SOCIAL NETWORKS AND HEALTH DECISIONS: A CASE OF TWO VILLAGES OF TAMIL NADU

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Abstract

A common question always had been of interest to understand as to how people make decisions. It is well known that decisions are not made in isolation but they are the products of influence and confluence of social correlates. Studies of some Sociologists report that often decisions are made in consultation with their community members. This understanding shifts the focus from individuals 'choice' to socially constructed patterns of decisions, including the consultation with others (Pescosolido, 1992). Therefore, one can conclude that even health issues have been decided in consultation with the community members. Community is an interactive agency and it is a part of social network. Social networks provide the mechanism through which individuals learn to hand their problematic issues. Therefore, it will be of interest to understand the extent of social network influence on health issues of rural population of Tamil Nadu. In this paper our a presentation of field information on the processes involved in the health care decisions of rural population of Tamil Nadu is presented.

The social network theory suggests that the social relationships among individuals are based on exchange. Each individual's feelings, ideology, emotions etc. are exchanged with others in order to develop a strong bond among them. The similar interactive exchanges are found in health network. There are three major interactive subunits in the system of health care network; man, community and health care setup. They interact with each other for some common interests. The interaction between the above mentioned subunits results in the formation of a network

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in health decisions.   Man is a   decision maker. His decisions are the outcome of his interaction with his advisors (community), available facilities (setup) and so on. Keeping the above proposition in mind, the study was conducted to examine the extent of influence of community and health administration in the process of health care decisions.
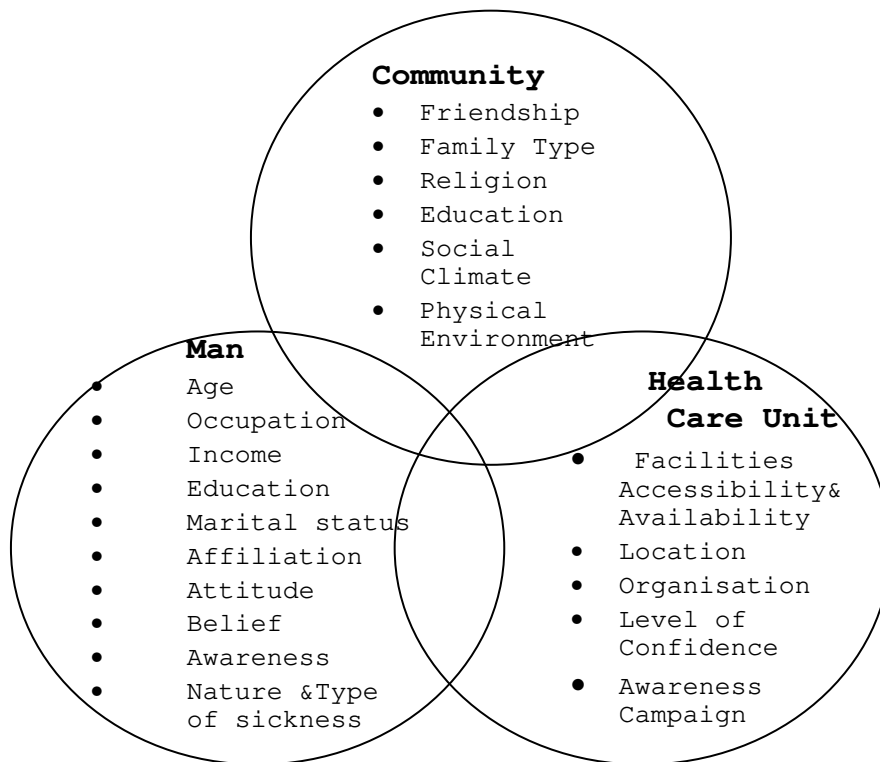
Figure 1.

Figure   1 shows the three interactive   units   Man, Community, and Health Setup. The unit of   man   consists   of   various elements   like, age, occupation, income, education, marital status, affiliation, attitude, belief, and awareness of medical options, nature and types of sickness. Likewise, Community   constitutes the elements like, friendship, family   type, religion, education, social   climate, physical environment   etc. Health   care   setup   shows   various   constituents like, facilities, location, organization set up, level of confidence generated, awareness campaign, delivery units, and extent of success and failures. One may observe that all the units as well as the   elements of the

units show certain amount of influence in individuals' choices made for their health care. However, one does not know the nature and extent of influence. Do all variables/sub elements are equally influential? Or some may have greater influence than others? While some may not have any influence?

There may be a possibility that some elements are important at one point of time? While some may be in oblivion? Whether elements' influences are culture specific or community specific? The present study is an empirical exercise and it is attempted to identify the set of sub elements, which is important in health care decisions. This study has adopted "Social network perspective to understand the empirical finding. Therefore, it would be beneficial that we have a quick glance at the theoretical perspective before the findings' analyses. 'Social Network Perspective As a lay term, "social network" conveys the following set of ideas: Individuals (or larger social units) are perceived as being "significantly" in direct contact with many others but not with all possible others. Indirect contacts, through one or more intermediaries, may also be significant. An individual may sometimes, if he or she makes an effort, succeed in making direct contact with someone to whom he or she has hitherto been linked only indirectly; indeed, this is one of the main ways in which individuals make new direct contacts. Intermediaries may facilitate or obstruct this process of converting contacts from indirect to direct, or may endeavour to interpose themselves as a barrier or filter between individual and a direct contact. Contacts between individuals may take the form of channels of communication, or of the flow of resources, or may manifest themselves merely the expression of attitudes and sentiments. Whatever form the contact takes, it may affect the behaviour of the individual. Since, every individual has her or his own set of contacts, the pattern of contacts as a whole affects the behaviour. And this will be manifested as the decision. Most of the occurrences of the term "social network" in social science that are more than twenty years old, as well as most of the popular uses of the term, imply no more than the very general and quantified ideas just listed. The ideas are uncontroversial and can scarcely be regarded as testable propositions. They constitute orienting notions and nothing more (Homans, 1967). On the other hand, social scientists in recent years have used "network" as a precise term and have developed definitions to generate testable, often quantified propositions.

Different practitioners have tried to propositionalize and quantify network notions in different ways.   In the great majority of instances, social science references to the social network are still confined to the very general ideas that have listed, and the only measurement involved consists in counting the number of contacts impinging on each of a collection of individuals.   Indeed, the use of "personal network" as a technical term for an individual's direct contacts constitutes a striking case of what we might call "operationalization by impoverishment".   By confining attention to direct contacts, this definition eliminates the value of the term "network" as an orienting idea.

The social network theory suggests the form of a network structure rather than the form of an organised group. In the organised group, the component individuals make up a large social whole with common aims, interdependent roles, and distinctive kind of sub cultural practices. In network formation on the other hand only some, not all, of the component individuals have social relationships with one another. In a network the component external units do not make up larger social whole; they are not surrounded by a common boundary.   John Barnes used it as: 'Each   person is, as it were, in touch with a number of people, some of whom are directly in touch with each other and some of whom are not. It is of a social field of this kind as a network.   The image is of a set of points some of which are joined by lines. The points of the image are people, or some times groups, and the lines indicate which people interact with each other (Barnes, 1954). From the analysis of Barnes three important dimensions of delimitation of social networks emerge. They are, (a) the extent of link i.e. total and partial, (b) number of persons in a network i.e. finiteness or infiniteness and (c) boundedness i.e. bounded or unbounded. In his usage "partial" means certain kinds of links only; "finite" denotes a limited number of people; and "bounded" signifies that some persons exist who are not in the network.

Whitten and Wolfe suggest the fourth dimension time and the fifth dimension social situation is implied in Adrain C.Mayer's concept of "action set." That is the relationship will vary time to time. In case of situation the relationship is different in different situations.

Since, health is an outcome of social interaction, in to a network relationship it is assumed that various constituents of the major components are in influencing the decisions of individuals' health and health care. The factors which are the bases of interaction can be classified into three major groups, (i) the factors which are individuals' bio-social elements like age, income, attitude, liking etc. and they are at the individual level(Man), (ii) the factors, which are common for the whole community such as, religiosity, caste affiliation etc. and (iii) health care organisational set up which initiate the interaction process.

Research Design

Two villages of Tamil Nadu namely, Naduppatti and Sangalpatti of Dindigul District were selected for the study. The Village Naduppatti located in the Western Ghats had a population of 51 and the Village Sangalpatti had a population of 156. The study included only the respondents completed 18 years of age.

Measurements

For Health a self-assessed scale based on five indicators was developed. They are, incidence of sickness, use of health measures, personal hygiene, nutrition, and sanitation.

For the variables, Caste, Income, Occupation, Education, and Age, SES scale developed by Kuppusway with some modifications was used.

For Religiosity, four indicators were used. They are, visit to place of worship, celebrating religious ceremonies, ritual performed, and diet restrictions.

Analysis and findings

In the analysis the influence of attitude of respondents belonging to different socio economic orders on health was established.

We have started with the assumptions that the respondents belonging to various socio economic orders make health decisions in a different manner. The assumption was confirmed this finding.

Table 1 Simple Correlations among four Socio Economic Variables and Health behaviour

	Caste	Income	Occupation	Education	Religiosity	Age
Health	0.64	0.15	0.31	-0.04	0.61	0.07
Caste		0.36	0.53	0.19	0.78	-0.04
Income			0.34	0.28	0.20	-0.03
Occupation				0.29	0.43	0.03
Education					-0.005	-0.26
Religiosity						0.07
Age						

Table 1 presents the results of an analysis in which zero order correlations of Socio Economic Status variables, ritualism and health. Which summarise the total effects of each of the variable on the other. The results show that the variables such as Caste, Religiosity, Education and Occupation have stronger relationship and other two variables Income and Age have weaker relationship with Health. This was the finding from the data collected from all the members of the population in two villages of study (N= 207).

Table 2 Stepwise Regression of Socio Economic Variables and Health

Independent Variable	Unstandard Coefficients	Standardized Coefficients
Constant	1.37 (9.049)	
Caste	0.42 (5.89)	0.51*
Education	-0.21 (-2.72)	-0.14*
Religiosity	0.19 (2.33)	0.20*

*$p < .05$ one tailed test   N=207

Metric coefficients with standard errors in parentheses are shown

For further analysis to study the relationship between these variables Stepwise Regression Analysis was conducted. Table 2 reports the results of an analysis in which the three point measuring the health status was regressed on the Socio Economic Status variables and ritualism. It is clear from the regression coefficients that the Socio Economic Status and ritualistic beliefs have significant independent effects. A closer look at the standardised coefficients (Beta) invites three inferences. First, the variable caste has a direct effect on the dependent variable through any of the other independent variables, and the magnitude of this effect (beta=.51). Thus, the respondents belonging to higher castes have greater access to the health facilities while respondents of lower caste have less access. Hence, the impact of caste status on health status is positive. Secondly, the ritualism,. which is reflected in a disciplined way of living, again shows a strong relationship(Beta=.20). This result suggests that the respondents who reported to be strictly following the routines, and leading disciplined way of living, which was a by-product of ritualistic behaviour could their maintain health in a better way. For example, the respondents who are highly religious were following some of the routines; they are, bathing twice in a day, while returning from their work they wash their feet and hands, keep the home environment clean etc. (please refer Chapter V for more details). Further, the respondents who are close relatives and friends of such persons are also follow disciplined way of living through which they keep themselves healthy. It is the outcome of the social interaction process. The interesting inference based on the statistical results(beta=-.14) value is the inverse relationship between the educational status and health. It is due to the prevalence of unemployment among highly educated youths. Since they are not able to get jobs, which can commensurate with their knowledge and training, they have to migrate to nearby urban localities to get a job. Thus, they are exposed to an environment where from they were likely to pick up bad habits, which were harmful for their health such as smoking, alcohol consumption etc. This leads to different kinds of diseases, amongst them. It is also observed that, the intoxicants are very commonly used by the educated

youths. It was observed that did not pay attention to the practices like early morning bath, going for a morning stroll, etc. which did the respondents who are staying in the village otherwise commonly follow.

Further, Table 1 shows that each unit comprises of various variables but they are not very influential. It is confirmed by the statistical results also (kindly refer Table 1). While Table 2 shows that in addition to education a number of variables have very strong effect n health behaviour of the respondents; they are age, income, affiliation, occupation, discipline in life- style, belief, etc. In following paragraph some further discussions are given to explain the influence of those variables.

Age

Age composition of respondents consisted of two categories; they are of independents and dependents. The persons who are between the age group of 15 and 60 are termed as independents. They are in the working group category. Since, they are economically independent, they make decisions for themselves. The children up to 15 years of age and old people above 60 years are placed in the category of dependents. Their care - takers generally make their health decisions, since they do not have an income of their own.

Income

There is an association between income and health. Even though income does not show strong statistical relationship with health, the respondents' responses have depicted relationship. Income plays a vital role in maintaining health. Majority of the higher income group respondents are economically well off, since they are the landowners also. Therefore, higher income group respondents in the event of health problem could afford to provide good care to their patients. They could afford to hire vehicles to take their wards to nearby hospitals for treatment. On the other hand, most of the landless labourers, who did not have much income either to spend money on costly medicines or take them to nearby hospitals for immediate relief? Consequently, in the event of need, they can only afford to take their patients either to the local quacks, or the missionary hospitals where they can get inexpensive treatments (in

case of village A). When Mr. Selvam, a respondent belonged to Vannar caste (washer men) of village A was seriously sick of stomachache, he was advised to take treatment in the Head Quarter Hospital, the relatives could not afford to carry him due to low income. Then his health status deteriorated to such an extent that he got Ulcer later. Likewise, income is an important social factor influence health.

Affiliation

Affiliations are of various kinds. It can be of friendship, neighbourhood, caste, family, etc. Among the respondents it was observed that they constantly consulted their affiliated members   in the matter of crisis. For example, in village A, the respondents had formed some playgroups and clubs where they very regularly meet. Whenever some critical decisions are made, the group, not by individuals, makes them.

For example,   Mr.Viswanathan a respondent of village A was sick. Mr. Rajendran, his friend came to know of his sickness. Mr. Rajendran met Mr. Viswanathan and narrated   his observations and experiences regarding hospital care. Mr.Rajendran told him that homeopathic doctor (of the vicinity) is very easily available and he took good care of his patients. Thus, Mr.Rajendran advised   his friend, Mr.Viswanathan to go to the homeopath of the locality.   And Mr.Viswanathan did so. He went for homeopathic treatment while his employer objected to it on the grounds that homeopathy would take more time and it may require more money as well. However, Mr.Viswanathan did not change his decisions and went for homeopathic treatment only, accepting his close friend's advice ignoring his employers' objection. This is not a unique case. Often it is observed that affiliations   like friendship, neighbourhood relationships influence this type of choices.   This boils down to the fact that units of man and community are in very close correspondence with relation to the health-care decisions made by the respondents of the present study.

Caste Status

Caste status of respondents had its own influence on the health care decisions. It is commonly observed among the respondents that a strong relationship existed among different caste groups. The respondents are mostly seen interacting   among their caste

groups. Thus, the socio-economic categories influence the decisions as well. It is true in case of health as well. The status is scaled in a three-point scale to assess the aspect of 'good health' the following five indicators were used:

(i)   Incidence of sickness,

(ii)   Use of physical health measures,

(iii)   Paying attention towards personal hygiene,

(iv)   Consumption pattern, and

(v)   Sanitation

For all questions 1 point to each positive response and zero value for negative response were assigned. The aspect of sickness is inclusive of frequency, type and duration. The total score ranged from 0 to 5. Those who secured 0 and 1 were   placed in 'less healthy' category, those who scored between 2 and 3 points were placed in 'moderately healthy' category, and those who secured 4 and 5 were placed in 'highly healthy' category (refer Chapter II for more details).

The Higher caste respondents are the people who are more dominant and having easy access to the village facilities, while the middle and lower caste respondents are having less access to the facilities, such as drinking water facilities, using the common land, etc. Likewise, the caste status is playing an important role.

Education

Result   shows that education has   stronger association   with health. The negative association   between education and   health is shown but that was only for the respondents who were highly educated and for them who have picked up bad habits like smoking, consuming alcoholic liquors, etc. It suggests the carelessness found among the educated persons with regard to their health protection. Sometimes the educated respondents were not able to do this again because of the association and affiliation. It was observed that the use of intoxicant material and consumption of liquor were very commonly found among the educated respondents of village A, especially among those who were coming from affluent groups. While the poor respondents of

village a due to lack of money and therefore having had less education did not go out for luxurious living.

Occupation

Occupation is an important factor responsible for the health care of individuals. There are three major categories of occupations among the respondents; they were, higher occupations, middle level and lower level occupational categories. The occupational hazards found among the respondents of lower level occupation categories who were engaged in agriculture work. These occupational hazards were not coming in the scenario of health care by choice but as a matter of force. However, occupation and health care choices had shown some link among the respondents as shown in Table 1. Since, statistically a weak relationship is observed.

From the above discussion it is clear that socio economic status variables, and religiosity influences the health of an individuals, in the process of interaction. In the process of interaction in a social network either an individual or a group influence the decision of another individual by means of various factors, which decides the health.

Conclusion

A classic problem common to sociology of management revolves around how people make decisions. Some recent studies have shown the need of some rational action strategy for health care helps (Pescosolido, 1991). The above Discussion presented in this paper had shown the influence of social correlates or social networks on individuals' decisions related to their medical helps. This orientation rests on fundamental principles that social interaction is the basis of social life and social networks provide the mechanism (interaction) through which individuals learn the techniques of handling their problematic issues. This approach shifts the focus from individuals' self decisions to socially constructed patterns of decisions. The findings make a case for reviewing theoretical approaches to decision-making and they provide some information essential to a theoretical exposition of social network relationships. The above findings support the utility of social network approach for understanding the dynamics of rural health management and planning.

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