Do Structural Inequalities Contribute to Marital Violence?

Ethnographic Evidence From Rural South India

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Ethnographic research was conducted in rural communities in Karnataka State, South India, to explore the contexts in which marital violence occurs and the relationships between structural inequalities (gender, caste, and class inequalities) and marital violence. Research highlighted that (a) marital violence is intimately linked to experiences of gender, caste, and class inequalities; (b) women's ability to resist violence hinges on access to economic and social resources; and (c) health care providers need to be actively involved in responding to violence. This study demonstrates the urgent need for violence prevention initiatives, particularly those that address the contribution of structural inequalities.

Keywords: *India; marital violence*

Violence is a fundamental part of many women's lives, constraining their present and defining their future. In India, violence against women takes many forms and occurs throughout the life span. It may be viewed as a manifestation of gender inequalities and a mechanism through which gender inequalities are produced and perpetuated. The current article focuses on ethnographic research on violence against women in the context of marital relationships in rural South India. It explores the contexts in which marital violence occurs and examines the relationship between structural

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inequalities (gender, caste, and class inequalities) and marital violence.

Worldwide, it has been observed that marriage is one of the principal arenas in which women experience violence—physical assault, psychological abuse, and coerced sex (Population Information Program, 1999). In many sociocultural settings such as in rural India, the social necessity of marriage, the near-universality of marriage among women, and women's young age at marriage, combined with gender inequalities, make women particularly vulnerable to violence within the home and marital relationship. Studies that have explored the contexts in which marital violence occurs have suggested that violence is associated with community- and household-level factors such as economic disadvantage and intra-household-level factors such as women's lack of access to resources and husbands' alcohol consumption (Jewkes, 2002; Kishor & Johnson, 2004). Qualitative research has documented marital violence resulting from husbands' perceptions of disobedient behavior, suspicions of infidelity, and alcohol consumption (Rao, 1997; Visaria, 1999). In a study in rural Gujarat, the prevalence of reported violence was higher among women belonging to the scheduled castes (those belonging to the lowest rung of the caste system) and other lower castes; a larger proportion of these women also reported that economic stress precipitated marital violence (Rao, 1997; Visaria, 1999).[1]

Few studies to date have explored how structural inequalities (inequalities based on gender, caste, or class) contribute to marital violence. The current article reports the findings of ethnographic research on marital violence conducted in a rural subdistrict of the southern Indian State of Karnataka. The article begins with a brief description of the conceptual framework of the study followed by a description of the ethnographic methods used. Next, we detail the results of the ethnographic research; and, in conclusion, we discuss the implications for violence prevention and health promotion programs.

CONCEPTUAL FRAMEWORK

The research described here has had two primary theoretical influences. First is the influence of feminist theory and praxis. The current study was conducted in the context of a feminist women's

health program. Although the meaning of *feminism* and taking *a feminist perspective* differed among members of the project, the common element was a commitment to women—"women as individuals and as a social category" (Reinharz, 1992, p. 241). The process of doing research was used as a mechanism for producing knowledge as well as for facilitating empowerment and social change—a form of so-called feminist praxis.

Second, the conceptual framework for the current study was influenced by critiques of feminist analyses of violence against women, particularly critiques that have highlighted the need to understand not just the role of gender-based power in violence against women but also the role of multiple forms of power, such as power arising from race, class, and caste. Feminist approaches have acknowledged that differences among women are important. In fact, according to Hester and colleagues (Hester, Radford, & Kelly, 1996), difference is fundamental to feminist analyses of women's experience, which seeks to understand how multiple forms of oppression, based on gender, race, class, sexual orientation, and other factors, affect women. The attempt here has been to understand individual women's experiences of violence within the context of economic, caste, and gender dynamics.

METHOD

Research was conducted in the context of the planning and implementation of a women's health program in collaboration with a community hospital in the Chickmagalur District of the central plateau region of Karnataka State, India.[2] Research was conducted by the author (a U.S.-educated researcher of Indian origin and fluent in the local language, Kannada), with the help of a research assistant (a sociologist from Bangalore, the capital city of Karnataka).

Ethnographic research was conducted during the course of the author's periodic residence in the research villages between July 1997 and July 1999. Research protocols were approved by the local collaborating hospital and the Committee for the Protection of Human Subjects at the University of California–Berkeley. The primary research method was participant observation. Marital violence was not an explicit part of the initial research agenda, which focused on perceptions of and practices related to

gynecological illness, contraception, sexually transmitted diseases, and HIV and/or AIDS. It emerged as important during interactions with women in counseling sessions and clinics conducted by the women's health program team. As a result, we explored these issues further in 20 semistructured and open-ended interviews and six group discussions with adult women and men. Women and men belonging to the major local caste groups and ranging in age from 25 to 45 years participated in these activities. Furthermore, seven semistructured interviews were conducted with health care providers, including biomedical and ayurvedic physicians and practitioners of other local forms of healing. The author facilitated the interviews and discussions and recorded the proceedings along with other observations in a journal in English. The research assistant supported the translation of interviews and discussions.

RESEARCH SETTING

Karnataka State is located in south central India, bordered on the east by Tamil Nadu, the south by Kerala, and the north by Maharashtra and Andhra Pradesh. Its population, according to the 1991 census, is 45 million (Office of the Registrar General and Census Commissioner, 1991). About 69% of the population (31 million) lives in rural areas. The majority of those engaged in labor (63%) are involved in agriculture, which contributed to 39% of the state's income in 1988 to 1989 (Population Research Center, 1995). The primary crops are rice, *ragi* (millet), and *jowar* (sorghum). However, about one third of cultivated land in the State is devoted to nonfood crops. Per capita income, which was rupees 2,041 (approximately US$45) In 1988 to 1989 (1980 to 1981 prices), is close to the national figure. Nearly one third of rural residents and one fourth of urban residents have household incomes below the poverty line. According to the National Family Health Survey (Population Research Center 1995), in 1992 to 1993, 39% of rural males and 63% of rural females were illiterate. Marriage is nearly universal: In 1998 to 1999, 97% of women age 15 to 49 years were married, divorced, or separated. More than one half of women age 20 to 24 years were married before age 18 (Population Research Center, 1995).

Research was conducted in one *taluk* (an administrative subdivision) of Chickmagalur District, which is located in the central plateau region of Karnataka State. It is primarily an agricultural region with paddy cultivation and estates growing coffee, tea, areca nut, black pepper, and cardamom and is considered one of the more prosperous regions of the State (Batliwala, Mohan, Anitha, Gurumurthy, & Wali, 1998). Poverty is not as widespread or as acute as in other parts of Karnataka, notably the north. Census data suggest that unemployment levels are low, particularly among men (Sringeri Taluk Office, 1999).

SOCIOPOLITICAL AND ECONOMIC RELATIONS: THE ROLE OF CASTE

Religion and caste are essential components of individual and collective identities in this region (as is the case in many parts of India). Social and economic segregation occur along caste and/or religious lines and have important implications for individual and collective experience and development. We briefly describe the economic and social significance of caste and religion to explicate the broader context in which marital violence occurs.

In the research villages, Hindus form the majority of the population. Other religious groups include Muslims, Christians, and Jains. Caste divisions are not formally recognized among non-Hindus, although de facto they may be observed. Given the numerical dominance of Hindus and the importance of caste in defining sociopolitical and economic resources, greater emphasis is placed on caste than religion in this discussion. The meanings and implications of caste have been the subject of a century of debate and discussion, and presenting a genealogy of caste is beyond the scope of this discussion. Rather, we focus on describing the contemporary forms of caste and caste relations in the research communities. It is important to note that caste orderings vary across space and over time, with particular castes taking advantage of opportunities that provide social mobility (see, e.g., Charsley & Karanth, 1998). Thus, understanding caste relations in this region today may not be generalizable to other parts of Karnataka or even to the region in other times, although it may shed light on the nature of sociopolitical and economic segregation.

TABLE 1
Selected Castes and Their Traditional Occupation[a]

Caste	*Traditional Occupation*
Brahmana	Priest and scholar
Okkaliga (*Gowda*)	Peasant
Achari	Smith
Nayak	Fisherman
Kumbara	Potter
Scheduled castes	Servant and laborer
Musalman	Trader

a. Based in part on Srinivas (1998).

Caste and/or religious groups found in this region include *Brahmana* (*Brahmin*), *Lingayat*, *Okkaliga* (locally known as *Gowda*), *Achari*, *Nayak/Mavalli Nayak*, *Shetty*, *Pujari*, *Nayari*, *Kumbara*, Scheduled Castes and Tribes (SC/STs, including *Madiga, Bhovi*), Jain, Christian, and *Musalman* (Muslim). The traditional occupations of a few numerically strong groups are shown in Table 1. It is important to note that not all individuals have continued to practice their traditional occupation or, in fact, ever did. Some have shifted to agriculture or taken on other occupations through education and migration. However, a broad division of labor along caste lines has remained, in part, because mobility and change have been constrained by caste affiliation.

Among the various castes in this region, there are two so-called dominant groups: Brahmins and Okkaligas (locally known as Gowdas; the term *Gowda* literally means "chief").[3] Their dominance is based on a complex set of religious, sociopolitical, and economic factors including ritual status, land ownership, education, occupation, and political prominence. The ritual status of Brahmins has been strengthened by the presence of a *Matha* (monastery), one of four centers of Vedantha philosophy set up by Adi Shankara, a Hindu philosopher of the 8th century with a predominantly Brahmin following.[4] The Matha owns large tracts of land and is an important employer of local village residents, whose jobs tend to be related to their caste affiliation. Local Brahmins are employed as priests at the Matha and its temples, although not all are solely engaged in priestly duties. Many Brahmins are engaged in secular employment as physicians, teachers, farmers, traders, and cooks.

The Okkaligas, traditionally the peasant caste, also wield considerable political and economic (as distinct from ritual) power. They are a powerful group at the local and state levels.[5] In Karnataka, the Okkaliga subcastes have been able to overcome strong intragroup differences for the purpose of collective economic and political advancement (Charsley & Karanth, 1998). Many of the major landowners in this region belong to the Okkaliga caste and hold influential positions in the community as informal village heads and as elected government officials.

The SC/STs, a third major caste group in this region, make up the most disadvantaged castes (Charsley & Karanth, 1998). Members of the SC/STs refer to themselves and are referred to by others by a number of different names, including Adi Dravida, Adi Karnataka, and Dalit. In this discussion, we use the term *Scheduled Castes and Tribes*—and specifically the acronym *SC/STs*—as this was the term most commonly used by members of this group and others in this region. The majority of SC/STs are landless agricultural wage laborers. Typically, an agricultural laborer earns rupees 25 to 40 (US$0.60 cents to $1) a day, sometimes with a midday meal. Women earn anywhere from rupees 5 to 15 less than men do. Poverty often leads to the curtailment of children's education and, thus, the curtailment of opportunities for social and economic advancement.

Although many traditional caste-based exclusionary practices are no longer followed, the politics of exclusion and difference continue to be an important part of people's lives in this region. Social and cultural segregation along caste and/or religious lines continue to be manifest. The most obvious is spatial segregation. Villages are divided into areas inhabited by specific caste groups. The two most distinct parts of many villages are the *agrahara* (the area occupied by Brahmins) and the *colony* (the area occupied by the SCs). The STs continue to reside in relatively remote settlements, typically in heavily forested areas, and studies elsewhere in Karnataka have also found that the segregation of the SC/STs appears to be less yielding than that of other groups to social change efforts (Charsley & Karanth, 1998).

Segregation is also apparent in social relations between caste groups. Often, SC/STs are not invited into upper-caste homes or allowed to drink from "caste" wells. Often, upper castes will not take food cooked or served by SC/STs. In one discussion of caste,

a participant noted, "Because I'm a Gowda, I can't go to an SC house; work in an SC's fields; or marry an SC. If I do, I shame my caste." Upper-caste identities appear to be, at least in part, based on segregation from and opposition to others. Similarly, SC/ST self-identity emerges in a context of segregation from and opposition to more privileged others.

Disentangling the social and economic implications of caste identity is difficult in this context. Discussions with SC/ST women and men frequently contained references to the absence of opportunity and choice in their lives, an accepted and expected part of the reality of upper-caste groups. Economic disparities are highly visible. Land holdings are consolidated in the hands of a few (primarily upper-caste) families and corporate estates. The relative prosperity of the region combined with the disparity between rich and poor shape the experience of being lower caste and poor. Although SC/ST men and women were aware of government programs to increase their access to education and employment, they noted their inability to take advantage of these programs in the face of continued poverty and discrimination.

To the extent that caste is an essential element of conceptions of life and ways of living (possibility and practice), it is also a crucial factor in determining and defining health. In addition, as the following discussion illustrates, caste identity and experience are also gendered and intimately linked to marital violence.

ETHNOGRAPHIC INSIGHTS ON MARITAL VIOLENCE

FORMS AND DETERMINANTS OF VIOLENCE

Although some women were reluctant to discuss violence, particularly marital violence, many found the opportunity to share and reflect on their experiences of violence to be therapeutic. Women's experiences of male violence were primarily located within the home and were part of their everyday reality. They described a range of experiences of violence, from verbal abuse to beating to burning. In a number of interviews, women and men noted that beating a wife is justified if she has not followed her husband's orders.[6] In a group discussion with female community health workers, participants compiled the following so-called

inventory of situations that sparked physical violence by husbands based on personal and field experiences. This inventory suggests the links between violence and the experience of gender inequalities:

A husband beats his wife because
he doubts her fidelity
the dowry is insufficient
his wife is earning and he is not: He wants to be superior
she objects to his behavior or actions
she refuses to give him money (which he wants to use for drinking [alcohol])
he doesn't have the courage or is not able to vent his frustrations in public
because other men—his neighbors and friends—expect him to do so.

Furthermore, expressions of control over women, such as through marital violence and "eve teasing" (harassment of women in public settings), and social consumption of alcohol were intimately tied to broader conceptions of masculinity. According to one community health worker (19 years old, Nayak caste), "Even educated men beat their wives; they might know that beating is wrong, but other men in the community question his manhood if he doesn't. So he beats her a little bit."

In addition to recognizing the influence of gender inequalities and norms on marital violence, our observations suggest that social and economic inequalities, at least in part arising from caste, were also important. Upper-caste women who were relatively well off rarely identified violence as a problem on the personal or community levels.[7] The extent to which this was because they were less likely to discuss marital violence or because violence was less common among them is difficult to determine.[8] During interviews and group discussions with upper-caste or -class women, we found that they were uncomfortable speaking about family relations, particularly marital relations. Their reticence appeared, in part, to be linked to a concern that sharing experiences of household conflict would lower the prestige and honor of their families.

Women who belonged to relatively poor, lower-caste households most often raised the topic of marital violence in discussions. They pointed to a number of sources of vulnerability to violence. Marital violence and husbands' alcohol consumption were

recurring themes in women's narratives on health and illness and part of a broader narrative on the stresses imposed by economic need and caste disadvantage. Alcohol consumption by poor men of lower-caste appeared to be facilitated by conditions at the community and state levels. Upper-caste men own the majority of liquor businesses, which are often situated close to the colony, the part of the village where SC/ST families reside. It is common for men to proceed straight from the fields to the *arrack* (local liquor) shop with their wages at the end of the day. A few landlords who own alcohol retail businesses provide arrack packets in lieu of a portion of wages. When we asked men why alcohol use was common, particularly among those who belong to poor and lower-caste households, they emphasized the lack of alternatives: What was there to do after returning home (where there is no electricity, no radio or television)? How else can one get respite from the realities of daily life?

At the state level, policies regarding alcohol seem ambivalent toward its social impact. Alcohol is heavily taxed in Karnataka (as it is in a number of other Indian states), and it is an important source of indirect tax revenues for the government (Rao, 1997). Taxation is known to have a negative impact on consumption and may be viewed as an anti-alcohol policy.[9] However, according to community leaders in the research area, because of the substantial revenue alcohol sales generate, the State government has helped sustain and promote alcohol distribution and sales. In February 2001, the State government relaxed its restrictions on alcohol sales by lifting the sales tax on alcohol and by allowing the sale of beer in grocery stores in Bangalore, the capital city (Rakesh, 2001; Rally on Monday, 2001).

Women who are poor and lower caste also linked their lack of social support to the incidence of conflicts within the household and the accumulation of stress. Lower-caste households, the majority of which are landless, also tend to be nuclear. Although many women in nuclear household settings felt that they could draw on social support from extended family, time and distance often limited their ability to do so. In contrast, upper-caste households, which were more likely to own land, also tended to be joint families (with greater potential for social support). Limited research on the link between family structure and marital violence indicates that further exploration into the effects of social

isolation on violence is needed (Martin, Tsui, Maitra, & Marinshaw, 1999). However, the relationship between stressors and marital violence is well documented, and factors such as poverty, low education levels, and multiple children enhance stress within families (Jewkes, 2002; Martin et al., 1999).

WOMEN'S RESISTANCE

Discussions of the potential for women's resistance to violence were themselves constrained by women's understandings of gender norms, as the following excerpt from a group discussion with women suggests:

> Author: Why don't wives beat husbands?
> [The group laughed. They had never heard of a woman physically hurting a man.]
> G (age 20, Nayak caste): If a wife yells at a husband, the community will think she's a bad woman and will pity her husband. But if he beats her, they'll say it's because she has done something wrong. Many women think of their husband as God, and don't question anything he does. So, they will not react to abuse from their husband. They just accept it.
> A (age 18, Gowda caste): But, women can and do abuse men vocally.

Our ability to identify forms of women's resistance was also constrained by women's reluctance to talk about issues such as marital relations. Questions about experiences such as marital violence often evoked defensive responses. One respondent (30 years, Brahmin caste) noted that this was because women "did not want to advertise having a problem. They think it's shameful." Another (age 35, Gowda) explained, "Usually women don't talk about such problems [violence]. Even if they did [talk to me], what could I do?" Thus, women who experience marital violence (and other forms of domestic violence) rarely seek help, and even when they do, the impact may be limited, as in the following case, recounted by a community health worker (age 19, Nayak caste), of a woman who sought the help of the village *panchayat* (council):

> This couple had a love marriage [as opposed to an arranged marriage]. Her family didn't want to have anything to do with her. After some time the husband started eyeing another woman, and he began to beat and abuse his wife. She had no one to turn to. Finally, she complained to the Panchayat office. They [the

> Panchayat] arranged a meeting between the wife and husband and tried to figure out whether the two wanted to stay together, whether that was possible. The woman did not want to divorce her husband. She agreed to serve and take care of her husband, as long as he did not come home drunk or beat her.

Women's decisions to remain with their husbands were influenced not only by community norms and perceptions but also by women's own internalization of gender roles and norms and by the socioeconomic constraints imposed by gender inequalities. Women who leave their husbands may not be accepted by their natal families or get support from neighbors and friends. A woman who is divorced is thought to bring a bad name on her family; and, in general, remarriage is much more difficult for women, although this may differ by caste or class position. Furthermore, she may even find it difficult to arrange marriages for her children, particularly daughters. Economic factors also limit women's ability to run a household independently. Women rarely inherit and own property and often receive lower compensation than men for their labor. For example, women engaged in agricultural labor in this region receive Rupees 5 to 15 (10% to 40%) less than men. Strong gender norms limit women's options socially and economically, which in turn influence their ability to respond to and resist violence (Go et al., 2003; Nayak, Byrne, Martin, & Abraham, 2003).

RESPONSE OF HEALTH CARE PROVIDERS

Health care providers may represent one of the few sources of support for women experiencing violence. At community health centers, women experiencing marital violence as well as other types of domestic violence rarely raised the issue on their own. The majority reported problems such as weakness, body aches, and vaginal discharge. Violence would emerge only during the health history interviews conducted by the community health workers, in which they posed specific questions about the household environment, including women's perceptions of safety in their home and community, experiences of physical and psychological violence, and their own and household members' consumption of alcohol.

Biomedical and ayurvedic health care providers in the area rarely collected such information routinely. The following account is illustrative:

> [A community health worker] took me to meet Lalitha (35 years), who lives in a "colony." When we arrived at Lalitha's colony in the late morning, it was deserted—nearly everyone had gone to the fields. The health worker told me that the majority of residents were engaged in "*coolie kelasa*," daily wage labor. Lalitha was at home because she was unwell. Three years prior to our meeting she had started having health problems and stopped working. She has two sons who are now 15 and 12 years old. Both had been good students, but she had to take them out of school to work to compensate for her lost wages.
>
> Lalitha said that she had had a good marriage in the beginning. However, when her health problems led to economic hardship, the relationship began to deteriorate. For the past five years, she had been experiencing burning, pain, and anger during sex. In her words: "In the evenings he drinks. Then, he calls me to sleep with him, and we fight because I do not want to. . . . Finally, my husband took me to see a doctor who gave me some tablets. Once my head is fixed, all my diseases will disappear."
>
> Lalitha noted that she was tired of trying to figure out what was wrong with her body. . . . She and her husband had spent quite a lot of money in visits to private physicians. She showed me the tablets the physician she had most recently seen had given her. One of the local doctors told me that they were tranquilizers.

In discussions with local health care providers and/or healers, although many acknowledged the underlying or contributory role of poverty and gender inequalities and, less often, caste inequalities, in shaping health, most felt that addressing those issues in the form of counseling or referrals was beyond the scope of their work (or skills) as health care providers or not feasible given the conditions in which medical care was being provided. Thus, their responses to patients' predicaments rarely reflected or addressed this recognition.[10] In fact, in our experience, when symptoms could not clearly be attributed to a so-called real, pathological problem, women were often termed "psychotics" and prescribed antidepressants. Even in instances when this may have been appropriate treatment, the underlying cause of the problem, which may have been violence, was not identified or addressed. Our observations suggested that these practices

differentially affect women who are poor and belong to lower castes, women such as Lalitha.

CONCLUSION

The link between marital violence and gender-based inequalities is now widely accepted. In the current study, women across caste and class groups reported having experienced marital violence. However, our findings suggest that, in addition to gender-based inequalities, violence prevention efforts need to consider how other forms of structural inequalities contribute to marital violence. Lower caste, economically disadvantaged men's expressions of violence may be linked to the stresses experienced by men by virtue of their caste or class position. Pressures to fulfill gender norms result in violence against women as an expression of masculinity and as an outlet for frustrations at the inability to meet such expectations (Jewkes, 2002). Qualitative research elsewhere in Karnataka (J. Mencher, personal communication, May 2000; Rao, 1997) and Tamil Nadu (Go et al., 2003; J. Mencher, personal communication, May 2000) has noted that men who consume alcohol are less likely to resolve marital conflicts without resorting to violence and are more likely to enter into situations of conflict. Women's ability to resist violence hinged on access to economic and social resources, including social support, and was, in turn, related to community norms and sanctions. Other research on marital violence corroborates our view and emphasizes the importance of examining the social context within which violence occurs (Jejeebhoy, 1998; Jewkes, 2002; Nayak et al., 2003).

Our observations at community health centers suggest that health care providers may be able to identify women experiencing marital violence using a few short questions as part of the health history assessment. Research in north India also found that health care professionals provide an entry for screenings and treatment for domestic violence (Martin et al., 1999). An assessment of violence in marital relationships may provide important insights into women's mental and physical health status. Health care settings are one of the few sites in which counseling support for women can be provided, particularly in rural areas where dedicated counseling services are lacking. However, training for

health care providers to identify and respond to violence in marital relationships is needed.

These findings have a number of potential implications for violence prevention and health promotion programs. At the individual or couple level, they suggest the need for programs to promote conflict resolution skills among men and women, marital counseling services, and programs that address alcohol consumption as part of violence prevention efforts. At the community level, they suggest the need for programs to establish community support for women experiencing violence and community participation in violence prevention efforts, such as efforts to change social norms regarding violence. However, it is also necessary for these programs to be complemented by wider social movements addressing structural inequalities that contribute to the production of marital violence.

NOTES

1. However, these differences in the distribution of reports of marital violence were not evaluated for statistical significance.

2. The program called *Swasthya* (which is derived from Sanskrit and means "comprehensive well-being") is a collaboration between a charitable hospital, an international student group of which the author is a member, and local women who have been trained as community health workers. Details of the partnership have been published elsewhere (see Vedanthan & Krishnan, 1999).

3. A so-called dominant caste has been defined by Srinivas (1998) as one that is numerically strong and able to exert economic and political power. Castes may have elements of dominance—for example, ritual superiority, numerical strength, or economic clout based on land ownership (Srinivas, 1998).

4. For further information on Shankaracharya and the *Mathas* he established, see for example, Cenkner (1983).

5. This has been attributed in part to broad basing, the joint mobilization of *Okkaliga* subcastes from a broad geographic region that has enabled the pooling and deployment of considerable political resources (Charsley & Karanth, 1998).

6. We conducted a survey of a representative sample of married women age 15 to 49 years in this region in 1999. In the survey, 34% of women reported ever having been hit and/or forced to have sex by their husband.

7. "Upper" caste refers to the *Brahmin* and Okkaliga castes.

8. Thiruchandran, in her ethnography among women in Tamil Nadu, a neighboring state in southern India, observed that upper-caste women were much less likely to talk about marital conflict because of concerns of social prestige (Thiruchandran, 1997).

9. Mahal (2000), in a recent analysis of alcohol policies and consumption in India, suggested that alcohol consumption, particularly by adults, may be significantly reduced through price regulation via taxation.

10. We found few differences between how biomedical or ayurvedic physicians (those with formal degrees) related with their patients. However, the interactions between other kinds of local healers and their clients were quite variable and could involve relatively detailed discussions of contextual issues, including marital and/or kin relationships.

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