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# **"Social Correlates of Health choices: A study in Rural Tamil Nadu"**

**Kannan Srinivasan<sup>1</sup>**

## **Introduction**

Social Network suggests that the decisions are not made in isolation but they are outcome of influence and confluence of social correlates (Srinivasan and Sharan 2005). They are products of consultations with other members of the community or the institutions. Many at times they happen mutually. Social exchange theory suggests that the interaction by the individuals is based on the mutual transactions. This also helps one to build bond with others. This is an important aspect of health. In general it is observed that the health seeking behaviour of individuals is influenced by other members of the community. When a need arises a person interacts with others and exchanges feelings and emotions required for health. The present paper explains the health seeking behaviour using systems approach. According to the framework, Health is a system in which there are three subsystems, which have many sub elements within each sub-system (Srinivasan and Sharan 2005). The three subsystems described are individual, community and health administration. Health of an individual is an outcome of the interaction among the subsystems. For example, an individual's choices are influenced by his or her characteristics, the community members, the availability and accessibility of required services and so on. In addition it is further influenced by the interactions among the sub-elements of all the three subsystems. For an example, the sub-elements of individuals such as age, educational qualifications, income, occupation, awareness and so on influence one's decisions on health. Likewise, the sub-elements in the community subsystem such as

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affiliation (caste), religion, friendship, and social climate and affinity affect health choices affect the one's decisions. The sub-elements of the health administration sub-system, such as, the availability (provision of services and medicine, and timing), the accessibility (location, connectivity and communication), and attitude of personnel, are also influencing health care choices. In total when a sick person while making decisions he or she is influenced by age, income, occupation, affiliation, religion, availability of facilities, accessibility of facilities, attitude of health personnel, and so on. The present paper studies the health seeking behaviour on the above framework. This is a cross sectional study which studies the impact of the three major subsystems of health among the rural population of two villages of Tamil Nadu.

The subsystem of individual consists of sub-elements such as, age, occupation status, income level, education status, marital status, caste affiliation, attitude, belief, and awareness of treatment options, and nature and types of sicknesses (acute or chronic). The community subsystem comprises of the sub-elements such as, friendship ties, type of family (nuclear or extended), religion, social settings, physical settings and so on. The Health administration subsystem consists of provision of services and medicine, timing of operations, location, organizational structure, trust built among the community, awareness created, and history of outcomes and so on. It is evident that all the above sub-systems and sub-elements influence individuals' health choices. However, we are not sure about the nature and extent of their influence. Whether all the above sub-systems and sub elements influence equally? Or some are dominant than other elements? Whether some elements do not influence the decisions at all? It may be possible that some have more influence in some instances than others. Whether these elements are specific to a culture? The present

paper tries to address these influences with primary data. It is also attempting to study the sub elements which are important for health decisions.

### **Research Design**

The present research is based on cross sectional study conducted during 1991 to 1995. For empirical study, two villages from the state of Tamil Nadu in India are selected. Both the villages are from Dindigul District. They are, (1) Naduppatti and (2) Sangalpatti. Naduppatti is a village located on the Western Ghats (hills) with 51 households and Sangalpatti village with 156 households. It is basically a household based study and all heads of households were interviewed. There were totally 207 respondents participated in the study.

### **Measurements**

For measuring one's health a self-administered questionnaire based on five indicators was developed. The indicators included are, history of illness, health seeking measures, personal hygiene, nutritional intake, and sanitation practices.

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 of sickness, type of sickness and duration of sickness. 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 (Srinivasan and Sharan 2005).

The Socio-Economic Status scale developed by Kuppusway with some modifications was used for studying other variables. The variables measured using Kuppuswamy scale are, Caste status, Income level, Occupation status, Education level, and Age.

In addition a scale for Religiosity was developed. It included indicators such as, visit to place of worship, celebrating religious ceremonies, rituals performed, and restrictions on diet.

**Analysis and findings**

Data was fed in to computer using dBase III+ and later converted to ASCII format for further analysis in UNIX system. For analysis SPSS-X on UNIX environment was used. I have done my first level of analysis using simple correlation by correlating all the variables viz. Health, Caste, Income, Occupation, Education, Religiosity and Age. Then regression analysis for the statistically significant variables was done.

**Table 1 Simple Correlation among Socio Economic Variables, Religiosity and Health**

	<b>Caste</b>	<b>Income</b>	<b>Occupation</b>	<b>Education</b>	<b>Religiosity</b>	<b>Age</b>
<b>Health</b>	0.64	0.15	0.31	-0.04	0.61	0.07

(N= 207)

The analysis established the influence of the above variables on their health. Among different variables the Caste had a strong correlation with health, followed by religiosity. Education was negatively correlated to health. On the other hand Occupation was positively influencing the health. However, this was not highly significant. Further they were analysed using stepwise regression method.

**Stepwise Regression of Socio Economic Variables and Health**

Regression Equation:

$$Y = 1.37 + 0.42(9.049) X_1 - 0.21(5.89) X_2 + 0.19 (2.33) X_3 \quad \text{-----Equation 1}$$

\* $p < 0.05$  one tailed test N=207, Metric coefficients with standard errors are shown in parentheses.

Y – Health, X<sub>1</sub> - Caste, X<sub>2</sub> - Education, X<sub>3</sub> -Religiosity

The Stepwise Regression equation is given in Equation 1. In this the three point health status was regressed against all the other variables. The regression results suggested three major inferences. First, caste has a positive influence on health. This was also statistically significant. This suggests that the respondents belong to higher caste status seek better health. This may also due to better access to facilities available for higher caste. The second variable which is positively influencing health was religiosity. The results were also statistically significant. This is due to the respondents who followed routines and lived in a disciplined way, were keeping themselves healthy. When the researcher observed the respondents, he found, highly religious respondents were strictly following the routines such as strict on their personal hygiene, sanitary practices, and were sufficiently taking nutritional food and so on.

The third variable which was statistically significant was education. As per the statistical results, education was inversely affecting health. This is substantiated by the observations made by the researcher. Based on the observations, the researcher found that the youths who are educated were exposed to alcohol, smoking, and to poor environment when they all migrated to urban centres for employment. Each one of the above are associated with a disease. It was also evident from the field that the educated youth in the study area were consuming intoxicants. In addition they were not strictly following the personal hygiene practices, and sanitary practices compared to the elderly population.

There were also other variables which were not statistically significant but influence the health of individuals and linked to their choices. They are age, income, affiliation, occupation, and religiosity. The following discussions explain their influence on health.

### **Age**

In general the age is divided in to two categories. They are (1) Independents and (2) Dependents. The persons who belong to 15 to 60 years of age are independents. Generally they were engaged in an occupation which earns them income for their livelihood. These individuals make their own decisions. The other group consists of children below 15 years of age and elderly people above 60 years of age. The dependents are the people who depend on their parents or caretakers to make their health decisions.

### **Income**

Other important variable which influences the health decision was the Income. The association of Income with health was not statistically significant. However, the observations of the researcher suggest it is an important variable in health choices. During the field work the researcher found that the respondents belonging to higher income group sought better health. This has influenced various aspects. In Nadupatti, a village in the Western Ghats, where the patients have to travel minimum of 25 kilometres for specialised medical treatments. While the high income group can afford jeeps and cars for the transportation of the patients to plains, the tribal people many at times carry on a blanket tied to a pole. This highlights the importance of income on the health choices.

## **Community Affiliation**

Community affiliations play a vital role in health choices. In many instances friends, neighbours, and members from the same caste or tribe, influence health choices of individuals. In case of need, all members belonging to a group regularly consult with their community members before seeking care. There were also existence of sports clubs and film fan associations in the study area. These bodies meet regularly. During the meetings these organisations influence members' healthcare choices.

Many at times this lead to shift in the type of care sought by individuals. There were instances of members of a community suggesting homeopathy treatment instead of allopathic procedures for certain illnesses. There was more than one case on influence of community members on health choices. This highlights the importance of community affiliations on health care choices.

## **Occupation**

Occupation is another important variable which influences the health choices. In general there were three major categories of occupations among the respondents. They were classified as higher occupations, middle level and lower level occupational categories (this was categorised based on Kuppuswamy scale). It was also observed that there were occupational health hazards among the respondents. There were people died due to some risky professions such as collecting algae from the tree tops. One of the sources of income for tribal population was collecting algae from a type of tree. There are some trees in the forest area in which a type of algae is grown on the top. They have a high medicinal value and were purchased by some pharmaceutical companies. They earn a couple of hundred rupees for a kilogram of such algae. Generally they need to climb at



least ten trees for accumulating a kilogram of algae. The trees were a thin stem with 30 feet high. Many at times the person climbing on the tree slips and falls on a rock and die. It is evident from the above that occupation is an important variable for health and living.

### **Religiosity and Health**

As the religiosity is a strong predictor variable for health, I have further analysed the relationship between religiosity and health. As mentioned earlier, religiosity was measured based on performance of various kinds of rituals, religious ceremonies and diet restrictions. The following items were used as indicators to measure the levels of religiosity.

There were four indicators used for measuring religiosity:

- (i) Visit to place of worship
- (ii) Celebrating religious ceremonies
- (iii) Performance of rituals
- (iv) Restriction on dietary practices.

Respondents who visited to the places of worship daily were assigned 3 points, the respondents who visited to places of worship once in a week were assigned 2 points, and the respondents who visited to places of worship once in a month or occasionally were assigned 1 point. For the questions on religious ceremonies and rituals, 1 point to each positive response and zero value for negative responses were given. For the respondents who kept fast and maintained restriction on diet at least once in a week were assigned 3 points, the respondents who kept fast once in a month and some restrictions on diet were assigned 2 points, and who kept fast once in a year or occasionally and who maintained occasional restriction on diet on some specific days were assigned 1 point. The total score

ranged from 2 to 8. Those who secured 2 points were placed in 'Less religious' category, those who scored 3 to 5 points were placed in 'Moderately religious' and those who secured 6 to 8 points were placed in 'highly religious' category. Thus, the scale was divided into three major categories: less religious, moderately religious, and highly religious.

The linkages between religious belief and health are studied well. There are also studies on importance of religion on health has been examined by studies (Vaux 1976), the dietary beliefs in health and illness (Chan Ho 1985), the role of religion in morbidity and mortality (Jarvis and North Cott 1987), the religion and other factors influencing health status (Idler and Kasl 1992) and so on.

In India studies are showing the importance of caste and religion are related to the health culture (Banerji 1982), and the magic and other beliefs among a south Indian caste and its impact on health (Dumont 1986). Based on the importance in the issue the present paper focuses its attention on various aspects of religiosity and health.

The rural population of India is very much influenced by religious beliefs. The cultural formation of individuals are closely inter linked with performance of individual's daily routine. Let us discuss the impact of religious practices and rituals as on health among rural population of India.

Some studies have shown the association between moral conduct of individuals and health (Cartstairs, 1965, Hasan, 1967). The studies reported that the roots of illness extend into realm of human conduct and cosmic purposes. Further, these studies have mentioned that villagers did not pay attention on their health care but they do care to follow certain

practices in a very rigid manner. For example, the villagers are in habit of taking early morning walk either for a dip in the holy rivers or toilet purposes, following of certain kind of restrictive diet on certain days; keeping fast on certain specified days etc. All of these hygienic and health practices are linked with the aspects of religiosity. Likewise, the habit of bare-footed trekking and of smoking from the same hobble-bubble are some of the in unhygienic traditional practices directly affecting the health (Carstairs, 1965, Hasan, 1967) These habits are known as religious practice; and they have roots in the frame-work of religion.

### **Definition**

In sociological tradition, religion is considered as an institutionalized system of symbols, belief values, and practices. Thus, beliefs and rituals are the main components of any religion. Sociological definitions of religion take two main forms: substantive and functional. Substantive definition defines religion as a belief and institution directed towards deities or other super human beings such as ancestors or nature - spirits (Tylor, 1871). Functional definition of religion arose principally from Durkheim's rejection of the Tylorian approach. According to Durkheim religion is a binding force and this balances the growth of a society. In history of society religion is based on the functional requirement of individuals. Functional requirement is to have faith in something for ones own reassurance and confidence. Evolutionists such as Tylor and Muller attempted to explain religion in terms of human needs. Tylor saw it as a response to man's intellectual needs, Muller saw it as a means for satisfying man's emotional needs. (Harlambo).

The religion has two forms. They are animism and naturalism. Animism is the belief in spirits. Edward B Tylor believed this as the earliest form of religion. He argued that

animism derives from man's attempt to answer questions on the relationship between life and death. Tylor suggested that religion, in the form of animism originated to satisfy man's intellectual nature to meet his need to understand the events of death, dreams and visions (Tylor, 1970). On the other hand, proponents of naturalism believed that the forces of nature have some supernatural power. Contradicting Tylor's arguments, Malinowski put forward that naturalism was the earliest form of religion. According to him, naturalism arose from man's experience of nature, in particular the effect of nature upon man's emotions. Nature contained surprises, terrors, marvels and miracles such as volcanoes, thunder and lightning. Awed by the power and wonder of nature, the primitive man transformed abstract forces into personal agents. The force of the wind became the spirit of the wind, the power of the sun became the spirit of the sun (Malinowski, 1954) Animism seeks the origin of religion in man's intellectual needs, while naturalism seeks it in fulfilment of man's emotional needs. In the context with the rural masses of India, one finds the peculiar blend of animism as well as naturalism

To some extent Durkheim in his book 'The Elementary Forms of Religion' has supported the blend of natural power and the supernatural beliefs. He said, that all societies divided the religious acts into "the sacred" and the "the profane". Sacred things are considered to be superior in dignity and power to profane (non-sacred) things. According to Durkheim, religious beliefs are neither to fulfil intellectual needs nor emotional as suggested by Tylor and Malinowski but religious beliefs and practices are needed for the survival of a man. Religion in all forms and types has functional use in a man's life and therefore they were always present.

## **Rituals**

The Latin 'Ritus' from which the term ritual is derived means 'custom', a notion which has misled certain sociologists to believe that ritual was the routine of an organized religion. There is, however, no denying that without ritual there cannot be an organized religion, but this does not necessarily mean that all rituals are religious. There are many rituals which exclusively have social character, not to speak of the magical and what we would like to call the metaphysical rites, none of which can be confused with the religious ones. Certain rites are as much a part of the daily routine of the individual and hence as much as eating, drinking and the other odd chores of domestic life. Unless the necessitous is defined strictly in physiological terms without any sociological admixture, rites cannot be placed in the category of the extra-necessitous. And if the term is defined in this manner, not only rites but several other practices too, will have to be included in the other category. The popular distinction between the sacred and the profane again does not seem to be a sound basis for distinguishing rituals from ordinary practices. It is in fact the ritual 'touch' which makes certain practices sacred, not that an act becomes ritual because it happens to possess a sacred character. The objects and beliefs treated as sacred are sacred only because they are endowed with a ritual-value.

Rituals are often understood as a form of symbolic action. Sometimes symbolic actions differ from the ordinary ones. However, the distinctive characteristic of symbolic actions is that they are not governed by the laws of logic which normally govern the other ordinary action.

All human beings believe in supernatural power. People believe there is a power beyond human-power and knowledge. It is true even in the case of health and illness. People believe that one is healthy and other is not because of the effect of some supernatural forces. There

are instances among the rural masses where illnesses are associated with God. Diseases like small pox, chicken pox, measles and cholera are generally associated with a particular God or Goddess or deities as well as the power of natural elements like certain kind of wind pressure, sun light and Neem tree. In rural India, people believe that the health problems arise due to the sins committed in last birth. They generally associate the outbreak of epidemics with the non performance of certain rituals by the population. Likewise, respondents of the study believed certain diseases can never be cured with any amount of medical aids and they can only be cured through the help of divine power which can be aroused by offering, prayers, chanting of mantras' etc. they did mention to the investigator that dreaded diseases like small-pox, plague, cholera have cures in divine offerings and religious rituals. In the back-drop of the above discussion, one can appreciate the importance of ritualistic action with in the frame-reference of religion.

Using the above two measurements, we arrived at three levels of health-status (high, moderate and low) and three levels of religiosity as presented in Table 1.

**TABLE 2 LEVELS OF HEALTH STATUS AND RELIGIOSITY OF RESPONDENTS**

<b>CATEGORIES OF RELIGIOSITY</b>	<b>HEALTH CATEGORIES</b>			<b>TOTAL</b>
	<b>LOW(%)</b>	<b>MIDDLE(%)</b>	<b>HIGH(%)</b>	
<b>LESS</b>	11 (42.3)	28 (50.9)	0 (0)	39
<b>MODERATELY</b>	15 (57.6)	24 (43.6)	57 (45.2)	96
<b>HIGHLY</b>	0 (0)	3 (5.4)	69 (54.7)	72

<b>TOTAL</b>	26 (100)	55 (100)	126 (100)	207
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The Table 2 suggests the frequency distribution of respondents into various categories of health status and religiosity. The table shows that religiosity and health-status are in correspondence with each other. It means highly healthy respondents are the highly religious persons. It shows, that the majority of respondents who are having good health (i.e. 69 out of 126) are termed as highly religious persons too. Likewise, those who have scored low on scale of religiosity, have scored low on health scale too (i.e., 11/26). However, it is worth noting that a very low percentage of the total respondents fall in the category of low health status (i.e., only 26 respondents). Out of these 26 cases, only 11 are in the category of low health status. This finding suggests that most of the respondents were very religious and therefore, they were following the traditional practices

**Religiosity and Health Status.**

The respondents who are placed into the category of highly religious are visiting the places of worship once in a day. They used to perform certain daily routine practices as sacred functions or rituals, such as taking bath before going to a temple, use of sandal mark on forehead, smearing of sacred ashes (made of burnt cow dung cakes) on the forehead, carrying flowers and camphor sticks etc. Most often highly religious respondents kept fast for a day once in a week along with certain kind of restrictive diets on rest of the days. They normally consume vegetarian diet consisting of items like card, fresh vegetables, unpolished rice, seasonal fruits, coconut, etc. Generally, their food was served on banana-leaves Their practices suggested inoculation of certain amount of discipline and

regularity in their way of living which in turn was able to provide a mechanism of maintaining good health. To some extent this assumption got confirmed through the answer pattern of respondents. After having a discussion on ritualistic practices as routine action, it would be useful if we can have a look at the offerings performed by the respondents. Each respondent was asked whether they are offering. On response to the question, all respondent excepting two respondents performed offerings

**Table 3 Religious Rituals for common cure**

Kinds of Offering	Number
Goat	192
Pongal	193
Money	115
Hair	4

Table 3 shows 205 respondents perform offerings in the form of animals, pongal, hair etc. for common cures. It is interesting to observe that almost all the respondents performed either for common cure or tangible benefits excepting 2 respondents who mentioned that they did not believe in offerings. 83 Normally these offerings were made in the form of promises at the time of sicknesses and as soon as the sick persons became healthy - the promises of offering were fulfilled in front of the deities.

Based on respondents' description of ritual practices, some characteristic of rituals has been observed. They are:

(i) Rituals performed for tangible gains: Attainment of tangible objects like wealth success, physical, power political gains etc. were the major motives related with



certain kind of distribution of money/gift etc. Once Murugan appeared in the Secondary School Examination, he prayed to Lord *Murugan* that if he passes the examination, he would offer a coconut. When he succeeded in the examination he offered it. Likewise, rituals are performed for tangible benefits.

(ii) Supernatural ritual performances are part of the religious system for attaining salvation in some form. Sometimes their effectiveness is presumed to depend upon the "will" of a supernatural being; thus, when respondents speak of prayer or supplication, they imply that the supernatural being who is addressed may fulfil the wishes of the petitioner. In some rituals, however, the performance is automatically effective provided that it is carried out according to certain prescriptions. For example, in case of spread epidemic diseases like smallpox, measles (a variety of viral disease). In the study villages, it was observed that, whenever a child is ill of chicken pox the members of the family worshipping the child by saying the Goddess has gone into the child.

(iii) Rituals as moral conduct: According to Durkheim in all modes of life, relating to serious acts such as happiness, grief, sufferings, etc one is suppose to perform certain prescribed rituals.

For example, thanks giving celebrations, death rites, funeral-procession etc. These rituals are brought in practice form to inculcate some moral order and discipline. Among the respondents of the study it was a common practice that whenever there was a happy occasion like the birth of a child, or a marriage, they performed some rituals to celebrate the happiness as a symbol of thanks giving Similarly, when a person died,

the villagers performed rituals on the second day which they call “*Paal Uthuthal*” (milk offering ceremony) This ceremony was performed to show certain amount of respect towards the departed soul.

(iv) Transcendental aspect of rituals: Ritual imposes a transcendental obligation - an obligation which does not stand or sanctions but enforces itself spontaneously Its impact on human mind may be characterized in metaphysical terms as awesome, faith or devotion in contradiction to the psychological 'appeal' of dynamic morality. Love, compassion, charity and loyalty, the tenets of the dynamic morality are the universal principles of human existence. In conforming to these, man simply obeys the law of his nature; he will cease to be a human being if he refuses to abide by them.

An overview of some of the above it can be suggested that health is as much a socio-cultural phenomenon as it is a biological explanation. Religious values such as deeds of the past, attributing to sins committed by people and consequent of wraths of gods and goddesses and treatment sought through magico-religious practices, are indicators of the influence of our tradition and cultural life. With the spread of education, exposure to mass media, urbanizing and industrializing influences resulting in occupational and spatial mobility and economic well being, choice of people to accept modern medicine over folk medicine has increased. Even villagers or tribal folks look forward to modern medicine for relief from pain, sufferings or physical ailments. Medicine, whether folk or modern has a dual nature. Irrespective of the technological level of a society, people still would lend support to the physicians' efforts with their prayers and propitiation of gods and goddesses. This mix of scientific temper and faith healing in medicine needs to be understood in the context and situation in which it operates. It may be only

making tall claims that modern medicine has stalked death. It has only postponed death but at the same time, the scientific development has increased the "at risk factor" for the health of man. In other words, the life span of man has increased but his rate of becoming unhealthy has increased many folds. Indian villagers in this modern world still wants to try out various systems of medicine and when they feel dissatisfied with one, they are inclined to try their hand on another, till they are forced to entrust themselves to the folk medicine which is close to their cultural milieu.

## **Conclusion**

A classic problem common to management sciences is on how people make decisions. Studies show the need for some rational action for health care (Pescosolido, 1991). The above findings show the influence of social correlates individuals' health care choices. This suggests social interaction is the basis of life and social networks provide interaction, which helps individuals to handle their health problems. This suggests a shift from the self centered choices to social centered choices. The above findings support the utility of socially constructed approach for understanding the dynamics of rural health management and planning.

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