Abstract

This study focuses on the relationships between socio-economic status and health conditions of the people of the Jaffna peninsula, Sri Lanka with special reference to the impacts of exodus in 1995 in the Valikamam area of the peninsula. A cross-sectional study titled 'Jaffna Socio-Economic and Health Study – 1999' conducted during March to June 1999 and comprising a sample of about 1120 families drawn by a two-stage cluster sampling technique gathered the data required for this study. Food consumption patterns, poverty problems, nutritional status, housing environment, health practices, physical disabilities, mental disorders, morbidity, and mortality under the post exodus scenario were separately analyzed in this research. Multivariate statistical analysis and categorical data analysis were employed to obtain results. Our study reveals the following results.

The consumption of some important food items such as meat, fish, pulses and cereals of the Jaffna society is lower than the national consumption status and produced higher degree of protein deficiency. There were three distinct groups of families in the society with varying food consumption patterns. Family demographic features had more influence compared to the characteristics of parents and monetary status of the families in this clustering. The occupational levels were relatively lower in general and there was a severe degree of unemployment and under employment. The effective income of the families as controlled by non-health expenditure and the value of food subsidy provided by the government was the major factor of monetary status. The revenue from the sources other than regular occupations influenced the monetary status of the families.

Housing, kitchen, and latrine facilities, sleeping space per head and floor space of the house, type of waste disposal, and hygienic status of the sources of drinking water were unsatisfactory. Per capita occupational income as controlled by per capita expenditure on food and miscellaneous activities and amount of food subsidy, per capita energy and protein consumption, housing-kitchen-latrine conditions were the important factors causing the poverty problems and socio-economic status of the families. Socio-economic class stratification of the society reveals that there were four socio-economic classes known as the rich, the upper middle, the lower middle, and the poor. The poor socio-economic class was identified as the poverty group and the incidence of poverty was 26 percent. Multivariate poverty lines consisting canonical descriminant axes are constructed to identify any families to classify under any of the four socio-economic classes. The current rehabilitation scheme 'food subsidy', locally known as 'Nivaranam', along with the new temporary better housing conditions of the resettled families, show that the incidence of poverty was only 12 percent.

Higher percentages of malnutrition in infants, acute and chronic malnutrition (wasting and stunting) in preschool children were identified in comparison with the pre exodus scenario. The current rates of malnutrition in infants and preschool children are alarming in the society. Protein-energy malnutrition was strongly prevalent in the families. Family size and per capita expenditure on food determined the nutritional risks of the families.

Smoking and liquor drinking habits have been substantially reduced before and after exodus. Changes of occupational levels after exodus have induced some men to become current liquor drinkers and to give up smoking habits. There were distinct groups of husbands in the different combinations of smoking and liquor drinking habits. Changes in the occupational levels, per capita income-expenditure, and per capita protein-energy consumption had some influence on these health practices. Self assessed health statuses of the couples in terms of physical, mental, and social well-being showed four distinct types of couples having 'very good', 'good', 'poor', and 'very poor' health statuses. Housing environment, smoking and liquor drinking habits, and per capita income-expenditure had strong association with the self-assessed health status of the couples. The high degree of changes in the self-assessed health status due to exodus was reported and no improvements were noted after exodus.

Physical disabilities of the parents such as inhibition in self-awareness, knowledge acquisition, identification, personal safety, family role, occupational role, visual tasks, symbolic communication, and household activities were strongly prevalent in the society. Mental disorders of the parents such as low spirit, poor memory, sleeplessness, feeling lonely, restlessness, failure in expectation, poor appetite, fullness of head, feeling hot all over suddenly, feeling weak all over, troubling by head-ache, palpitations, and acid stomach were strongly prevalent. There were distinct clusters of parents on behavior / communication disabilities, personal care / body disposition / situational disabilities, psychological disorders, physiological / psycho-physiological / ambiguous disorders. The relationships between these clusters and some socio-economic variables were explained.

Variation in the prevalence of various groups of diseases and health problems in the six DS divisions (zones) of the study area and in four socio-economic groups are reported. The two urban zones and the poor socio-economic group had more association and the two western rural zones had less association with most of the diseases and health hazards. The other two rural zones had mixed behaviors with health hazards. The people of the urban zones had more access and utilization to medical and surgical treatments. About 67 percent of the people of this region received the services of the health care institutions. The prevalence of malaria was much higher after exodus and specifically in the families who returned from the Wanni area compared to the people displaced within the peninsula. The crude death rate, age-sex specific death rates, infant mortality rate, maternal mortality rate were very much higher in this region compared to the mortality rates of the other regions of Sri Lanka. Majority of the causes of deaths was due to the diseases of the circulatory system, infectious and parasitic diseases. The death rate in the war atmosphere was about 12 persons for every 10,000 persons of this region in a year. Occupational, regional, and socio-economic class differences in mortality and cause specific mortality variation across the region were also noticeable.

This study identifies different areas for future socio-economic and health research in the Jaffna society. A number of suggestions are proposed in this research to improve the quality of life of the people of this region. Our suggestions may or may not be feasible to be implemented in the near future because of the prolonged political unrest and everyone in Sri Lanka is now longing for a peaceful political solution. We emphasize the importance of a stable socio-political and socio-economic environment that would lead to a successful rehabilitation of the people of this region.