillary information about concept and mode of treatment of each kind of sickness was noted. Though complete reliance was placed on the declared statement about different diseases in a family, yet there was the inescapable effects of recall lapse and unintentional omission of old instances of sickness. Nevertheless, records about a substantial volume of sickness per family could be gathered from the survey. In the field every attempt was made to verify the reported disease by relevant documents. But in many cases such documents were not found. Truly speaking, in a number of cases field investigators had to rely fully on the declared verbal statement of the informants. In spite of such limitations, each and every household under investigation yielded sufficient positive information about diseases of one kind or other.

Incidences and causes of illness of sick members per family were transcribed and then causes of illness were codified as per World Health Organization's (WHO) International Classification of Diseases. In doing so, the nomenclature that has been given by WHO under Tabular List of Inclusion and Four Digit subcategories has been utilized for the present study to classify the reported diseases under appropriate Disease-groups.

A total of 17 disease-groups has been considered to include the reported cases of sickness per family under proper category. After ascertaining the group-position of a disease the place of the family that had reported the disease concerned had been marked against the appropriate broad disease-group. Whatever might be the frequencies of one or more than one disease in a family occurences of this or that specific disease had been counted once in determining the position of the family against the disease-group concerned. By this method the position of a family under one or more than one group within seventeen disease-groups has been located.

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Family incidence Rates of different disease-groups have been calculated by the following method:

$$100 \times \frac{\text{No. of families affected by a particular disease-group}}{\text{Total Number of Families}}$$

Family Incidence Rates of different disease-groups have been calculated separately for each village and each semi-urban area as well as for rural and semi-urban areas as a whole.

The seventeen disease-groups (WHO categories) have been abbreviated as follows:

GroupI: IPD (Infective and Parasitic Diseases)

Group II: N (Neoplasms)

Group III: ENMD (Endocrine, Nutritional and Metabolic Diseases)

Group IV: DBBO (Diseases of Blood and Blood-forming Organs)

Group V: MD (Mental Disease)

Group VI: DNS (Diseases of Nervous System and Sense Organs)

Group VII: DCS (Diseases of Circulatory System)

Group VIII: DRS (Diseases of the Respiratory System)

Group IX: DDS (Diseases of the Digestive System)

Group X: DUGS (Diseases of Urino-genital System)

Group XI: CPCP (Complications of Pregnancy, Child Birth and the Puerperium)

Group XII: DST (Diseases of Skin and subcutaceous Tissues)

Group XIII: DMCT (Disease of Musculo-skeletal System and Connective Tissues)

Group XIV: CA (Congenital Anomalies)

Group XV: DPNM (Certain Disease of Peri-natal Morbidity and Mortality)

Group XVI: SILC (Symptoms and Ill-defined Conditions)

Group XVII: ACV: (Accidents, poisonings, and Violence)

On the basis of religion-affiliation of the head of household the household concerned has been classified under three social groups (communities), namely, Hindu, Muslim, and

Christian. Again, on the basis of community - affiliation the family incidence rates of disease-groups for each broad social group have been calculated to point out differential disease-prevalence and thereby health problems in the given rural or semi-urban society.

The disease-group which has included larger entries of diseases as reported by the given families and thereby has yielded higher Family Incidence Rate has been treated as Dominant disease-group. By this definition four Dominant disease-groups could be identified in the survey area, irrespective of its rural or semi-urban character.

Family-based information about incidences of various types of disease has received principal focus in the course of analysis that has been followed in the present study. Such information has further been examined in terms of community (social group) affiliation of the families.

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Table A. Distribution of families by social group (community) over different villages and semi-urban areas surveyed in Sonarpur P.S., 24-Parganas, West Bengal, 1974-1975.

Village/Semi-Urban Area	Social Group (Community) affiliation of the family			Total Family
	HINDU	MUSLIM	CHRISTIAN	
(1)	(2)	(3)	(4)	(5)
1. Bohoogly	305	348	55	708 (24.8)
2. Chowhati	549	13	-	562 (19.7)
3. Dingalpota	155	-	1	156 (5.5)
4. Hogalkuria	128	-	51	179 (6.3)
5. Jagannathpur	15	178	-	193 (6.7)
6. Jayenpur	67	28	1	96 (3.4)
7. Kumarkhali	158	204	-	362 (12.7)
8. Kusumba	6	118	-	124 (4.3)
9. Nischintapur	75	2	-	77 (2.7)
10. Ramchandrapur	143	27	-	170 (5.9)
11. Ukhila	8	221	-	229 (8.0)
ALL VILLAGES	(1609) (53.6)	(1139) (39.9)	(108) (3.8)	2856 (100.0)
1. Elachi	224	69	-	293 (50.3)
2. Jaggadal	289	1	-	290 (49.7)
ALL SEMI-URBAN AREAS	513 (88.0)	70 (12.0)	- -	583 (100.0)
ALL AREAS	2122 (61.7)	1209 (35.1)	108 (3.2)	3439 (100.0)

3. Important Findings

A) In the area of Survey the incidences of Infective and parasitic diseases (IPD) were reported in highest order by the families, irrespective of their rural or semi-urban living. Among the rural families the family incidence rate (FIR) for the disease-group I (IPD) was as high as 60% and interestingly enough, among their semi-urban counterparts such rate was almost of the same order (59%). That high FIR for the disease-group I did vary a little between rural and semi-urban settlements of Sonarpur P.S. was of immediate interest to reflect upon the key-source of health problems in the local society. (Table 1).

When as high as 60% of the total fa milies (3439) of the survey-area declared that one or other kind of disease that has been identified under group I (IPD), prevailed among their constituent members during the reference-period in question, it is difficult to realise that major health-disturbing force was significantly generated alone by Infective and parasitic diseases. This force was equally penetrating in both rural and urban surrounding of Rajpur town.

In spite of the above general state of development which was associated with ill-effects caused by infective and parasitic diseases on family health, the impact of these diseases were not found to have spread uniformly over the villages under survey. Family incidence rate (FRI) of disease-group I (IPD) happened to fluctuate between as high as 100.0% (village KUSUMBA) and as low as 26.0% (village CHOWHATI). Moreover, in another four villages, namely UKHILA (FIR: 99%), Jagannathpur (FIR: 97%), Kumarkhali (FIR: 90%), Ramchandrapur (FIR: 82%), and Nischintapur (FIR: 73%) family incidence rate for disease-group I was difinitely of high order. It is, thus, clear that a little more than one-half of the total rural habitats under examination was seriously exposed to damaging effects of various infective and parasitic diseases. Did these villages form any endemic area for infective and parasitic diseases around Rajpur town? Convinving answer to this query may be formulated in the light of the fact that of all rural families (1717) which reported about occurrences of diseases of Group I (IPD), the families (1060) of the said six villages only, taken together, accounted for as good as 62 per cent. Such a high rate of incidence of infective and parasitic diseases on family level in a relatively smaller area is a significant pointer to rural health problems at large.

In contrast, relatively a low family incidence rate for infective and parasitic disease-group in village Chowhati was quite a though-provoking affair. This village sheltered

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562 families and of these families only a little more than one-fourth reported illness due to one or more kind of diseases falling under Group I. In village Hogalkuria FIR for disease-group I (IPD) was found to be 37%. Thus the families of these two villages appeared to have suffered relatively less detrimental influence of the principal health-affecting diseases of the area. In the remaining three villages, namely, Bonhoogly, Dingalpota and Jayenpur, the families concerned were affected by the diseases of Group I relatively moderately, FIR being X varying from 45% (Bonhoogly) to 53% (Jayenpur).

As far as the semi-urban areas of Rajpur municipal town is concerned, impact of infective and parasitic diseases on families concerned were not at all insignificant. It is interesting that as high as 67 out of 100 families of Elachi reported sickness due to the said diseases. In spite of the fact that both Elachi and Jagaddal constitute two important sections of the only municipal town (RAJPUR) of Sonarpur P.S. 24-Parganas district, 59 per cent of resident-families were as late as in 1974-75 under the grip of various infective and parasitic diseases.

All the more, over-all FIRs of Disease-Group I (IPD) for both rural and semi-urban families of the survey-area were observed to be on matching strength. Does this fact mean that town (urban or rural) living on the part of the affected on families exercised no discriminating influence on infective and parasitic diseases to affect volume of sickness?. In general, it may be observed that the families under study did suffer health-problems very largely due to various infective and parasitic diseases.

B) Next in order of importance the diseases of Respiratory System (DRS: Group VIII) prevailed in the survey-area. But such diseases on family level were reported relatively more in semi-urban areas of Rajpur town. Here out of every 100 families as good as 39 envinced occurrence of one or other kind of disease related to the disease-group VIII. In contrast, the rural families complained about incidence of the diseases of respiratory system in only 29 per cent cases. From this general picture of development it seems that rural, open-air living of the families concerned, had some discriminating role to influence events of illness due to respiratory system-linked diseases. In any case, family health problems created by different diseases of the GroupVIII were not insignificant in both rural and semi-urban areas of Sonarpur P.S. and accordingly, appropriate health care measures to prevent and cure diseases are still needed for the welfare of the local society.

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Village Jagannathpur maintained a distinguished position in having relatively the highest family incidence rate for disease-group VIII. In this village as high as 63 out of every 100 families reported one or other kind of disease related to respiratory system. Next was the position of village Nischintapur (FIR: 49%) where about one-half all families suffered health problems due to the disease-group VIII . Family incidence rates of the disease-group VII for the families of four villages, namely, Ukhila (35%), Kumarkhali (35%), Chowhati (34%) and Bonhoogly (32%) were noticed to vary within a small range. It appears that the families of these four villages had faced more or less similar experiences of health problems which might have generated by the diseases of respiratory system (Group VIII) in the area.

That the families of each one of these four villages suffered health problems due to respiratory diseases relatively significantly leaser than the families of either village Jagannathpur or Nischintapur is, indeed, an interesting fact. This was more so in the case of the remaining villages. In this respect village Ramchandrapur struck a distinction in presenting family incidence rate of diseases of respiratory system in the lowest order (16 per cent). Thus, FIR of disease-group VIII (DRS) is observed to vary from a high 63 per cent to a low 16 per cent. This signifies that the effect of respiratory system-linked diseases was not uniformly present over the villages and thereby the rural families had differential experiences of health problems due to such diseases.

In semi-urban areas of Rajpur town families of ELACHI reported relatively more cases of illness due to respiratory system-linked diseases. Here 42 out of every 100 families had health problems under the influence of respiratory diseases. But in Jaggadal 37 per cent of total 290 families declared incidence of one or other disease of Group VIII. It seems that respiratory system-related diseases caused health problems on family level relatively more in Elachi than Jaggadal. The FIRs of disease-group VIII (diseases of Respiratory System) for the town families are found to stand in closer proximity of the FIRs of the same disease-group for the families of villages like Ukhila, Kumarkhali, Chowhati, or Bonhoogly. Thus, the families of these particular semi-urban and rural areas of Sonarpur P.S., 24-Parganas district happened to experience similar stress and strain in taking care of their health problems generated by the diseases of respiratory system.

C) Third important disease-group is related to the disease of Skin and subcutaneous tissues (Group XII). In both rural and town areas this disease-group (DST) yielded family incidence rate in almost similar order. In total number of rural families (2856) 22 per cent reported occurrence of skin-linked diseases and in town area, on the other hand, 22.5 per cent of the total number of 583

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families showed cases of illness under similar diseases. Thus, a consistency between rural and urban rates is observed in the incidences of diseases falling under the disease-group XII. Moreover, it becomes evident that the families of both rural and semi-urban areas of Sonarpur P.S. suffered infective and parasitic diseases in highest order, diseases of respiratory system in higher order, and skin-linked disease in high order. These three disease-groups were, no doubt, the principal sources of health problems for the families in general. Relative decreasing order of importance of these three disease-groups (I, VIII and XII) was uniformaly maintained by both rural and town families. Such state of development in health-area should at once be highlighted.

With respect to this particular disease-group XII (DST) village Kumarkhali occupied a distinguishing place as 40 out of every 100 families residing in the village reported incidences of skin disease of one kind or other. This family incidence rate happened to be 18 points above the over-all rural rate. In the village the disease of Group I (IPD) and Group XII (DST) were relatively more mentioned by the families concerned. Next was the position of village Nischintapur where the FIR of disease Group XII is observed to be 38 per cent. Ohter family incidence rates of skin-linked diseases which are worth mentioning are 34 per cent (village Hogalkuria) and 31 per cent (village Kusumba) and 30 per cent (village Ukhila). Lowest family incidence rate of the disease-group XII was yielded by village Jagannathpur (3 per cent). Thus, it is quite clear that the families of the villages under survey did not suffer health stress uniformly under the influence of diseases of skin and subcutaneous tissues (Group XII).

In semi-urban areas ELACHI gave family incidence rate of disease-group XII as 22 per cent and the same was slightly higher for Jagaddal (23 per cent). These rates are definitely higher than those obtained for only four villages, namely Chowhati, (17%), Dingalpota (13%), Bonhoogly (14%) and Jagannathpur (3%). For the rest of eleven villages the rates were found to be higher than those observed for either of two semi-urban settlements of Rajpur town. In general it may, thus, be thought that the rural families were relatively more exposed to skin-related diseases than town families. Though over-all rates of disease-group XII (DST) did not vary markedly between rural and semi-urban settlements, yet it was the rural families which are found to face health problems due to these skin-diseases more extensively.

D) The last important disease-group (XVI) is a group of all Symptoms and Ill-defined conditions of physical sickness (SILC).

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Occurences of such symptoms and ill-defined conditions were extensively frequent in both rural and town families. Physical sickness by a single or multiple causes was reported by the families in very large number of cases, but such sickness could not be identified with any specific disease-group in question. Physical sickness due to headache, fever, pain, cough, loss of appetite and so on was very, very often mentioned by the families and they have been clustered, as per WHO classification, under one broad disease-group, namely, Symptoms and Ill-defined conditions. It appears that all the families-rural or semi-urban had the same experiences of many by frequently-occuring minor physical ailments which do not demand generally any serious medical surveillance. These diseases may be taken as household disease of common happening. Eventually family incidence rates of all Symptoms and Ill-defined conditions of physical sickness were as high as 87% in rural and 94% in town areas of Sonarpur P.S., 24-Parganas district.

It is thus clear that in survey-area predominance of infective and parasitic diseases had to be merited with all seriousness. Then, the health problems generated on family level by diseases of respiratory system need due medical attention. Third important source of health stress in families rural or urban was related to occurences of diseases of skin and subcutaneous tissues. 60 per cent of total 3439 families (rural and urban combined) reported incidences of infective and parasitic diseases. Again, 30 per cent of these 3439 families complained about physical illness due to attack of various diseases of respiratory system. On the other hand, 22 per cent of the same 3439 families yielded information about health hazards due to different diseases of skin and subcutaneous tissues.

E) In the backdrop of this morbidity condition an attempt has been made to sift out the most commonly reported disease or diseases under each one of the above first three dominant disease-groups. In disease group I (Infective and parasitic diseases) though a number of diseases which was reported on family level, has been included, yet two particular diseases, namely, Dysentery and Diarrhoea were most frequently mentioned by rural and semi-urban families. It has been observed that family incidence rate of disease-group I for rural families as a whole is 60 per cent and out of this 60 per cent as good as 31 per cent reported incidences of dysentery and diarrhoea only. In semi-urban areas of Rajpur town the family incidence rate of infective and parasitic diseases is 59 per cent and out of this 59 per cent families as good as 19 per cent reported about occurence of dysentery only (Table 2.)

Thus, it is noticed that in survey area as a whole dysentery

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as an infective and parasitic disease has been reported mostly. When out of every 100 families as good as seventeen gave declaration that they suffered from a single disease of dysentery, one can visualise what alarming health situation was prevailing in both rural and town areas of Sonarpur P.S. as late as in 1975.

It is interesting to focus that family incidence rate (FIR) of dysentery disease was not of the same order in between village and town areas. FIR of dysentery for semi-urban families was 19 per cent against only 16 per cent found for rural families. Two semi-urban settlements, namely, ELACHI and JAGADDAL, are part and parcel of the municipal town of Rajpur and yet they evinced the disturbing fact that their resident-families suffered health problems due to attack of dysentery relatively more intensively than their counterparts living in rural environment. The semi-urban families did not report diarrhoea to be a most commonly-occurring disease.

Now for the rural area it is observed that in four out of 11 villages of all the infective and parasitic diseases reported on family level, diarrhoea was more often mentioned. These four villages are Hogalkuria, Kumarkhali, Kusumba, and Ukhila. But in the remaining seven villages the diseas e of dysentery was pointed out most frequently by the families concerned. Diarrhoea-infested families were found relatively highest in village Kusumba where 66 out of 100 families reported this particular infective and parasitic disease. Next was the position of village Kumarkhali where 57% of resident families gave information about diarrhoea. Village Ukhila and village Hogalkuria presented family incidence rates of the disease of diarrhoea only as 47% and 12% only. Dysentery was not mentioned as a commonly occurring disease by the families of these four villages.

In Kusumba centper cent families were found to have suffered from one or other kind of infective and parasitic disease (Group I), but diarrhoea as a single major disease of Group I was claimed by a high as 66 per cent of total families. On the other hand, in village Kumarkhali 90 per cent of total resident families reported incidences of diseases of Group I and again, 57 per cent of the same families of the village were found to have suffered from diarrhoea as a single source of infective and parasitic diseases. In village Ukhila family incidence rate (FIR) of infective and parasitic disease was 90% and such rate for the disease of diarrhoea only was as good as 47%. For village Hogalkuria FIR of infective and parasitic diseases was relatively lower (37%) and accordingly, FIR of diarrhoea was also very low (12 per cent).

To what extent the families of these four villages only could distinguish between an attack of diarrhoea and dysentery could not be ascertained during survey and as such true cases of dysentery might have been under reported. For under reporting or misreporting dysentery as a most commonly reported disease was not obtained, among the families of these four villages in

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sharp contrast to their counterparts living in adjacent seven villages. It seems that many cases of dysentery in these four villages of Kumarkhali, Kusumba, Ukhila, and Hogalkuria might have been reported as cases of diarrhoea only.

Among the remaining seven villages where the families had declared dysentery as the most commonly occurring infective and parasitic disease village Ramchandrapur and village Jagannathpur deserve special attention. In Ramchandrapur 82 out of every 100 resident-families reported one or other kind of infective disease etc, diseases and of these 100 families as high as 54 per cent complained health hazards due to a single infective disease of dysentery. Such a high FIR for dysentery is a significant pointer to the prevailing health condition in the local rural society. On the other hand, 97 per cent of total families living in village Jagannathpur had one or other kind of infective and parasitic diseases amongst their constituent members and again, 47 per cent of these families reported disease of dysentery only. As a single infective and parasitic disease dysentery happened to creat health problems on family level more glaringly in the given two villages of Sonarpur P.S., 24-Parganas district.

In this very respect position of village Nischintapur and village Jayenpur was not all bright. In the former village 73 out of every 100 families showed incidences of infective and parasitic diseases and of these 100 families as good as 44 reported infection from only dysentery disease. In the latter village family incidence rate of infective etc. disease was fairly high (53%), such rate for dysentery disease only was very significant (32%). Incidences of dysentery in these two villages can not be belittled, rather they should be given importance as seriously as one must offer to village Ramchandrapur or village Jagannathpur.

In the remaining three villages, namely, Dingalpota, Chowhati and Banghoogly reporting of only dysentery as a most frequently-occurring infective and parasitic disease was made by the families concerned of each village in lesser volume, family incidence rate being ranging between 20 and 13 per cent. It appears that these three villages suffered relatively in leaser order from dysentery indiced health problems than the rest of the villages in question. In any case, the very presence of dysentery in seven out of 11 villages under survey is certainly alarming. In conjunction with the incidences of dysentery in semi-urban areas of Sonarpur P.S., these infective and parasitic diseases demand immediately appropriate medical and public health measures for the welfare of the local people.

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It may rightly be surmised that environmental sanitation in the local area under study is not satisfactory enough to negate appreciably the wide spread of several kinds of infective and parasitic diseases and particularly dysentery and diarrhoea. Family health problems are accordingly not insignificantly voluminous in both rural and semi-urban (town) life. More than one-half of the total families under examination was exposed under several infective and parasitic diseases (especially dysentery) and this single event is strong enough to point out what medical welfare activities are to be launched at once to protect the people from health hazards and family stress.

In the second dominant group of diseases of respriatory system two specific diseases of cold and flu had most frequently been referred to by the families. In semi-urban settlements the disease of cold only was most frequent. Family incidence rate (FIR) of diseases of respiratory diseases (Group VIII) for semi-urban families is found to be 39 per cent and for the same families FIR of disease of cold alone was 32 per cent. It becomes, thus, evident that in the occurrence of respiratory diseases on family level it was the disease of cold which generated health problems in large majority cases among town families. An y other relatively more serious respiratory diseases like peneumonia, asthma, pleurisy and like so were not reported by most of the families of both semi-urban and rural settlements. Cold happened to be a common household disease in the survey area. Such type of disease was declared relatively more by town-bred families than their rural counterparts (Table 3.)

In general, 31 per cent of total 3439 families enumerated in Sonarpur P.S. did complain about physical sickness due to some respiratory diseases. And of these families as good as 19 per cent showed incidence of cold only on family level. In town area 32 per cent of 583 families reported about the lone disease of cold and in contrast, 17 per cent of 2856 rural families recorded about the same disease. The difference between semi-urban and rural rates for the disease of cold should be especially noted. If widespread occurrence of the disease of cold is taken to be any indicator of bodily deficiency in respiratory system, then proper medical attention in this direction is urgently needed for especially the town-bred families of Rajpur. It is more true for the families of Jagaddal where 33 out of 100 families had trouble of cold-disease. Incidences of the disease of cold were not insignificant in ELACHI (30 per cent).

In the villages, families of Chowhati stood in closer

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proximity to semi-urban families in having incidences of cold-disease among 32 per cent cases. Like Chowhati in another set of five villages, namely, Bonhoogly, Dingalpota, Hogalkuria, Jayenpur and Ramchandrapur, only the disease of cold had been reported to be the most commonly occurring disease under the disease group VIII. In the remaining five villages the families concerned declared disease of flu as the most commonly occurring disease of respiratory system. Family incidence rate of flu only is observed to be 14 per cent in rural areas.

In semi-urban areas the disease of flu was not the most commonly occurring disease. With respect to total 3439 sample families the disease of flu happened to occur in only 11 per cent cases.

Among the five villages where the families had reported 'flu' as the most commonly occurring disease under the disease group VIII (DRS), village Jagannathpur attracts immediate attention. Here the family incidence rate (FIR) of only 'flu'-disease has been found to be 62.7%. In this village the over-all FIR of diseases of Respiratory system (Group VIII) was 63.2%. Under the situation it becomes clear that the rural families of Jagannathpur suffered almost fully from attack of 'flu'-disease. What was the possible reason for such high rate of 'flu'-disease? A thorough medical probing among the constitutent members of the families of the village can only answer the problem.

In this respect next came village Nischintapur where 48 out of 100 families complained about illness due to 'flu'. The over-all family incidence rate of disease of respiratory system was observed to be 49% in this village and the lone disease of 'flu' explained as high as 48% of total cases of respiratory diseases. This state of affair is serious enough to urge for immediate medical intervention. Both Jagnnathpur and Nischintapur require special medical attention to root out high incidence rate of 'flu'-disease which posed definitely serious health problems to the local families and their inhabitants.

In the remaining three villages, namely, Ukhila, Kumarkhali and Kusumba, the incidences of 'flu'-disease were not insignificant. In Kumarkhali 33 out of every 100 families reported 'flu' as the most commonly occurring disease, while in Kusumba it was 27%. But in village Ukhila family incidence rate of the disease of flu was slightly higher (35%). Further, in Ukhila FIR of diseases of Respiratory system happened to be 35.4% and 'flu' alone explained for 34.9% of the local families. Thus, it is

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observed that the villages which were more disturbed by health problems created by the diseases of respiratory system were actually having the particular disease of 'flu' as the most prevailing one among all diseases of the said System.

For the third dominant group of diseases of Skin and subcutaneous tissues (DST) the families of both rural and semi-urban settlements under survey had reported only the disease of 'itch' as the most commonly occurring one. Family incidence rate (FIR) of the disease of 'Itch' only for rural families as a whole was 16 per cent. This rural rate was slightly higher than semi-urban rate (14 per cent). In general, the FIRs of diseases of Skin and suncutaneous tissues were not very high in the area of survey (rural FIR: 22.2% and semipurban FIR: 22.3%) Eventually, the FIRs of the lone disease of 'itch' could not be very impressive. The finding of 'itch' as the most commonly occurring skin-linked disease among the families suggests that the diseases of skin might not be a source of serious health problem to the families in question (Table 4).

In the background of the above situation special attention was drawn by two villages, namely, Kumarkhali and Nischintapur. In the former village as good as 40 out of every 100 resident-families reported one or other kind of skin-disease and in the latter village 38% of total families evinced the presence of such disease. On the other hand, villages of Hogalkuria and Kusumba occupied the next important position in showing family incidence rates in the order of 34% and 31% respectively. In contrast, village Jagannathpur showed relatively the minimum incidence of skin-linked diseases, FIR being only 3 per cent. Apparently it appears that the families of the villages in question had differential experiences about skin-linked diseases. Family incidence rates varied from a high 40 per cent to a low 3 per cent.

In semi-urban settlements of ELACHI and JAGADDAL the families reported occurrence of skin-related morbidity in 22% to 23% cases. This rate was almost similar to the over-all rural as well as semi-urban rates (22%). In any case it becomes clear that not more than one-fourth of total families surveyed faced health stress from skin-linked diseases.

To go into the details of the incidences of different skin-linked diseases on family level it has been found that of all kinds of diseases the disease of 'itch' was referred most frequently by the families. In rural areas out of every 100 families, when 22 per cent reported skin-related diseases, 16 per cent referred to 'itch' only as the most frequent skin-disease. Similarly, in semi-urban areas out of every 100 families when 22 per cent showed presence of one or other kind

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of skin-related disease, 14 per cent claimed only 'itch' as the most commonly occurring disease. In this respect, special mention is made for the village Ramchandrapur where the families did not refer 'itch' as the most frequently occurring skin-ailment, but the disease of 'dermatitis' was reported. Here out of every 100 families 13 showed the incidences of 'dermatitis' only and 27 reported skin-disease of various types (including 'dermatitis').

For the fourth and last dominant disease-group namely, Symptoms and Ill-defined conditions (Group XVI), it may be pointed out that in the survey area 88 out of every 100 families did experience one or other kind of sickness effected by some physical trouble. Such sickness could not be properly explained by or identified with any organic disorders. Accordingly, it was gound that sickness due to 'fever' or 'cough' was very widely mentioned. For this disease-group of Symptoms and Ill-defined conditions of bodily sickness nothing definite can, thus, be pointed out.

So far emphasise has been given on those diseases and disease-groups which were found relatively more dominantly present among the families-rural or urban of Sonarpur P.S., 24-Parganas district. Eventually useful knowledge about current diseases and health problems in a society located in a rural environment (not far from the Metropolitan City of Calcutta) can be roped in. Family incidence rates of the most commonly reported diseases as well as the disease-groups can be estimated from the survey findings. Trends of development in health area which were shown by the families under examination are expected to throw light on rural health problems in general. Volume of family sickness per human settlement could be examined from these findings which were, of course, limited by recall lapse, under reporting, mis reporting and other circumstantial factors. Health information which is obtained from the present study can hardly be available from other sources.

Incidences of infective and parasitic diseases, diseases of respiratory system or disease of skin and sub-cutaneous tissues have been found to occur more expansively in the survey-area and to call immediate attention to the diseases of these disease-groups only is not to imply that no effort should be made to tackle diseases of the remaining disease-groups under reference. Occurrences of different diseases which have been included in each one of the remaining disease-groups were relatively lesser in magnitude and as such these disease-groups have not been discussed separately.

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Nevertheless, in this respect one important point has to be highlighted. It was found that none of the families in either rural or semi-urban areas had reported any disease which falls, as per WHO classification, under any one of the following disease-groups: (i) Neoplasms (GroupII); (ii) Mental disorders (Group V); (iii) diseases of Urino-genital system (Group X); (iv) Congenital anomalies (Group XIV); and (v) diseases of peri-natal morbidity and mortality (Group XV). These disease-groups go completely unrepresented. Such state of affairs is really difficult to explain. Either the families did truly not experience any health hazards due to any disease coming under the above five groups, or these disease-groups had suffered from recall lapse or under-reporting. Third possibility may be that the families concerned did not bother to report those diseases which would come under these five specific groups. But it is certainly significant to note that both rural (2856) and semi-urban (583) families behaved in similar manner in not reporting any disease of any one of these five disease-groups. How such consistent behaviour in between rural and urban families could arise with reference to these five disease-groups only? It seems that only a further probing in-depth can furnish a clue to this query.

Another important issue is revealed by the findings as noted in Table 1, that the family incidence rates of each disease-group for rural and semi-urban families maintain more or less a consistency in most of the cases. Divergences of low order are, of course, not absent between rural and semi-urban rates of (1) Endocrine, Nutritional and Metabolic disease-group (Group III) (ENMD); (2) Disease group of Nervous system and sense organs (Group VI) (DNS); (3) Disease group of Digestive system (Group IX) (DDS); and (4) Disease group of the Musculo-skeletal system and connective tissues (Group XIII) (DMCT). In these disease-groups the semi-urban rates were always higher than the rural rates. But the over-all family incidence rate of each one of these four disease-groups was initially low either in rural or town area and as such these rates have not been offered that much of importance which was given to those four dominant disease groups mentioned earlier.

Incidentally, it may be noted that family incidence rate (FIR) of the diseases of Digestive system (Group IX) was 9 per cent in semi-urban areas against 3.5 per cent available for rural areas. That semi-urban FIR of disease-group IX was more than double the rural rate is a fact of immediate interest to those who are concerned with medical and public health measures in the local society.

F) Family incidence rates (FIR) of four dominant disease-groups

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have been examined above in some detail with reference to the rural and semi-urban families in question. Now an attempt has been made to classify the families by community (social group) affiliation and thereby to study community-wise family incidence rates of the disease-groups concerned. It is presumed that though these communities have different ways of life and living (culture) and different mental disposition towards health care, the families belonging to different communities would be affected alike by the diseases and thereby the stress of health problems.

With respect to the rural areas as a whole family-incidence rate of infective and parasitic diseases (group I) happened to be 60 per cent. But among the rural Muslim families as high as 81 out of every 100 cases reported the diseases of the Group I against what was evinced by the Hindu families (48%). The Christian families reported relatively the lowest rate (34%). Thus, of all the rural families the Muslim families were found to have relatively more health problems caused by the infective and parasitic diseases than the non-Muslim families.

Moreover, it is known that the diseases like Dysentery and Diarrhoea were the most commonly reported diseases among the rural families and accordingly, it is not difficult to visualise that it was the Muslim families which suffered relatively most from these two particular infective and parasitic diseases in Sonarpur P.S. (Table 6).

That the Muslim families of semi-urban areas suffered also relatively in greater degree from infective and parasitic diseases (Group I) is evident from the fact that 71 out of every 100 Muslim families reported incidences of the given diseases in sharp contrast to 58% only yielded by the Hindu families. Thus, in both rural and town areas of all the three communities the Muslim community alone showed the highest incidence rate of the Disease-group I (IPD). On the other hand, it is also observed that the rural Hindu families evinced relatively lower family incidence rate of the Disease-group I than their counterparts living in town area. Community-wise differential rates as available from the findings of Table 6, constitute a significant pointer to understand different levels of development in health conditions among the local dwellers. That volume of sickness per family due to infective and parasitic diseases was more intensive among the Muslims in comparison to the Hindus or the Christians of the survey-area is a capital knowledge. This knowledge would greatly help in the formulation of appropriate strategy of health welfare programmes and actions.

In this respect attention is drawn to the Muslim families

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of the following villages since all the families of the villages reported to have suffered from one or other kind of infective and parasitic disease (especially, dysentery or diarrhoea): (1) Jagannathpur, (2) Kumarkhali, (3) Kusumba, (4) Ukhila. Family incidence rate was 100% or a very little less than cent per cent. Among the Hindu counterparts of these village family of infective and parasitic diseases fluctuated between a high 100% (village Kusumba) and a low 67% (village Jagannathpur). Truly speaking, three villages of Kusumba, Kumarkhali and Ukhila seemed to be the worst-affected areas as far as intensive occurrences of infective and parasitic diseases were concerned. Irrespective of their community (social group)-wise affiliation, the families of these three villages had to endure the impact of infective and parasitic diseases like dysentery or diarrhoea most intimately as well as extensively.

On the other hand, the Hindu families of the following villages were found to report relatively more cases of infective and parasitic diseases (Group I) than their Muslim counterparts: (1) Nischintapur, and (2) Ramchandrapur. In village Nischintapur the Hindu families yielded relatively higher family incidence rate (73%), the same was only 50% among the Muslim families. In village Ramchandrapur the Hindu rate for the disease-group I was a little higher (83%) than the Muslim rate (78%). The lowest family incidence rate of infective and parasitic diseases (Group I) was evinced by the Hindu families of village Chowhati (25%) and again, by the Muslim families of village Bonhoogly (50%) or village Nischintapur (50%). That the lowest Muslim rate for infective and parasitic diseases was double than the lowest Hindu rate was singularly significant to stress the fact that the Muslim families of the survey-area formed the most extensively affected group to suffer health hazards.

With respect to the second dominant disease-group VIII (Respiratory system-linked diseases) it has been found that 29% of rural families and 39% of semi-urban families reported such diseases. In rural area among all the families (2856), a sizeable magnitude of Muslim families (38%) showed relatively more cases of respiratory system-linked diseases (especially the diseases like cold and flu,) than their Hindu (31%) or Christian (13%) counterparts. Like the highest family incidence rate (FIR) of infective and parasitic diseases, here again the Muslim families presented the highest FIR of diseases or respiratory system. But, in this very respect the difference (7.3%) between Muslim and Hindu rates for respiratory system-linked diseases was not as high as was found for the difference (33.8%) between the rates of infective and parasitic diseases. It is significant to note that the Muslim families of the villages under study suffered most from both infective and parasitic diseases and diseases of respiratory system. Next was the position of the

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Hindu families and the Christian families occupied the third position in order of importance.

On the other hand, among all town families it was the Hindu families which presented highest (FIR) family incidence rate (40%) for the diseases of respiratory system and next was the position of the Christian families (FIR) (39%). Here the town families belonging to the Muslim community evinced the lowest FIR (36%) for diseases of respiratory system. Nevertheless, the range of variation between the given rates was within a narrow limit (40% to 36%). This shows that the semi-urban families, irrespective of their community (social group) affiliation, did suffer on more or less similar level the problems of health which were caused by various diseases or respiratory system (especially by the disease of cold), One point is stressed here that in reporting incidences of diseases of respiratory system the Muslim families occupied the last position in order of importance in contrast to their rural counterparts.

Examining community-wise family incidence rate (FIR) for diseases of respiratory system over the villages it is observed that the Hindus of the following four villages evinced higher FIR than what was shown by their non-Hindu counterparts: (1) village Chowhati, (2) Village Hogalkuria, (3) Village Kumarkhali, and (4) Village Kusumba. In these villages the Hindu rates varied from a high 50% (Kusumba) to a low 29% (Hogalkuria), where as the Muslim rates fluctuated between as high as 35% (Kumarkhali) and as low as 15% (Chowhati), on the other hand, the Muslims of the following four villages presented higher FIR for diseases of respiratory system than that was offered by their non-Muslim counterparts: (1) Village Bonhoogly, (2) Village Jagannathpur, (3) Village Ramchandrapur, and (4) Village Ukhila. In these four villages the Muslim rates varied from a high 64% (Jagannathpur) to a low 35% (Bonhoogly). But the Hindu rates were from a high 53% (Jagannathpur) to a low 10.5% (Ramchandrapur). Over these four villages in question.

Thus, it is clear that in the villages occurrences of diseases of respiratory diseases (especially the diseases like cold and flu) had a wide fluctuations over both Hindu and Muslim families and thereby the families had differential experiences of respiratory system-linked health problems within the close bound of their specific community-enclosure. That the families belonging to different communities (social groups) suffered from respiratory system-linked diseases in unequal magnitude is immediately highlighted. Community-wise variations in the incidences of either infective and parasitic diseases or diseases of respiratory system are quite evident. Such variations have

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to be given due weightage in any family health welfare plan and/or programme that may be envisaged for the inhabitants of the locality.

With reference to the third dominant disease group XII of skin-related diseases it has already been pointed out that rural and semi-urban family incidence rates varied only very little (22.2%:rural and 22.5%: urban). But in both rural and town areas the Muslim rates for the disease-group XII were definitely higher than the Hindu rates. The rural Muslim rate (25%) was, on the other, hand much lower than that of the urban Muslim rate (40%). But the Hindus of rural and town areas maintained an equal rate (20%). There is no doubt that the Muslim families suffered in general most from skin-linked diseases, especially from the disease like itch.

It is quite significant that the Muslim rate for skin-linked diseases as found in town areas, was double than that evinced by the Hindu families of the same area. Why the Muslim families alone of town areas suffered skin-linked diseases in such high degrees? Proper medical probe into this specific problem is imperative to have a satisfactory clue. In villages community-wise variation in family incidence rates for skin-related diseases was, of course, of low order. It seems that the Muslim families of town area had in general been exposed more to physical ailments under influence of skin-linked diseases (especially 'itch') than their Hindu counterparts.

In the following three villages the Muslim families yielded higher family incidence rate (FIR) for skin-linked diseases than the Hindu families: (1) Village Chowhati, (2) Village Kumarkhali, (3) Village Ramchandrapur. The Muslim rates over these four villages varied widely. Village Kumarkhali is especially noted since 51 out of every 100 Muslim families of the village reported such diseases and it was the diseases of 'itch' which prevailed most. In this village the Hindu families offered FIR for skin-linked diseases as only 26%. In village Chowhati the Muslim rate (46%) was much higher than the Hindu rate (17%), but in village Ramchandrapur the Muslim and the Hindu rates were very close. It appears that the Muslim families of villages Kumarkhali and Chowhati require special medical attention to tackle physical sickness under skin-related diseases.

On the other hand, the Hindu families of the following two villages were found to offer higher family incidence rate for skin-linked disease: (1) Village Hogalkuria and (2) Village Jayenpur. In Hogalkuria when 34 out of 100 Hindu families reported occurrence of skin-related disease (especially 'itch'), 31.5% of the Muslim families had the sufference from the same

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diseases. Next, in Jayenpur village 29% of total Hindu families evinced skin-linked diseases against 25% of Muslim families. This shows that in these two villages the Hindu and the Muslim families faced on more or less similar level the experiences of health problems generated by various diseases of skin and subcutaneous tissues (Group XII).

In general, it may be stated that the Muslim families of rural areas of Sonarpur P.S., 24-Parganas district, faced health problems under the impact of infective and parasitic disease like dysentery and diarrhoea more than their Hindu or Christian counterparts. This state of affairs was also true in the cases of respiratory system-linked diseases like cold and flu or in the cases of skin-linked diseases linked itch. For these three distinct but dominant disease-groups the Muslim families in the given villages evinced always highest family incidence rates. These rural Muslim families were followed next by the rural Hindu families in order of importance. The rural Christian families offered in general the lowest family incidence rates for the said three dominant disease-groups, Thus, the need for the study of incidences of most frequently occurring diseases in villages by community (social group)-affiliation of the families concerned becomes very much pressing.

Family incidence rates (FIR) of different disease-groups or of the most frequently reporting diseases under any broad disease-group as have been presented above, require to be evaluated in consonance with waht has been obtained for different communities (social groups) of the local stratified society. These two sets of family incidence rates are complementary to each other and a proper investigation of these rates would certainly provide greater insights into the nature and magnitude of the health problems which prevailed lately among the people of the survey area in 24-Parganas district or for that matter of the State. These rates would be some useful indicators in the field of health planning. Priority of medical as well as public health care can be fixed on the basis of higher or lower family incidence rate obtained for a particular disease-group and again, for a particular community (social group). The findings of family health problems as available now, are expected to help the organization of medical help and public health care among the local inhabitants in terms of their geographical location, community affiliation and family incidence rate for different diseases and physical sickness.

4. Concluding observations

The present discourse has been made with 'Family Health' as an important goal of approach to ongoing national programmes

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on public health. Precisely speaking, the role of family (classified by its social affiliation) in national health has been highlighted here. The need of treating the family as a whole as the focus of attention in the matter of health and family welfare services has been stressed and eventually a family rather an individual appraoch has gained importance in the analysis of available health data.

Health surveys have already been accepted as some significant tool to generate flow of useful health information. Inspite of many limitations the present survey had truly yielded substantial volume of such information which, on the other hand, would help in more than one way the plan and programme of health-services envisaged for the area in question. This information reflects immediately upon family distribution of diseases and the same may be thoroughly utilized to guide forward planning of health services. The present findings of the survey provide comprehensively with the much-needed knowledge about disease prevalence on family level. It is felt that family-based distribution of disease in conjunction with population-based distribution of disease would certainly strengthen the very base of the data on national health. Moreover, these two types of distribution would be complementary to yield better health statistics. Importance of the present discourse had therefore to be merited in the light of the above issued. It is strongly hoped that the present family-based health statistics shall eventually help to inculcate new attitudes to the administration of health services as a whole in the country.

World Health Organization had already stressed seriously upon the need for new approaches in health statistics (WHO Tech. Report. No.559, 1974). In this new approach emphasis has been laid on new types of health statistics which can no longer be just concerned with the quantity and population distribution of disease. New orientation of attitude towards environmental factors in disease and health and again, an inclination to see patients as members of family and community groups have lately been urged. Many health indicators are in vouge today but those which embrace not only measures of morbidity of the population but also measures of those social (including economic) characteristics that are the detreminants of levels of morbidity are, no doubt, more useful. With reference to particular population groups such useful health indicators are desired to be employed more. The present study has, indeed, taken the patients as members of family and community groups of the locality and proceeded to offer a kind of health statistics which was not concerned with population distribution of disease. To assist in the formulation of health care plans for families and/or communities of a rural society the present study may have a role to play.

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Family incidence rates of different diseases in the local communities have been measured to indicate volume of sickness per hundred families. The rates were not uniformly manifested by the communities. There existed noticeable variation in the incidences of different diseases on family as well as community level. Adequate knowledge on family incidence rates is hardly available. This knowledge may be fruitfully used to develop some health indicators which serve to provide a real guide to the social and medical action plan for the people in question.

The present study reveals that infective and parasitic diseases caused highest family incidence rate in the area and especially the diseases of dysentery and diarrhoea were more frequent to affect health of the family members. Dominance of these diseases was marked in both villages and town. Rural or urban living of the families has no special discriminating role to play in effecting greater or lesser incidences of infective and parasitic diseases. But within the villages prevalence of such diseases did vary to indicate that some of these were running relatively higher risk of exposure. These villages are Jagnnathpur, Kumarkhali, Kusumba, Nischintapur and Ukhila. The families of these villages should get highest priority for proper medical care. To draw attention to these five villages should not imply that other villages do not require such care. Villages in general demand proper medical help for rooting out the diseases once and for all. Muslim families of these five villages were, on the other hand, affected relatively more with infective and parasitic diseases like dysentery and diarrhoea. The Muslim community of the area constitutes the focal point for immediate health services.

Family incidence rate of diseases of respiratory system happened to be in second highest order in both rural and semi urban areas. Of these diseases incidences of cold and flu were most frequently reported on family level. Amond the members of the families the diseases of respiratory system ranked second in order of importance. Rural or urban living of the families did matter little to influence higher or lower spread of these diseases among their members. But among the villages there existed variations in family incidence rates for respiratory system-linked diseases. In this respect the families of village Jagannathpur, village Nischintapur, village Kumarkhali, and village Ukhila may be again referred as a relatively more affected group. In these villages prevalence of the disease of flu was very marked. In the remaining villages the disease of cold was more frequent on family level. Thus, it becomes clear that the local families had mostly either cold or flu as prevailing disease among them and accordingly whatever appropriate medical attention is required to tackle these diseases

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has to be organised early in the very interest of the progress of local health welfare. One additional point is made here. The town families showed relatively higher incidences of the disease of cold than their rural counterparts and naturally they can not be left behind in the plan and programme of necessary health services for respiratory system-linked diseases.

Diseases of skin and subcutaneous tissues had a place of third importance among the rural or town families. It is pointed out here that of various kind of skin-diseases the families in question reported the disease of itch most frequently. This was true for both rural and semi-urban settlements. It seems that skin-linked diseases were not posing as a potent source of any serious health problems to the local families. With their existing way of life and living under tropical condition the members of the families are expected to suffer from 'itch' and remedy for which needs generally no serious medical survelliance. In spite of this fact the families of the following villages may need proper medical care for curing trouble 'itch': 1) Kumarkhali, 2) Nischintapur, 3) Hogalkuria, and 4) Kusumba. In these villages 30 to 40% of families reported physical sickness due to 'itch'. In town area the families affected with skin-disease like 'itch' was of course, not high.

Family incidence rates of disease-group other than the above three dominant groups were low and as such no detailed discussion has been made here. But these rates should not be overlooked, since they indicate to what extent the members of the families rural or urban were exposed to various kinds of physical illness and morbidity condition. Here attention is especially drawn to the family incidence rates for (a) diseases of digestive system, and (b) diseases of musculo-skeletal system. Both the rates were decidedly higher in town areas and this indicates that town families need greater medical care to tackle their health problems generated by the diseases of these two disease-groups (IX and XIII) only.

In human society the family remains ever to be a part of the individual and the individual is an integral part of the family. And as such any sick person is never alone in his/her suffering and no diseased person is an isolated individual. In this social situation whatever assessment of health condition on the strength of individual sick persons may be made, the same can hardly depict family centered dimension of health problems. In any attempt for forward planning for health services in any population group as has lately been urged by the World Health Organisation, adequate knowledge about Family Health problems is sine qua non. In this direction the present study indicates a useful methodology in examining the role of family in community and/or national health.

TABLE 1 Family Incidence Rate* of different Disease-groups for the Families surveyed in villages and semi-urban areas of Sonarpur P.S., 24-Parganas, West Bengal, 1974-75

Disease-group(WHO catagories)	Rural area (name of the Village)											All Rural areas	Semi-Urban area		All Semi-Urban areas
	Bon-hooghly	Chow-hati	Ding-alpota	Hogal-kuria	Jagan-nath-pur	Jayen-pur	Kuma-rkhali	Kus-umba	Nisc-hinta-pur	Ram-chan-drapur	Ukh-ila		ELA - CHI	BAGA - DDAL	
(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	(9)	(10)	(11)	(12)	(13)	(14)	(15)	(16)
I. IPD	44.8	26.0	48.7	37.4	97.4	53.1	89.8	100.0	72.7	82.3	99.1	60.1	67.6	50.7	59.2
II N	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
IIIENMD	1.9	1.3	0.6	0	0	0	0	0	0	2.3	0	0.9	1.4	2.1	1.7
IV DBBO	1.7	0.9	0	0	0	1.0	0	0	0	0	0	0	0	0	0.4
V MD	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VI DVS	1.4	1.4	3.2	0	0	13.5	0	0	0	4.7	0	1.5	2.4	1.7	2.1
VIIDCS	2.9	2.1	0.6	3.3	0	4.2	0	0	0	4.7	0	6.2	7.5	4.5	6.0
VIIIDRS	31.9	33.8	28.8	27.7	63.2	20.8	35.1	29.0	49.3	15.9	35.4	29.2	41.6	36.9	39.3
IX DDS	4.7	4.5	4.5	2.8	0	3.1	0	15.3	0	5.3	0	3.5	9.5	7.6	8.6
X DUGS	1.7	0.7	1.9	0	0	2.1	0	0	0	0.6	0	0.8	1.0	0.7	0.9
XI CPCP	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XIIDST	14.1	17.3	12.8	33.5	3.1	27.1	40.1	30.6	37.7	27.0	29.7	22.2	22.2	22.8	22.5
XIIIDMCT	1.4	4.6	3.2	0	0	0	0	0	0	9.4	0	2.0	5.8	3.8	4.8
XIV CA	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XV DPNM	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
XVISILC	92.1	83.7	94.2	85.5	45.6	94.8	88.1	86.5	100.0	83.5	99.6	86.8	100.0	89.3	94.2
XVIIACV	0.3	1.4	0	0	0	1.0	0	0	0	1.2	0	0.4	1.7	1.0	1.4
No. of Families surveyed	708	562	156	179	193	96	362	124	77	170	229	2856	293	290	583

Disease-groups:

I.IPD: Infective and Parasitic Diseases (code 000-136)
II.N: Neoplasms (140-239)

III.ENMD: Endocrine, Nutritional, and Metabolic Diseases (240-279)