

INFLUENCE OF CULTURE ON HEALTH AND DISEASE OF  
RURAL PEOPLE

Thesis submitted to The University of Calicut  
for the Degree of  
Doctor of Philosophy in Sociology

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June – 2008

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**I hereby declare that this thesis on “Influence of Culture on Health and Disease of Rural People” is a bonafide record of research work done by me and that no part of it has been presented earlier for the award of any degree, diploma, or similar title of any other University.**

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## **Acknowledgement**

**I am happy that I could carry out this study under the supervision and guidance of Dr. Joni. C. Joseph, a distinguished sociologist and former best teacher award holder and the former member of the faculty of the Department of Sociology, The Zamorin's Guruvayurappan College, Kozhikode. He gave me valuable guidance and encouragement for the successful completion of my research work. I take this opportunity to thank him whole-heartedly.**

**I would like to express my sincere thanks to Mrs. Alice Joseph, wife of Dr. Joni. C. Joseph for giving me constant encouragement and whole hearted support for completing this study. Words fail to express my thanks to her.**

**I express my gratitude to Smt. S. Shobhana, Librarian in charge, CHMK Library, University of Calicut for the interest she has shown in my research**

**I extend my thanks to Sr. T. M. Mohanakrishnan, I. T. Administrator, The Zamorin's Guruvayurappan College, Kozhikode, who has processed the data according to the requirement of the study and designed the thesis in this attractive fashion.**

**I am thankful to M/s. Print O Fast, Calicut for printing and binding the thesis in an attractive format.**

**On this occasion I would like to prostrate before all my teachers who lit the lamp of knowledge in me.**

**I am obliged to my loving husband, Sri. Syamsuresh. L. S., who encouraged me with all his mind and heart to fruitfully finish my mission.**

**Last but not the least; I am grateful to my children who patiently supported me in the work.**

**I am grateful to all my respected respondents who have shown the willingness to co-operate with me in this matter.**

**Let me thank Almighty for blessing my mission and me.**

**S. Nirmala**

## Preface

There is an inextricable inter relationship between culture and health of any community. Health care system is amazingly advancing in modern times. But certain sections of the population of India, nay, the world over are averse in availing themselves of the advancement due to various reasons, *interalia*, cultural barriers.

Even in Kerala a state which is at the forefront of rational thinking and practices culture is very much modulating health care. This is particularly true in the case of rural community. This researcher has formulated a strong conceptual framework, which indicates the influence of culture on the beliefs, awareness and practices relating to the health care of rural community of Kerala. This background gave impetus for the formulation of this study and conducting it. The empirical part of the study was carried out in the rural areas of Malabar region of the state. Malabar region was chosen for the reason that rural characteristics are more prevalent here than the rural sides of other parts of the state reflect.

The thesis is prepared in ten chapters. The first chapter states the problem and reveals the rationale behind the study. The second and third chapters respectively discuss the literature analysis and methodology of the study. The fourth chapter named as Research Setting portrays the physical,

**demographic and cultural profiles of the study area. The next five chapters are analyses chapters. The fifth chapter gives an overview of the sanitation condition of the study area based on the primary data. Of the rest of the chapters, sixth, seventh and eighth respectively analyse the inter-relationship between culture and beliefs, awareness and practices relating to the various aspects of health. The ninth chapter contains five case analyses which also reveal the inter relationship between the two profiles of the rural community. The final chapter summarises the results and interpret them.**

**S. Nirmala**

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# **CHAPTER - I**

## **INTRODUCTION**

Health of individual and community is largely influenced by social and cultural factors. These factors have wide variations from one community to another and within the community itself. Living with others within a social structure, influences many aspects of our everyday life. Study of health care, behaviour of people and their relationships to the socio-cultural factors is a crucial area of research in community medicine. Despite, some common bio-physiological aspects pertaining to all human beings, the concept of health and disease are relative as well as oppositional in nature.

We are the products of culture and the historical context in which we reside. From a very young age we learn, with a startling amount of accuracy, that certain types – shelter, food, tools, clothing, music, sports, and art - characterize our culture and make it different from others. Without much conscious effort, we also learn what to believe, what to value, and which actions are proper or improper in both public and private. Comparing, our beliefs and behaviour to those of others sheds a great deal of light on the structure and process of society as well as the motivation behind individual behaviour. We can also gain insight into why certain rituals, behaviours and values exist in some culture but not in others, or in some eras and not others. Such differences can be found in many areas of cultural variations. (Newman,1997: 104).

Improving a person's health in India, or in any country, needs to start with an understanding of culture. We know that people in some countries live longer and are healthier than people in other countries, but we usually do not associate health and illness with culture. Description of medical treatment and the sick role, both illustrate the enormous influence of culture on lives and the conflict that can arise over cultural differences. Medical beliefs and behaviours must be consistent with the prevailing cultural values of a particular society. Claims of illness are always subject to group or societal validation; that is, you can not claim to have a disease that do not exist in your culture.

The history of disease in society is as old as the society itself. It has been a fundamental problem for all societies and hence every society has been developed according to its cultural experiences, both empirical and transcendental systems of values regarding health and disease, and also its methods for coping with them. In other words, every known society has created a pharmacopoeia and therapeutic system is it magico-religious, secular or scientific (Castilians, 1947: 26).

The situation of health and disease at the global level presents a canvas of contrasts. These contrasts can be with regard to notions of health problems, methods of treatment and causation of health and disease - are

influenced by the complex interaction between individuals, their socio-cultural settings and the physical environment (Pokarna, 1994: 15).

Health is one of the most difficult terms to define. Health can mean different things to different people. To some it may mean freedom from any sickness or disease while to some it may mean harmonious functioning of all body systems. Modern medicine and modern medical practice tends to view health as simply the state of absence of all known diseases (Guptha, 2003: 5). The widely accepted definition of health is the one given by the World Health Organization in the preamble to its constitution which is as follows: “Health is a state of complete physical, mental and social wellbeing and not merely an absence of disease and infirmity”. Recently the scope of this definition was widened to include the ability to lead a “socially and economically productive life” (Park, 1997: 11).

According to WHO, definition of health consists of three components - physical, mental and social. Some social scientists have also suggested another component, “spiritual health”. It may be considered as a component of mental health. In societies like ours religion has played an important role in shaping the cultural ethos. Many individuals strongly believe in the supernatural. In such situations a positive mental health empowers spiritual health. Spiritual health may be seen as health to resolve both internal as well as external conflicts.

Disease usually refers to a deviation in the normal functioning of the body which produces discomfort that adversely affect the individual's future health status (Mechanic, 1962:52). Every society has certain norms values and ideals with regard to health and disease, a deviation of which is treated as disease. Illness in all cultures is physiological crisis for the individual and his /her family.

The social and cultural environments in which people live have a profound effect on their patterns of health and disease. Culture, which is the creation of human beings in turn, conditions him. The group's culture affects every aspect of development of human being, that is, from acquisition of it's goal and aspirations including exposure to risk factors, to modes of it's responses and adaptations.

In traditional India disease has been attributed to extra-biological reasons such as man's disobediences of natural religious laws. It had also been attributed to the sins and crimes committed by a person in the present life or in the previous live. Appeasement of deities who where believed to be associated with prayers, invocations, offering of milk, flowers and rice, fast, sacrifices etc., where considered necessary for preventing and curing diseases. Thus in India, the approach towards disease and its curative aspects have been inextricably linked to socio – cultural norms and practices of the people. This was particularly the case with the people of rural settings. This study is aimed at finding out how socio -

cultural backgrounds influence health and diseases of rural people especially of Malabar Region.

This thesis is developed in ten chapters. The first chapter presents the research problem in a very brief manner indicating the importance of study. The second chapter analyzes the literature available on the topic. The third chapter describes the methodology of the study. The fourth chapter gives a brief account of the research setting, consisting of Vettom in *Malappuram*, Thiruvangoor in *Calicut*, Panamaram in *Wayanad*, Pappiniseri in *Kannur*, Pirrayiri in *Palakkad* and Anandashramam in *Kasargod* districts respectively. The physical and socio-cultural aspects are portrayed in this chapter. The fifth chapter portrays the environmental sanitation of the six districts where the empirical study was carried out. The sixth chapter focuses on the beliefs related to health and disease of rural people. The seventh chapter deals with the awareness. The eighth chapter describes the practices related to the health and disease of the people. The ninth chapter contains case studies. The tenth chapter is the concluding chapter. It gives the summary of findings and suggestions of the study.

## **CHAPTER - II**

### **SURVEY OF RELATED LITERATURE**

The recognition of the fact that health of an individual is more than a biological phenomenon has brought into the forefront the significance of behavioural dimensions of health. As a consequence of the cultural relativism, every society views health problems from the perspective of its own culture and provides coping responses according to the understanding, knowledge, values, attitudes and beliefs of the people comprising it. As such, traditional or quasi-traditional societies are likely to have different orientations toward the social and cultural aspects of health and disease than modern advanced societies of the west.

The oldest perception on health is, that health is the absence of disease. In some cultures health is defined as “being at peace with the self, community, God and cosmos” (Park, 1997:11). Ancient Indians and Greeks shared this concept and attributed disease to disturbance in bodily equilibrium that, they called “Humorous”.

However, during the past decades, there has been a re-awakening that health is a fundamental human right and a world-wide social goal, which is essential to the satisfaction of basic human needs and to an improved quality of life and is to be attained by all people. In 1997 the 30<sup>th</sup> World Health Assemblies decided that the main social targets of the governments and World Health

Organization in the coming decades should be “the attainment by all citizens of the world of the year 2000 of a level of health that will permit them to lead a socially and economically productive life”, for brevity called “Health for all” with the adoption of health as an integral part of socio-economic development by the United Nations in 1976. Health while being an end in itself has also become a major instrument of overall socio-economic development and the creation of a new social order.

## **HEALTH**

The widely accepted definition of health is that given by the World Health Organization in the preamble to its constitution. According to the document “Health is a state of complete physical, mental and social well being and not merely an absence of disease or infirmity (Park, 1997: 12).

Recently, the scope of the definition has been widened to include the ability to lead a “socially and economically productive life” (Feld, 1973:7). Health is a common theme in most cultures. However, communities have their own concept of health, as part of their culture.

Health implies a sound mind in a sound body, in a sound family, in a sound environment. According to WHO definition, health consists of three components - physical, mental and social. Some sociologists have also suggested another component, namely, spiritual health.



As mentioned earlier, traditionally, health has been viewed as absence of disease and if one was free from disease then the person was considered healthy. This is called biomedical concept of health. Deficiencies in the biomedical concept gave rise to another concept. Health implies the relative absence of pain and discomfort and a continuous adoption and adjustment to the environment to ensure optimal function (Dubos, 1965: 181).

The physical health of an individual is manifested by a normal complexion, clear skin, bright eyes, normal breath, sound sleep, smooth and co-ordinate body movement. Physical health implies the notion of “perfect functioning” of the body.

Mental health is not merely an absence of mental illness. A mentally healthy person should feel comfortable about his person and feel reasonably secure and neither should be underestimated himself, he/she should have self respect, he/she should be able to take responsibility for others, he/she should be able to set responsible goals for himself/herself and for others, be capable of shouldering the responsibilities of daily life and should not be bowled over by emotions of fear, anger, love or guilt (Basu, 1997:16).

More recently, mental health has been defined as a state of balance between the individual and surrounding world. A state of harmony between

oneself and others, a co-existence between the relatives of the self and that of other people and that of environment (Sortorius, 1983: 61).

Mental ill-health has certain organic and hereditary causes but it is greatly influenced by psychological factors like worry, anxieties, stress, tension, frustration and unhappy marriage; economic factors like poverty, industrialization, urbanization, a changing family structure, population mobility and economic insecurity. Thus the overall social environment not only determines the individual's attitude but is also responsible for his mental well-being (Basu, 1997:16).

Social health becomes an important issue for medical scientists. It has come to involve abilities like creating bonds of friendship and sustaining them; assuming responsibilities in accordance with one's capacities, achieving satisfaction, success and happiness through accomplishments in one's field; living in harmony with others and displaying consideration towards other beings (Dak, 1991: 75).

Social health can also be defined as the fullest exploitation of an individual's genetic heritage. A person should be capable of existing in harmony with his/her environment so that his/her genetic potentialities are transformed into phenotypical relatives (Ibid.).

Spiritual health is considered the fourth dimension of health. It includes integrity, principles and ethics, the purpose in life, commitment to some higher being and belief in concepts that are not subject to a state of the art explanation (Park; 1997: 13).

W. H. O definition of health is considered by many to be an idealistic goal rather than a realistic definition; the standard of positive health as a goal to be attained by all people.

Ideal health conditions, however, always remain elusive because of the rapid changes in the society, which foster conditions that are not conducive to the health of a person. Good health hence is a relative concept having no fixed standards. What is considered normal in one person may be abnormal in another (Basu 1997:16). This fact is illustrated by the following examples. A newborn baby weighs 2.8 kg on an average in this country as compared to 3.5 kg in developed countries and yet they are considered healthy. It is generally observed that even normal healthy people show signs of heart murmurs, enlarged tonsils and other disease. Yet they are not considered to be unhealthy. Health is hence a relative concept and its standard varies from person to person and from society to society (Ibid: 19).

This implies that health in any society should be defined in terms of prevailing ecological conditions. That is, instead of getting universal standards,

each country will decide on its own norms for a given set of prevailing conditions and then look into ways to achieve that level (Park. 1997: 14).

Health has been a prime concern of humanity since the dawn of history. Some of the earliest written records refer to the struggle against disease and to the contrast between the factors that made a long and healthy life and those that made life short and harsh.

Today we have the knowledge and tools to prevent many diseases. We know how to improve our health how to give our families, our communities, and ourselves the best possible chance of staying healthy. Unfortunately, that knowledge and those tools are not evenly distributed among humanity. They are neither always used well nor given appropriate priority.

Great advances have recently been made in health science. We now have a better understanding of risk factors for many conditions and better epidemiological information on health status, ill–health and premature death at different levels of society. As a result we are more aware of inequalities of health (Philip, 1994:1).

Over the years, it has become clear that substantial improvements in health cannot be achieved without improvement of social and economic conditions – lack of education, illiteracy, (including health illiteracy) and the lack of

information or ability to make decisions about one's health - these are all major impediments to health (Ibid).

## **DISEASE**

Webster's dictionary defines disease as "a condition in which the body health is impaired, a departure from a state of health, an alternation of the human body, interrupting the performance of vital functions". The Oxford English Dictionary defines it as "a condition of the body or some part of organ of the body in which its functions are disrupted or deranged". From a sociological point of view, disease is considered a social phenomenon, occurring in all societies and defined in terms of the particular cultural forces prevalent in society. The WHO defined health but not disease.

Health and disease coexist. In the struggle for existence, human beings face great challenges besides the disruptive forces that tend to destroy them. The survival and continuance of human society depends upon health and wellbeing of its members. Since ancient times, it has been the endeavour of the society to seek ways of eradication of illness and human suffering (Pokarna, 1962: 83).

Disease usually refers to a deviation in the normal functioning of the body, which produces discomfort or adversely affects the individual's future health status (Mechanic, 1992:176). Every society has certain norms, values

regarding health, and disease is a deviation from them. Disease can also be explained in terms of an organism by germs, bacteria or other pathogenic balance and result in some form of malfunctioning (Ibid, 1997: 76).

From ecological point of view disease is defined as maladjustment of the human organism to the environment (Park, 1997: 27). The simplest definition is, of course, that disease is just opposite of health i.e., deviation from normal functioning or state of complete physical or mental well being - since health and disease are mutually exclusive (Ibid).

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### **Disease, Illness, Sickness**

Distinction is made between the words disease, illness and sickness, which are not wholly synonymous. The term disease, literally means 'without ease', (uneasiness) the opposite of ease – something is wrong with bodily function. Illness refers not only to the presence of a specific disease, but also to the individuals perceptions and behaviour in response to the disease on the psycho - social environmental (Park, 1997: 28), 'sickness' refers to a state of social dysfunction, a social role assumed by the individual that is defined by the expectations of society and thereby extends beyond the individual to affect relations with others (Sussur, 1985:16). The clinician sees people who are ill rather than the disease, which he must diagnose and treat (Jean Millar, 1971: 94).

Even within a given society, comparative and historical studies in disease are made problematic by a number of considerations. Illness occurs in all societies and is defined and fought in terms of particular cultural forces prevalent in society. The cultural difference provides a different understanding of illness itself. Everybody can potentially fall sick at some time in his or her life, since no one is immune from all disease, disabilities and disorder. In fact, illnesses are everyday facts of life which we all live with or consult about or treat or see in other people or pass judgment on or fear or ignore or take precautions against.

Thus disease is a universal phenomenon and, therefore, affects everyone, everywhere despite understanding and controlling of disease but not always in the same degree or in the same way (Coe, 1970: 16). A disease is an abnormal condition of an organism that impairs bodily functions, associated with specific symptoms and signs. Human being is often used more broadly to refer to any condition that causes discomfort, dysfunction, distress, social problems, and/or death to the person afflicted or similar problems for those in contact with the person. While many diseases are biological processes with observable alternations of organ function or structure, others primarily involve alternations of behaviour.

Each society's definition of illness becomes institutionalized within its cultural patterns, so that one measure of social development is a cultural

conception of illness. In primitive societies illness was defined as an autonomous force or being, such as an evil spirit which attacked people and settled within their bodies' in order to cause them pain or death. During Middle Ages illness came to be defined as a punishment or sin and care of the sick was regarded as religious charity (Cocker ham, 1989: 149).

Today, illness is defined as a state or condition of suffering as the result of a disease or sickness. The medical view of illness is that of deviance from a biological norm of health and feeling of wellbeing (Ibid: 151).

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In medical sociology disease is considered as adverse physical state consisting of psychological dysfunction within an individual. An illness is a subjective state, pertaining to an individual's physiological awareness of having a disease usually causing that person to modify his or her behaviour, while sickness is a social state, signifying an impaired social role for those who are ill from the ecological point of view. Disease is defined as 'maladjustment of the human organism to the environment' (Alan, 1956:104).

Sickness is a condition that is a deviation from normality. A basic distinction between disease and illness is fundamental for an understanding of medical behaviour. Modern medicine understands diseases as being specifically related to change in specific organs of the body caused by the specific agents which if once allowed to affect the body, in predictable ways, the situation almost



never appears thus to people suffering from the disease. For when individuals are sick, they have a feeling that something is wrong with them as whole individuals and their sickness is apt to permeate every thing that they do and all the ways in which they perceive themselves (Kenneth: 1997: 677).

According to Brody and Sobel 'disease is regarded as a pattern of disruption that manifests itself in different ways at different levels'. By disease, we mean an objective phenomenon characterized by altered functioning of the body as a biological organism. However, apparent their manifestations, diseases are hidden processes which can only be understood as their observable signs are related to a body of knowledge about the way in which the human organisms works. By illness we mean a subjective phenomenon in which individuals perceive themselves as not feeling well, therefore, they tend to modify their normal behaviour. The distinction between these two concepts is important to sociology in that it permits analysis of behaviour of sick persons and those around them as consequence not only of differences in knowledge and perception but also of structural properties of interaction of roles and statuses (Coe, 1978: 98).

However, this deviation is not wilful in the sense that one has no control over one's sickness and cannot get over it by merely wishing for it. In that sense the role of a sick person is contingent, which means that anybody irrespective of age, sex, class and caste can fall sick. The values and customs of a

community significantly determine the perception of the disease, interpretation of symptoms and the techniques of the treatment.

Talcott Parsons has consistently characterized the 'sick role' as a form of deviance. Sickness for which a person demands or accepts medical care is a deviance from the norms of the everyday performance of social roles (Parsons quoted in Pokarna 1994: 34). All societies have social mechanisms to deal with the strains and conflicts that deviance of any kind inevitably creates. Parsons' strong interest in positive normative pattern and mechanisms of social control led him to de-emphasize the elements of deviance involved in patients' assumption of the sick role.

Twaddle identified three signs as helpful for perceiving sickness (i) changes in the feeling states the most important being the occurrence of pain and weakness, (ii) incapacity for normal role performance, and (iii) other systems or changes in the biological state of the organism regarded as important, because of their presumed implications for future action (Ibid ; 36 ).

Parsons' social systems were linked to systems of personality and culture to form a basis for social order, unlike other social theories preceding him. Parsons include an analysis of the function of medicine in this theory of society and while doing so, was led to consider the role of the sick person in relation to the social system within which that person lived. The result is a concept that

represents the most consistent approach to explaining the behaviour or explaining the behaviour characteristic of sick people in western society (Cocker ham, 1997:153).

Parsons' concept of the sick role is based on the assumption that being sick is not a deliberate and knowing choice of the sick persons, though illness may occur as a result of motivated exposure of infection or injury. Parsons' insists that sickness is dysfunctional because it represents a mode of response to social pressure that permits, the evasion of social responsibilities (Ibid).

The specific aspects of Parsons concept are described in four basic categories.

- 1) The sick persons are exempt from "normal" social roles.
- 2) The sick person is not responsible for his/her order condition.
- 3) The sick person should try to get well.
- 4) The sick person should seek technically competent help and co-operate with the physician (Ibid: 154).

### **Determinants of Health and Disease**

The factors, which influence health, lie both within the individual and in the society in which he/she lives. The health of individual and the whole community may be considered to be the result of many interactions. The most important determinants/variables are heredity, environment, life style, socio-

economic conditions, health and family welfare services and such other factors (Park, 1997:15).

### **The Role of Heredity**

The physical and mental traits of every human being are to some extent determined by the nature of his/her genes at the moment of conception. The genetic makeup is unique that it cannot be altered after conception. A number of diseases are now known to be genetic in their origin. Mental retardation, some types of diabetes are examples for such disorders. The state of health, therefore, depends partly on the genetic constitution of man (Park, 1997: 15).

Heredity is one of the powerful factors that contribute to the formation of human personality and influences man's social behaviour. It refers to the biological process of the transmission of certain biological and physiological characteristics from parents to their children through what are known as genes (Rao, 2000: 167). One recent study has revealed that certain qualities such as sociability, compulsiveness, and societal case are said to be influenced by heredity, while certain traits such as leadership, impulse control, attitudes and interests are believed to be more sensitive to environmental influence. As Mac Iver has pointed out, "Every phenomenon of the life is the product of both, (heredity and environment) each is as necessary to the result as other ....." No society or no organism is the product of either heredity or environment. (Mac Iver & Page, 1996 : 171)

The supporters of heredity theory make us believe that our temperaments, emotions of love, fear and anger are all inherited and as such the influence of heredity is very deep and cannot be ignored.

The effects of genetic factors on the various components of health and the ageing process are not yet well known. It has been estimated that only 20-25 percent of variability in the time of death is explained by genetic factors (Robert Beagle, 1997:83). About 50 percent of variation in human life span is attributable to survival attributes that are fixed for individual by the time they are aged 30, but only a third to a half of this effect is thought to be due to genetic factors. The influence of genetic factors on the development of chronic conditions, such as coronary heart disease and diabetics, varied considerably. However, for a practical point of view, the environmental determinants of these conditions still offer the greatest scope for preventing and control efforts.

## **ENVIRONMENTAL INFLUENCE**

Every phenomenon of life is the product of heredity and environment. Each determines the character of the individual. In fact heredity and environment are two aspects of the same principle. The environment consists of those conditions that nature provides for men (Sharma, 1992: 166).

An individual who lives in a society is surrounded by certain conditions. He/she is required to observe certain customs and adhere to certain conventions. He/she is also required to perform certain ceremonies and rituals. All these factors would influence his/her conduct and behaviour. In other words all these conditions, which surround us and influence our conduct and behaviour constitute our environment. These conditions are cultural, social, economic and natural (Mukhi, 1995).

Environment cannot be separated from life and affects our life mentally, morally and physically. Environment is classified as internal and external. The external (macro) environment consists of those things which man is exposed to after conception. It can be divided into physical, biological, psychosocial and socio-culture components. Any or all of these can influence the health and diseases of man and his susceptibility to illness. The internal environment of man pertains to “each and every component part, every issue, organ and organ system and their harmonious functioning within the system” (Park, 1997: 15). Faulty functioning of one or more component parts results in disharmony or disease. For example dysfunction of liver affects not only digestion but also the mental and physical functioning of the body as a whole (M. C. Gupta, B. K. Mahajan, 2003:14). Environment is the source or reason for the agents of disease. It helps the transmission of the agents to the host, bring about their contact and interaction. During such interaction, the environment may be favourable to man and unfavourable to the agent or vice versa.

The environment may be living or non-living and the former may be biological or social.

Thus the environment has direct impact on the physical, mental and social well-being (health) of those living in it. The “micro-environment” (or domestic environment) includes the individual’s way of living and life style. Eating habits, smoking or drinking, use of drugs etc may be cited as examples (Ibid).

The physical environments are the conditions, which have been provided from nature for man and include physical features and natural resources. The physical factors include soil, climate, seasons, weather, humidity, temperature, machinery and physical structure.

The biological environments, which have relation with biology e.g.: animals, Plants etc. Like physical environments in this case also, human beings have very little influence on their process of growth and decay. Each individual has certain social environments. Every society permits as well as taboos certain customs. It has social conducts, rituals, mores, customs, and way of eating, drinking and dressing. It has certain notions about gods and super – gods (Mukhi, 1995 : 93 ).

The physical, social and biological environment of man is a very important determinant of health. Poor environmental sanitation, inadequate safe drinking water, excessive level of atmospheric pollution, etc., are important determinants in the physical environment affecting health. The socio-economic status, employment potential, harmonious marital relationships, positive employer-employee relationship etc., are all important factors in man's social environment. The biological environment is composed of disease bearing arthropods, insects, domestic and animals, etc. All the members of the animal kingdom can compromise health status of man (M. C. Gupta, B. K. Mahajan, 2003: 7).

### **Socio – Economic Environment**

Society is literally the set of arrangements that make stable social and economic life possible and its influence on human health. The social and economic environment is an enduring structure external to and enveloping the individual, pre-dating birth and persisting after death (Hart, 1997:96). It comprises economic institutions to produce and distribute the material livelihood of the people, ideological beliefs (religion, morality and political culture) to uphold and share values, linguistic codes to facilitate communication and social institutions regulating relationships – protecting the right - of the every citizen.

The socio- economic status deteriorates as a result of poor health rather than the reverse. It has also been observed that the socio-economic conditions experienced during childhood are independently associated with



morality and health-affecting factors such as social isolation, health promoting life styles, and working conditions in adult life (Green, 1999: 131).

Socio-economic status are intertwined with crucial features of life that affect health: physical environment, social and cultural environment, development and socialization process and the health related behaviours (Ibid.)

The health status of a whole population is determined primarily by their level of socio-economic development indicated by GNP, political systems, health service, education and employment.

#### **a) Economic Status**

The per capita GNP is the most widely accepted measure of general economic performance. In many developing countries it is the economic progress that has been the major factor in reducing morbidity, increasing life expectancy and improving the quality of life. Economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behaviour in the community (Park, 2005: 16). It is also an important factor in seeking health care. Ironically, affluence may also be a contributory cause of illness are exemplified by the high rates of coronary heart disease, diabetes and obesity in the upper socio-economic groups (Ibid).

As we are aware, economic environments change the very shape and structure of the society. It is usually believed that our economic environments not only change our way of living and behaviour but also influence our family culture, art and architecture (Mukhi, 1995: 93). There is no doubt that low per capita income is strongly associated with poor health.

As a sociological and political concept, life style refers to a set of condition that surrounds the social group, including their cultural history and socio-economic circumstances, but it is still the behaviour of their group that is the object of interest. The public health application of this notion of life style has been to seek policies and environmental regulations that would redirect life style or 'make healthy choices the easier choices' (Green , 1997 : 133 ).

## **b) Education**

The patterns of health related behaviours tend to vary by socio economic characteristics such as income and education. Recent research emphasizes the role of social circumstances in influencing individual's behaviour. This implies that income and education are highly influential determinants.

Thus the second major factor influencing health status is education (especially female education). The world map of illiteracy closely coincides with the map of poverty, malnutrition, ill-health, high infant and child mortality rates

(Ibid: 16). Education generally emerges from epidemiological studies as a powerful and pervasive correlate of health related behaviour (Ibid 134.).

As education advances, so do the individual, the family and the community on each of these dimensions of development. With education comes personal, family, or community development which results in improved health, reduce exposure to environmental threats to health, increased purchasing power to buy primary health care and advanced medical care.

Education is both a measure of intellectual training and an indicator of socio-economic status. As a family variable education of the main earner often stands as an indicator of family's socio economic status, although research generally shows that the education of the female head of the household is more influential, in determining family health and the health behaviour of other family members (Ibid:135). Education can also increase self confidence, self image or self efficiency any of which might have an independent effect on health with or without behavioural change (Ibid :136). Studies indicate that education to some extents compensates the effects of poverty on health, irrespective of the availability of health facility. The small state of Kerala in India is a striking example (Park: 2005, 18)

It is widely accepted that education is decisive in improving health and reducing mortality, especially in developing countries Parental education,

particularly of mothers is strongly related to improve health care for children. Education improves a woman's skill for survival and her capacity of self-care and maintenance of good health during pregnancy; it enables her to acquire greater knowledge and learn better child care practices (WHO, 1986: 78).

In south India, education has fundamentally affected women's attitude to childcare and their ability to provide it. Kerala has an estimated infant mortality rate of 17 compared to 80 for India as a whole in 1990. A major factor is its highest female literacy rate of 86 to 93 percent compared to 39 to 42 percent for the country as a whole (India, Government of India, 1986).

According to Duncan (1961) wide differentials in child survival are closely related to difference in the educational levels of the mothers. The World Fertility Survey noted that the decline in mortality accelerated as mothers proceeded from primary to secondary education. The evidence available also points to a close relation between educational levels and acceptance of family planning. Education has a positive impact on mortality via changes in reproductive behaviour which all produce a chain effect - higher child survival rate, ready acceptance of family planning, spacing of births, improved health of mothers and children, and better care for children (WHO,1986:76).

### **c) Occupation**

The very state of being unemployed usually shows a higher incidence of ill-health and death, for many, loss of work may mean loss of income

and status. It can cause psychological and social damage (Park, 1997:16). The relationship between occupation, life expectancy, and disease specific mortality has been the subject of a special enquiry following every census in England and Wales since 1911 (Hart, 1999: 95)

## **Health Service**

Health and family welfare services cover a wide spectrum of personal and community services for treatment of disease, prevention of illness and promotion of health. The purpose of health service is to improve the health status of the people. For example, immunization of children can influence the incidence/prevalence of particular diseases. Provision of safe water can prevent mortality and morbidity from water-borne diseases. The care of pregnant women and children would contribute to the reduction of maternal and child morbidity and mortality. To be effective, the health service must reach the social periphery, equitably distributed, accessible at a cost the country and community can afford and socially acceptable (Park , 2005 :19). In developing countries such as India where traditional life-style still persist, risks of illness and death are connected with lack of sanitation poor nutrition, personal hygiene, elementary human habits, customs and cultural patterns. Since ancient times, it has been the endeavour of the society to seek ways of eradication of illness and human sufferings (Pokran, 1994:83). Health services can also essential for social and economic development. It is well to remind ourselves that “health care does not produce good health” (WHO, 1986:295).

The health service technological interventions ignored the crucial role of socio-economic factors as well as the inter-relatedness of technologies. The total dependence on technology in areas such as malaria control and family planning has already led to failure of these programs.

The curative priorities and dependence on highly centralized technology has made the health service organization top heavy where most of the human and material resources concentrated. The peripheral units of the districts and Primary Health Centers (PHCs), which are the nerve center of health activity, remain starved (Dak, 1991:188).

In the Indian setting, however, this gets further complicated due to organizational hierarchies of the larger social systems. The patients, especially if he/she is a common member become the least important element. If special attention is bestowed on any of the patients, it is more often due to their social than disease status.

These basic characteristics of the health services, are logical consequences of the planning process and its priorities are of those who have already acquired levels of living where elementary public services are assimilated into the life style itself and people need only the sophisticated curative services.

## **Political System**

Health is also related to country's political system of the country. Often the main obstacles to the implementation of health technologies are not technical but rather political. Decisions concerning resource allocations, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of society can shape community health services (Banerji, 1985: 165). The percentage of GNP spent on health is a quantitative indicator of political commitment. Available information shows that India spends about three percent of its GNP on health and family welfare (Park: 2005:19).

To achieve the goal of health for all, WHO has prescribed the target of at least 5% expenditure of each country's GNP on health care. What is needed is political commitment, and leadership, which is oriented towards social development and not merely economic development. If poor health patterns are to be changed, then changes must be made in the entire socio-political system in any given community. Social, economic and political action is required to eliminate health hazards in peoples' working and living environments.

In modern societies where public authorities are democratically accountable and where the protection of health is among the rights of citizenship, trends in public health offer a potent means of evaluating the integrity and competence of elected Governments. Public authorities may prefer to confine

debate to issues of Government resources for medical treatment as a means of deflecting attention. From the true sources of physical and mental well being in social and economic life (Hart, 1999:120).

Today, the scope for achieving even minor improvement outside the sphere of social and economic policy is negligible and public health specialists must be simultaneously social and medical scientists to comprehend the ramification of government policy on health of the people (Ibid; 121).

There are some other contributions to the health of populations derived from systems outside the formal health care system, that is, health related system. Food and agriculture, animal husbandry, industry, housing, public works and communication, rural development, as well as adoption of policies in the economic and social fields was explicitly recognized as vital for improving the health and well-being of the population (WHO, 1986:13).

Health for all was accepted as a goal to be achieved by the end of the century, and by being included in the international covenant on economic, social and cultural rights become a universal human right. Health is on the one hand a highly personal responsibility and on the other hand a major public concern. It thus involves the joint efforts of the whole fabric, viz; the individual, the community and state to promote (Park: 1997: 16).



## **Culture: A Conceptual Analysis**

The concept of culture in recent years has been concerned with a distinction between cultural and social behaviour. Man is more than a social animal; he is also a culture-bearing creature. He and he alone has culture and some capacity to create and change it and from these facts spring many of his difference from other form of life, as well as the nature of many of his conflicts and stresses granting man's biological capacities and limitations and his life in groups. His culture more that anything else explains his uniqueness in distinguishing him from other creatures. The concept of culture superimposed upon that of society provides a third identifiable and definable category of environmental variables, or in another sense a third level of adjustment that is difficult to separate from the societal level but it is not to be found except, perhaps, in most vestigial forms, in the adaptations of any other species (Simmons, 1954: 62).

Culture is one of the most important concepts in social science. Culture and society go together, they are inseparable. Culture is a unique possession of man. It is one of the distinguishing trails of human society. In the words of McIver and Page, culture is "the realm of styles, of values, of emotional attachments". It is the entire 'social heritage' which the individual receives from the group. Culture is the product of human societies, and the man is largely a product of his cultural environment (Park; 2005, 491).

Historians use the word culture in yet another way to refer to the so-called “higher” achievements of group life or a period of history. By ‘higher’ achievements they mean achievements in music, literature, philosophy, religion and science. Thus, a cultural history of India would account for historical achievements in these fields. Sociologists use culture to mean “all” the achievements of group life. In general, it is widely held, that culture stands for the customs, beliefs, laws, religion and morals, art and other capabilities and skills acquired by man as a member of society.

Anthropologist, Edward. B. Tylor has defined culture “as that complex whole which includes knowledge, belief, art, morals, law, customs, and any other capabilities and habits acquired by man as a member of society” (Tylor, 1924:1)

Culture is not inherited biologically, but learnt socially by man. It is not an inborn tendency. Culture does not exist in isolation. It is not an individual phenomenon. It is a product of society. It is the culture, which helps man to develop human qualities in a human environment. Deviation of company or association of other individuals to an individual is nothing but deprivation of human qualities. A perceptive analysis of the subject has to emphasise both the dimension, culture for the people and culture by the people (Mehta; 1992, 113).

For a long time many anthropologists were quite content to define culture as behaviour peculiar to the human species acquired by learning, and transmitted from one generation to another by mechanisms of social inheritance. In operational sense, culture is a construct representing the total life of people. It is also viewed as a reflect of nature and in essence is a man made part of the environment (Ibid).

If society is considered as a system of social relationships, then the culture of society is the content of these relationships, the particular manner in which people behave. Behaviour is here considered to include all the activities of an individual, whether physical or mental, over or hidden (Sussur and Watson, 1962: 23). Culture, therefore, includes all learned patterns of behaviour such as language, attitudes and skills, as well as the value systems and ethical judgments that underlie them, and the particular material items that people use. In short, a culture denotes a whole way of life (Ibid.). All children must be taught to walk and to speak, but the manner in which this is done and the language the children learn is imposed by the society into which they are born.

Culture is sometimes called “super organic”. By “super organic” Hebert Spencer meant that culture is neither organic nor inorganic in nature but above these two. It implies that the social meaning of the physical objects and physiological acts. The social meaning may be independent of physiological and physical properties and characteristics. For example the social meaning of a

national flag is not just a piece of coloured cloth. The flag represents the nation. Similarly, priest and prisoners, professionals, players, engineers, doctors, farmers and other are not just biological beings.

### **Culture and Sub Culture**

When we use culture in a broad sense, it represents human life and portrays human achievements. In this sense the term culture is understood as the great social heritage of entire mankind. It is sometimes used in a limited sense to mean a “national culture”, that is, to refer to the culture of a nation. A nation consists of a number of groups and sub groups. Each group may have a way of life of its own. In other words, each such group has a culture of its own. They “constitute relatively cohesive cultural systems. They are within the larger world of our national culture” (Ibid: 194).

Culture is not uniform pattern that is possessed alike by all who are exposed to it. It is important to keep in mind that a person’s exposure is not to “culture in general” but to the cultures of the particular groups in which he/she lives. It is so because in large societies, each person’s groups are multiple. For example, we are members of Indian society and therefore, share an Indian Culture. But we are also members of smaller population segment within larger society. Regional groups, religious groups, nationality groups, racial groups, urban groups, rural groups, etc.... represent such population segments (Ibid: 195).

According to Sutherland, Woodward, Maxwell et. al. the main sub-cultures are regional sub culture, ethnic or nationality sub culture, urban and rural sub-culture, class sub-culture, occupational sub-culture and religious sub-culture.

Different religious groups within the society hold mutually incompatible beliefs or values. For example, Hindus consider cow as sacred animal and worship it whereas Muslims and Christians practice beef eating. In spite of this incompatibility such religious groups hold some values – such as religious tolerance, human welfare etc., which permit them to get along with each other. Such values even help them to co-operate among themselves within limit. The co-existence of two religions (for example Hinduism and Islam) at best creates a problem of integration. Moreover, the different parts of culture (such as religion and science, science and politics, economy and education, religion and political institutions etc) are interrelated on the purely cultural level. The integration of culture is not necessarily affected by the historical organ of its various items (Rao; 2000: 201).

Religion integrates the social group since those who share religious beliefs feel themselves united to each other by the simple fact that they have a common faith. The highly charged atmosphere of religious rituals serves to dramatize this unity and so promotes social solidarity. In this way religion functions to meet the essential requirements of social life (Heald ; 1999: 526).

## **Health and Disease – Cultural Space**

The concept of health or illness becomes institutionalised within the social and cultural milieu of each society and its level of development. In other words, one measure of social development could be a cultural conception of illness. Primitive human beings relied more upon their instincts to stay healthy and since they could not largely comprehend the functioning of the human body, magic become an integral part of the beliefs about the causes and cures of health disorders ( Du Bos 1969 : 118).

The perception and meaning of health and health problems, the formation of various health institutions and practices and health behaviour of individuals are manifestations of people's cultural responses to problem of health and disease (Banerji, 1997:72). Consideration of the social-ecological setting is also important in analyzing the generation of health problems within a human group. Social ecological conditions also mediate between the disease, causative agents and individuals and are often direct causative agents.

In a country like India, the challenge of community health is much more urgent and indicate because of the nature, size and extent of the health problems, acute shortage of resources and because of a social, cultural and economic setting which is radically different from that of the affluent countries (Sahu, 1991: 71).

There are many linkages between the health and culture of community. Culture defines the sickness and sick role, its cause and belief system and practices associated with it (Ibid.).

A health problem has to be seen in terms of the dynamics of the biological interactions between the causative agent and a human group against a background of human ecology which include cultural, social, economic and political conditions, which influence the natural history of the health problems in that group or community (Ibid).

Culture appears to play an independent role in health status (Corpa, 1994,103). Culture is intimately related to accepted social practices, many of which are turned to health and disease. Epidemiological evidence for the impact of culture on health comes from ecological studies of diet and coronary heart disease and cardiovascular disease. Studies of Japanese men living in Japan and emigrating to California revealed that coronary heart disease and brain stroke rates comparable to those of the country of residence only in subsequent generations. This is a clean argument against the hypothesis that genetic factors have the dominant influence on heart disease and for the hypothesis that cultural factors play prominent role. Dietary practices appear to be powerfully influenced by culture (Rozin, 1984: 428).

Factors that influence health behaviours can be grouped into three major categories - pre disposing, reinforcing and enabling (Green, 1991: 128). Pre-disposing factors reside in the individual and include attitudes, values and beliefs. Reinforcing factors are positive consequences of behaviour, such as peer acceptance, or negative consequences, such as social disapproval. Enabling factors are generally conditions of the environment that allow the behaviour or alternatively create barriers to it (Gilbert, 1997: 128). For example in the case of smoking predisposing factors include attitude about smoking and knowledge of health effects of smoking. Reinforcing social factors include social support; peer influences and cigarette advertising, enabling factors include availability and cost of cigarettes.

Numerous factors influence alcohol use and abuse. Predisposing factors may include expectations about the effect of alcohol, psychological stress and low self esteem, perceptions of invulnerability to adverse consequences of drinking such as losing one's job, being a child of alcoholic and early drinking experiences. Reinforcing factors include advertising and modelling in the visual media. Enabling factors and barriers include availability of non-alcoholic drinks, cost of alcohol beverages access to alcohol and supervision of adolescents (Ibid: 129). Studies showed that social background was one of the significant causes of smoking habit (Sussur and Watson, 1986:157).



Smoking is thus displaying a pattern common to transmissions of many forms of behaviour among children as they grow into social beings by acquiring the mores, the habit and the knowledge of their culture. Infant feeding is another behavioural problem related to health and diseases. In underdeveloped societies all health workers are confronted by the crucial role of feeding practices in infant growth and development.

In some tribal and peasant cultures from the Arctic to Africa, custom and taboo restrict the food intake of pregnant women, often of vital foods. Pregnant zulu bride, for instance, may not take milk in the patrilocal *karral* where she must live with her husband and his family and eggs too are frowned on since they are thought to make women licentious (Cassel, 1995: 15).

Feeding practices vary between societies and between racial and socio-economic groups in the same society. The distinctiveness of breast-feeding practices is illustrated in comments made by some black women about the practices of white mothers in South Africa and reflects the values implicit in the role of mother in two cultures within the same society (Sussen and Watson, 1985:158). The investigators in Scotland concluded that the mother who chooses the breast feeding in contemporary urban society often accepts a heavy load of discomfort and disability and this arises less from psychological factors than from her way of life. Most working class women preferred bottle feeding, and many gave up breast feeding despite the strongest medical advice (Ibid: 159)

According to Freud in *Culture and Personality*, culture was viewed as “personality writ large” or alternatively personality was viewed as microcosms of the culture as a whole (Freud). If we use the term socialization to signify the universal process by which the norms, values, beliefs and behaviour patterns of a society are transmitted from generation to generation then the term enculturation may be used to describe the particular way in which this process occurs in a specific society (Ibid : 161)

The Irish suffered more from alcoholism, from pre-occupations with sin and guilt and from fixed delusions. The Italians showed markedly more avert homosexuality, behaviour disorder and hostility towards authority. These contrasts were attributed to the influences of their social and cultural background. A number of other comparative studies points to variations in the content and expression of mental illness with social and cultural differences (Ibid: 170).

Values always underlie the behaviour of individuals and dissimilar values may induce courses of action that are directly opposed, even when motives are similar. Dissimilar values confuse understanding between individuals in many social situations. The doctor needs to be aware of the social determinations of his own practices and attitudes. Culture cannot be neglected in his ethical assessment of the individual patient for those have helped to shape the patients.

In our effort to bring greater specificity and insight to bear upon the analysis of social data relating to the problems of illness, concepts of subgroups and sub cultural units are useful. It is probably pointless to attempt in detail to comprehend the impact of the entire culture or the manifold relationships of the total society upon the individuals' experience of illness. Even in the simplest societies the contents of the culture is too rich and as we have seen the multiplicity of intern member relationships is too great for any one person to share more than limited segments of the whole. Each individual is exposed chiefly to selective aspects of the culture and related himself closely to only limited number of fellow members. Thus the concept of subculture delimits the area and helps to direct attention to the more relevant factors (Simons and Wolf, 1994: 98).

Among human beings with their capacity for greater modifiability in behaviour and with their possession of a culture the possibility and the expectance of such subgroup divisions into various organized units are vastly multiplied (families, clubs, associations etc). Recognition of identifiable subgroups with corresponding subculture elements take on special importance in our approach to medical care. It gives us a close range view of an essentially relevant subdivision of the social and cultural forces operating in the life of the individual and provides the useful perceptive of subgroup subculture segments of society that deal in a specialized way with the commonly shared problems of diseases and health.

The advances made in medical science in the past few decades have undoubtedly made a great dent in prolonging lives, improving health care and lowering disease and death rates. However, the improvement in the field of health and disease control is not entirely due to the advancement in medicine. The reduced incidence of several diseases can also be attributed to the gradual improvements in the standard of living (Simons and Wolf,1994: 73).

The old epidemiological approaches seeking bacterial or viral explanation for new diseases are no longer of much help in controlling the new set of diseases. The attention therefore, has shifted to the etiology of disease which lay emphasis on behaviour patterns, life style and cultural factors to unearth the cause of diseases and their likely control or prevention (Dak, 1991:15).

For centuries now it has been established that life style, customs and traditions, beliefs and practices, vocation and profession have serious consequences on the health of an individual. With the increasing attention towards prevention rather than therapy it is now recognized that many chronic diseases can be efficiently prevented and controlled by a timely change in behaviour, lifestyle and dietary pattern (Ibid).

Many diseases occur more frequently among a particular socio-economic, racial, religious and ethnic group than among others. Many diseases are known to be caused by smoking - coronary diseases, peptic ulcer, and cancer

of the bladder, mouth and lungs may be given as examples of such diseases. Diseases are also classified according to sociological variables such as social mobility, alienation, anomic and over work. The study group of ICSSR–ICMR (1981) takes cognisance of relationship between health of the people and the surroundings and consider health care services necessary, but health is a function of not only of medical care but of the over all integrated development of society, (cultures, economic, educational and political). Health also depends on a number of supportive services, viz nutrition's, improvements in environment and health education (Govt. of India, 1981).

Socio-economic status and social class has been correlated with several diseases particularly those resulting from industrialization, modernization and urbanization. The review of the studies attempted by Graham and Reader (1977) clearly pointed out that the socio economic status is closely associated with hypertension, blood pressure, coronary heart diseases and tuberculoses. The vulnerability and prevalence of serious illnesses were found to be greater among the poor. The explanation offered by scholars for this phenomenon includes poor housing, crowded living, low income, lack of education socio-economic status etc. (Graham and Reader 1977: 87)

Another group of studies reviewed by Graham and Reader concerns itself with role of ethnicity and religion and notes that certain diseases are prevalent more among particular ethnic and religious groups than others. The

degree of religiosity was found to have an inverse association with the incidence of myocardial infraction. The low incidence of different types of concerns among religious groups in the United States was repeatedly due to religious prescription against alcohol, tobacco and caffeine.

The behavioural characteristic peculiar to individual families particularly those concerning child-rearing practices tend to protect against certain diseases. In certain families diseases may be due to either social or genetic inheritance.

Many diseases can be prevented if socio-cultural causes are neutralized or removed and approach doesn't remain confined toward therapy only. The nature and type of work condition are also largely responsible for a variety of health problems. Besides inadequate lighting poor sanitation, insufficient ventilation and mental stress during the work also affect the physical well being of a worker. Some health problems caused by different types of occupations pursued by women have been brought to the notice by the national commission on self-employed women and women in the informal sector.

The association of socio-cultural processes with certain diseases was also clearly brought out in the review attempted by Graham and Reader. It uncovers how the modernization process in the underdeveloped countries has led to an increase in the mental disorders and heart diseases as individuals were

required to adapt to modernized cultural mode involving geographical, occupational and social matters. The individuals and the groups with rapid geographical and social mobility show higher rates of mortality and suffer more from coronary heart diseases than those who are less mobile. These analyses suggest that many diseases can be prevented if the socio- cultural causes are neutralized or removed and the approach neither does nor remain confined towards therapy only (Dak, 1991: 18)

### **Approaches to Illness in Traditional Cultures**

Disease is a universal phenomenon and therefore affects all people everywhere despite understanding and control of disease, but not always in the same way (Coe, 1970: 66)

Research evidences suggest that patterns of illness and death in a society are influenced by the values affecting the organization of the family, work and recreation. Cultural patterns affecting child rearing, family life, aspirations and competition and decreasing social solidarity affect mental health of people. It is also observed that group norms concerning smoking, drinking, sexual practice and standard of living either predispose or protect persons from risk of diseases. Different cultural groups vary in their perception regarding causes of diseases. In our country religion is very important in guiding the individual and according to Hindu theory of Karma, disease is regarded as a punishment for one's deed in earlier period. (Mehta, 1992: 12)

Hassan points that in our villages, people attach no importance to health. Their beliefs, values, customs and practices are directly related to the phenomena of health and diseases. Further lack of knowledge in rural areas affects and influences health behaviours of the people. The habit of walking bare-footed by villagers and the habit of indiscriminate defecation increases the chance of infestation of worms. Further the eating from common utensils and smoking from same huka (hubble-bubble) are some of the unhygienic practices reported by Hassan as factors directly affecting the health of people (Hassan. Quated in Mehta, 1992: 115)

Caste in our social setting is an important factor influencing health behaviour. In the Villages, both synthetic and natural drugs are used by the Hindu castes, while Muslims are prohibited by religion to use intoxicants. More over an upper caste layman may have more knowledge about medical treatments than lower caste Hindus (Ibid. 115)

In ancient times, the disease was also considered to be a sign of wrath of gods and goddess or supernatural beings. The cause of disease or illness and its cure depended not on an individual's biophysical condition but on the supernatural beings. Today however it is accepted that diseases are influenced by social psychological and cultural factors (Basu, 1977: 16)



In the primitive era, treatment was not based on rationality but depended entirely on magic spells, prayer, manual rites and dances (Banks: 1953: 95). A religious practitioner or a magician was the person who administered medicine. The religious beliefs and practices governed the diagnosis and cure of the ailment.

Traditional medicine is an established part of culture, though in some countries the systems of cure and prevention may not be as well developed as in China and other Asian countries. It is still practiced to some degree in all cultures. Traditional societies regard health as a state of balance or equilibrium, both internal and external (Man, 1982: 8)

The traditional practitioner in many parts of the world would define life as the union of body, sense, mind and soul and describe positive health as the blending of physical, mental social, moral and spiritual welfare. The moral and spiritual aspects of life are here stressed. (Ibid, 1982:9).

Traditional healers play an important role in their communities, especially in regard to common ailments and mental disorders, and for several of these, the healers constitute the core of primary health care workers (Ibid, 1982: 9)

For Western physician, physical weakness signifies malnutrition and anaemia and calls prescriptions of tonics and other vitamins concentrates. But for

the local people of traditional society physical disability is connected with moral weakness and transgressions of the ethical code for which the ideal remedy would be pilgrimages, ritual baths, to wash away one's sins and atonements rather than tonics (Marriot: 1995: 239)

The support of traditional healers and magico-religious leaders is widely prevalent among local population. Pokarna has noted the dominant role played by the traditional healers in the magico-religious herbal and massage therapies.

A religious preacher or magician was the person who administered medicine, even in the medieval period and till as late as the 19<sup>th</sup> century. Religion dominated every sphere of human activity. The religious beliefs and practices governed the diagnosis and cure of ailment (Clive Wood, 1992: 425)

In societies that are yet to touch modern medicine the kin group decides whom it will consult and having consulted with him, takes his advice about immediate action. (Read; 1996: 12).

Appeasement of deities who were believed to be associated with a particular disease with prayers, invocations, offering of milk, flowers and rice, fasts, sacrifices and giving alms were the common practice. Visit to scared places such as temples, rivers, mountains were also undertaken. Thus in India, the

approach towards disease and its curative aspects have been inextricably linked to religious and cultural norms and practices. (Hussan, 1987: 65).

Marriott observed that members of the same village or family often highly varied in medical beliefs and followed widely divergent practices (Marriott, 1985: 87). As a consequence of the uneven spread of cultural items it is found today that, whereas, certain cultural items are found all over India, there are others which have remained confined to particular sections of society (Ahlowali, 1997: 1007)

The concepts of disease causation are part of a society's total worldview, which is also reflected in other spheres such as agriculture, politics and interpersonal relationships. For example, in a study of Shamanism, E.B. Harper describes a Shamanistic session in the Malanad region of Mysore. A Shaman in South Indian setting is a man who has familiar spirit that he can ask to possess him whenever he desires – when he goes into trance, the spirit speaks through him. The purpose of the shamanistic possession is to allow people in the human world to have advice and help from a super-human being whose knowledge and ability to accomplish certain ends is superior to that of any human (Bhatkal, 1992 : 407)

Traditional medicine established 'faith' and 'assurance' in the patient. Modern medicine lacks this aura. Conviction of traditional medicine is required to justify itself dramatically and without 'delay' (Ibid.)

Traditional societies regard health as a state of balance or equilibrium both in internal and external forces. This equilibrium is said to be based on variation of humeral substances and forces involving balances of the opposing qualities of hot and cold, wet and dry, portraying in effect in Chinese principles of Yin and Yang (Bannermen, 1982 : 8)

Acupuncture, another practice of healing believing that a needle struck into one's foot should improve the functioning of ones liver is obviously incredible. It has been applied as a therapeutic medical technique in China for at least 2000 years. Originally stone knife and other sharp instruments were used. The term itself is derived from Latin word Acu - with a needle and puncture – pricking. Traditional medicine still remains the only source of care for many people in the developing countries.

## **CULTURAL FACTORS AFFECTING HEALTH AND DISEASE OF RURAL PEOPLE**

The rural and urban communities distinguish among themselves on the basis of physical, social, cultural environments, way of life, norms and values and a large number of other factors such as density of population, birth and death rates, economic activities, poverty, caste and class, family and religion. These are the vital social organizations, which characterize a rural community and differentiate it from an urban community (Desai, 1987: 101).

Rural people have cultural differences that make it hard for them to accept health services, as well as making it difficult for providers, who are not aware of the cultural differences to serve ruralists appropriately. Population density is definitely lower in rural areas. Fewer people living in an area often means that they are more likely to know each other, and they have fewer choices of other people with whom to associate. The lack of anonymity or privacy results in certain conventional behavioural expectation, as well as pressure to conform to them. Unusual behaviour rapidly become the subject of community wide gossip, so rural people tend to worry a great deal about how their actions will be perceived. It is generally more difficult for rural people to share problems and feelings with strangers. Rural people have fewer kinds of social activity options. Rural areas have more teen parents, venereal disease, alcohol and illicit drug use, and smokers at most age levels than urban areas.

All people whether rural or urban, have their own beliefs and practices concerning health and disease. Some of the cultural factors, followed by centuries of practice, have stood in the way of implementing health programmes. Information about these factors, i.e. customs, mores, habits, beliefs, superstitions, is still woefully lacking. The cultural factors relating to health and diseases are:

**1. The concept of etiology and cure.**

Broadly, the cause of disease as understood by majority of rural people, fall into two groups:

**a) Supernatural**

Supernatural causes are divided into five.

**(i) Wrath of Gods and Goddesses:**

There are good many people (even among the educated) who believe that certain diseases are due to wrath of some God or Goddesses. Small pox and chicken pox are typical examples. They are respectively known as Bavi Matha (Sitala Devi) and Chhoty Matha, as it has not been dispelled in the rural folk despite the discovery of smallpox virus and its eradication from the world. (Pokarna;1994:112). Due to the wrath of God or Goddesses administration of drug is considered harmful. Pujas are made to propitiate gods.

The particular worldview of a community and its faith in deities who control the universe, greatly influence their thinking about life and death, health and disease etc. When faced with illness and suffering our forefathers relied more on the experience of their cultures and very often-sought solace from power outside them. As we turn today to science they turned to their religious faith (Ibid: 113).

Most cultures have extremely complex theory of disease and misfortunes, based on certain premises and their cultural aspects, so different from those of scientific medicine that there is no way in which the explanation offered by modern medicine can be fitted into

the existing culture. Even if germ theory of disease is accepted, still an explanation as to why only some get disease and others do not is essential. Explanations for them come from belief in witchcraft, evilness antisocial action or a broken taboo (Ibid).

- (ii) Another belief is that tuberculosis occurs mainly because of supernatural and physical factors. Disease such as leprosy and tuberculosis are believed by some, to be due to their past sins.

Social pattern and health beliefs and behaviour are another principle area of sociological concern in public health. The past and present beliefs affect both consumers and providers in the recognition of illness, the seeking care and treatment and the evaluation of out come. It is important to understand the attitudes and beliefs the people hold about health and disease (Foster, 1983: 19).

- (iii) Breach of taboo is believed by some people to be responsible for certain diseases. Venereal diseases are believed to be due to illicit sexual intercourse with a woman during menstruation.
- (iv) Another widely held belief throughout the country is the effect of evil eyes. Children are considered to be most susceptible to the effects of evil eyes. In order to ward off the effects of evil eye charms and amulets are prescribed and incantations recited by the exorcist.

- (v) Some diseases such as hysteria and epilepsy are regarded as due to a spirit or ghost intrusion into the body.

### **b). Physical Causes**

Physical factors related to the causation of disease like, the effect of hot and cold weather, quality of blood, diet, water, air, fire, earth, addiction, exercise, germs and rational factors like pathogenic micro organisms etc.

According to Foster these beliefs are considered by villagers as non-secular beliefs and existed irrespective of caste, community, religion, occupation and education (Foster;1983:19). Impure water is associated with disease ex: Cholera, diarrhea, typhoid, cold cough, fever and intestinal diseases etc. Eating neem leaves and flowers is considered to purify blood.

## **2. Environmental Sanitation**

Environmental sanitation is responsible for health and disease of rural people. 98 % of the people in rural areas use open fields for defecation. Average Indian Villager is averse to the idea of latrines. They considered that latrines are meant for city dwellers, where there are no fields for defecation. They are ignorant about the fact it pollutes water and soil and promotes fly breeding (Park : 1997 : 455).

In the perspective of ecological sub system, sanitation is largely a matter of regulation of man – environment relationship in the interest of health (Schaffer. 1974: 59). The word “sanitation” has however, become



synonymous with a few technological interventions, such as latrines, waste disposal, sewage, water supply, vector control and more recently, air and water pollution control. This has led to the neglect in public health of the whole spectrum of cultural and behavioural interventions in man-environment relationship, which the term “sanitary” originally signifies.

Nearly half of the population of developing countries suffers from health problems related to unsafe water and inadequate sanitation. A survey in 1980 revealed that only 38 % of the rural population had safe drinking water compared with 74 % of the urban population, a mere 13 % made use of any sanitary facilities in the rural areas compared to 50 % in urban areas (Ibid.)

For some diseases, sanitary excreta disposal is more important than water supply. Efforts to promote improved methods of excreta disposal encounter problems related not so much to resource constraints or lack of technology, but to health behaviour and the perceptions of the communities regarding health priorities (WHO, 1986: 102)

The well occupies a pivotal place in the cultural environment of villages. It is also a common meeting place in the cultural environment of village, when they go to draw water. It is a place where people bathe and wash their clothes and where animals are washed. Their cultural practices

lead to the pollution of well water. Some rivers are considered “holy”. People go on pilgrimage to those rivers to have a dip, they not only have to dip but drink the raw water, which they considered sacred. Epidemics of cholera and gastritis’s have been due to these cultural practices (Park. 1997: 455).

Physical environment begins with the house, where the health risks are manifold. Many houses of rural people lack the minimum resources for a healthy lodging. Housing of poor quality often fails to protect against carrying insects and rodents. The air may be unhealthy as a result of poor ventilations. Absence of a separate kitchen, latrine, bathroom and drainage are characteristic features of an average rural house. Over crowding can intensify these health hazards. House in the rural areas of developing countries often have poor quality structures. They are built with semi permanent materials and are small with one or two multipurpose rooms. The roofs are most often covered with straw, coconut leaves or similar materials. Such housing conditions go together with ill health (WHO 1986: 105). Respiratory infections and diarrheal diseases are often associated with houses of poor quality.

### **3. Food Habit**

Food habits have deep psychological roots and are associated with love, affection, self-image and social prestige. The diet of the people is influenced by local conditions such as soil, climate, religious customs

and beliefs. Vegetarianism is given a place of honour in Hindu society. Various dietary regimes are followed during illness by the village people. Ghee, oil and heavy food are also restricted for the patient of diarrhoea/dysentery. Muslims do not eat pork and Hindus beef – these food habits have a religious sanction from early days. The concept of hot and cold food is widely prevalent in the rural people. Alcoholic drinks are taboo for Muslims and high caste Hindus. Eating from common utensils is considered a sign of brother hood among Muslims. Thus food is a subject of wide spread custom, habits and beliefs which vary from country to country and from one region to another (Park 1997: 455).

#### **4. Mother and Child Care**

Mother and child health is surrounded by a wide range of customs and beliefs all over the world. The various customs in the field of mother and child health have been classified as good, bad, unimportant and uncertain (Ibid.)

In rural areas most deliveries are conducted by the traditional *untrained dai* or birth attendant whose methods of conducting delivery are not safe. The villagers have great faith in her. In some parts of the country, the child is not breast fed during the first three days of birth because they believe that colostrums might be harmful and the child is put on water and sugar solution. The net result of these customs is high infant mortality and morbidity.

#### **5. Personal Hygiene**

Indians have immense sense of personal cleanliness, much is closely interwoven with ideas of ritual purification. Rituals are “a set or series of acts usually involving religion or magic with the sequence established by tradition”. Indians are very particular about oral hygiene. Many people in the countryside use twigs of neem tree as a tooth brush. Some people use ashes and some charcoal. Eating pan, leaves smeared with lime with or without tobacco is a common social custom. Smoking hubble-bubble is a social custom in some parts of the country. It can spread tuberculosis. Muslims and high caste Hindus observe Purdha. The incidence of tuberculosis is reported to be high among those who observe purdhas, which also deprives them of the beneficial effect of the sun rays (Park: 1997: 450). The transmission of hookworm disease is associated with bare feet (Ibid.)

## **6. Sex and Marriage**

Profound cultural changes are taking place in both the developed and developing worlds regarding sexuality. Sexual promiscuity poses serious health risks and exposes young people to sexually transmitted diseases, some of which have become resistant to antibiotics (WHO, 1986: 93).

The review of exiting literature almost in unambiguous terms reveals that cultural characteristics of groups are determinants of health and disease of their members.

For achieving the goals of health for all it is necessary to take consideration of the cultural factors of the people. The influence of culture may be more among rural people as their integration in culture is greater. This is not properly established by empirical investigations so far reported.

Further, this study has been conducted in the rural settings of Kerala, a state that is unique in her developmental processes. This is another significance of the study.

Another interesting feature of this study which makes it all the more significant is that one segment of this study is proposed to be carried out in a rural area in Malappuram. Malappuram is a district of Kerala that is far ahead of other states in health and sanitation matters. But the district is much backward than many other districts in matters relating to health, hygiene, female education, population control etc

## **CHAPTER - III**

### **METHODOLOGY**

Health and disease are intimately related to the socio-cultural characteristics of the group. The population of our country being predominantly rural and which are also underdeveloped research studies, which focus on the themes, have much significance. This study attempts to analyse the relationship postulated above with regard to the rural population of Malabar region of Kerala State. In this chapter the methodology resorted to in this study is elaborately discussed.

#### **Specific objectives of the study**

The major objective of the study is:

1. To analyse how rural people look upon the state of health and disease and the variations on their perceptions on account of their socio-cultural backgrounds.
2. To enquire into the belief system relating to the determinants of health and disease and how it varies according to the socio-cultural background of rural people.

3. To analyse rural communities' perceptions on and approaches to different systems of medicine and treatments and the influence of their socio cultural backgrounds on them.
4. To enquire into the personal hygiene and environmental sanitation of rural people and influence of their socio-cultural backgrounds on the matters.
5. To analyse the practices of health care and controlling diseases of and how they vary with the socio-cultural background of rural people

### **Hypothesis Formulated**

The primary hypothesis on which this study is based is that, the socio-cultural backgrounds of rural people have great influence on their concept of health and disease, beliefs relating to them and the method of maintaining health and curing diseases.

### **Subsidiary Hypothesis**

1. The sanitation scenario of the study area is not conducive for good public health and it varies with geographical location.
2. Rural population is generally ignorant about the social and psychic dimensions of health and their ignorance is related to socio-cultural characteristics, namely, age, sex, education, religious affiliation, occupation and income statuses.
3. Rural people have strong faith in the causation of diseases by supernatural forces and the faith is related to their socio-cultural background.
4. Rural people conceptualise health, by and large, on the basis of physical well-being and it varies according to their socio-cultural back ground.

5. Rural people have strong faith in traditional system of medicine and treatment and the faith is related to their socio- cultural characteristics.
6. Rural people are on the whole ignorant about the significance of personal hygiene and environmental sanitation in the maintenance of health and preventing diseases and their ignorance is related to the socio-cultural back grounds.
7. Rural people are by and large ignorant about proper waste disposal and usage of safe water and their ignorance is related to their socio-cultural characteristics.
8. Rural people, generally, are unaware of the necessity for special care of expectant mothers and newborn babies and the lack of awareness depends on their socio-cultural back ground.

### **Definition of concepts**

The following major concepts are explained for the sake of clarity of understanding of the research.

- 1) **Culture:** In this study culture means that complex whole which includes knowledge, belief, art, morals, law, custom and any other capabilities and habits acquired by man as a member of the society.
- 2) **Health:** Health can mean different things to different people. In this society health is considered as a state of complete physical, mental and social well being and not merely the absence of disease or infirmity.



- 3) **Disease:** Disease is defined as a condition of deviation in the normal functioning of body, which produces discomfort or adversely affects the individual's future health states.

## **Variables and Their Measurements**

The independent and dependant variables involved in this study are explained and the method of measuring them is discussed under the following heads:

### **a. Independent Variables.**

The independent variables in this study are rural culture. Culture as we know is the creation of group living. A group is segregated from others on the basis of its culture, which includes artifacts, metifacts, capacities and capabilities absorbed by individual as members of a group. So a group in fact, represent a culture. On the basis of this reasoning, in this study, we have chosen different groups as independent variables.

#### **1. Age groups**

Age is defined as the number of years the respondent has completed at the time of interview since his/her birth. In this study three age groups, namely, lower age group (Below 30 years), middle age group (30 – 60 years) and upper age (60 years and above) are considered.

#### **2. Gender Groups**

Gender differentiation refers to the processes in which biological differences between males and females are assigned social significance and are used as a means of social classification. Based on

gender in this study, the respondents are classified under male and female categories.

### **3. Religious Groups**

Religion is a system of belief and symbolic practices and objects governed by faith rather than by knowledge, which relates humans to an unseen supernatural realm beyond the known and beyond the controllable. The religious groups which are considered in the study, Hindu, Christian and Muslim. In the case of Hindus a subdivision based on caste is made as Hindus (forward) and Hindus (backward). This categorization becomes inevitable due to the wide difference existing in the socio-cultural features of the Scheduled Caste and non Scheduled Caste groups. .

### **4. Educational Groups**

Educational attainment refers to the number of years of formal instruction the respondents have had. The respondents of this study are divided into those who have No Formal Schooling, Primary educated and Secondary and Higher educated groups.

### **5. Occupational Groups**

Occupation refers to the main economic activity under taken by the individual, which provides regular income. In this study occupational status are divided into manual labourers, skilled workers, salaried persons and business people.

### **6. Income groups**

Income in the study refers to the average monthly income of the heads of the households from all sources (occupation, agriculture and other earnings). The respondents are grouped into the following, Low income group (below Rs.1000 per month), Middle income group (Rs.1000 – 2000) and Upper income group (Rs.2000 and above.)

### 7. Socio-economic status

Socio-economic status refers to a composite of social and economic status possessed by the respondent. It was estimated by indexing, *interalia*, indices as shown below.

Sl. No.	Items (Indices)	Level	Score
1.	Owner ship of Dwelling unit	Yes No.	2 1
2.	Type of house	Pacca Kacha	2 1
3.	Electrified	Yes No	2 1
4.	Number of room	1 room 2 rooms 3 rooms 4 rooms	1 2 3 4

		5 and above	5
5.	Type of flooring	Cement Tiles	1 2
6.	Type of roofing	Tile RCC	1 2
7.	Plinth area in Sq. metres	0-25 25-50 50-75 75-100	1 2 3 4
8.	Land owned (in hec)	Below 1 1 – 2 2 -3 3 and above	1 2 3 4
9.	Income (other than from occupation)	No other income Yes	0 1
10.	Type of water supply	Own well Own pipe system Common well Public tap Neighbours well Bore well	2 3 1 1 1 1
11.	Whether well protected with wall	Yes No	1 0
12.	Whether purify well water with purifier	Yes No	2 0
13.	Distance of well from leach pit	50 ft and above away Close	3 2

		Near	1
14.	Fuel	Electricity Gas Kerosene Fire wood	4 3 2 1
15	Toilet	Attached to bed room Attached to house Detached from house Open air	3 2 1 0
16	Type of latrine	Sanitary Other types	2 1
17	Waste disposal method	Manure pit Burning Dumping Throw on roadside	3 2 1 0
18	Education	No formal schooling primary Secondary Higher levels	1 2 3 4
19	Occupation	Manual labour White collar Business Professional	1 2 3 4
20	Income (Monthly in Rs.)	0 - 2500 2500-5000 5000 & Above	1 2 3

The total score was divided into three categories, Low Socio-Economic status (score<20), Medium Socio- Economic Status (score 20-29) and High Socio-Economic Status (score 30 and above).

**b) DEPENDENT VARIABLES:**

The major dependent variables proposed to be considered in this study are:

**1. Understanding about**

- i. Health
- ii. Disease
- iii. Causes of disease
- iv. Environmental influence on health and disease
- v. Food and health & disease.
- vi. Body exercise and health & disease
- vii. Waste disposal and health & disease
- viii. Quality of water used and health & disease
- ix. Religious dimensions of health & disease.
- x. Personal hygiene and health & disease
- xi. Mother and child care and their health & disease

**2. Preference for**

- i. Different systems of treatments
- ii. Different systems of medicine
- iii. Different types of food
- iv. Different approaches to mother and child care practices.

**3. Habit of**

- i. Keeping body hygiene
- ii. Keeping environmental hygiene
- iii. Undergoing medical treatment
- iv. Taking food
- v. Ensuring quality of drinking water
- vi. Providing proper maternal and child care

### **Population and Sample:**

Population of the study is constituted by the rural people of Malabar region of Kerala State.

### **Sample and Sample Selection:**

600 rural people (adult) constitute the sample of the study. 100 each of the persons were selected from six districts which come under the erstwhile Malabar province Kozhikode, Palakaddu, Malapuram, Wayanad, Kannoor and Kassarode are the districts. For selecting out of the 100 persons the following approaches was reported. Out of the Public Health Centers of the concerned districts one was selected at random. The researcher visited the selected PHC on a randomly selected day of a week. The first 100 out patients of the day constituted the sample segment from the district. When 100 patients were not available next visit were connected on next subsequent days till the requirements are satisfied. The details of the residential location of patients were collected. The method was repeated in other districts also.

### **Research settings**

The empirical part of the research was conducted in the selected areas of the six district of Kerala state namely, Kozhikode, Palakkad, Wayanad, Malapuram, Kasargod, and Kannur. Physical and socio-cultural characteristics of the districts are portrayed in the chapter on Research Setting (Chapter.IV).

### **Tools of Data collection**

Major tool of data collection was interview schedule. On the basis of literature survey, experience survey and other personal investigation the schedule was formulated. However, personal observation of the researcher supplemented the data collected through interview schedule. It was pre-tested and finalised. The interview schedule was capable of collecting data for testing the hypotheses formulated. The schedule is appended to the Thesis.

### **Data Collection**

The data collection was started on March 2006 and lasted for 6 months. Each of the respondents was met at their residence and the schedule was administered in a manner of informal talk. Care was taken to patiently listen to their opinion, comments etc relating to the topic. The rapport established was maintained properly till the interview was concluded.

### **Analysis of data**

The collected data was checked for accuracy, edited, coded and fed in to a computer. They were then analyzed in accorded with the objectives and hypothesis of the study. For establishing association between the variables chi-



square test of independence was primarily used. Both 5% and 1% off levels of significance were considered according to the situation. The strength of the association was mainly assessed on the basis of percentages calculated. Results were compared with descriptive information collected during interview. The implication of the results was revealed properly. The details of the analyses and interpretation are given in the chapters 5 – 10.

The practical implications of the results are explained. Suggestions for improving health and controlling diseases of rural people are also incorporated in the report.

## **CHAPTER - IV**

### **THE RESEARCH SETTING**

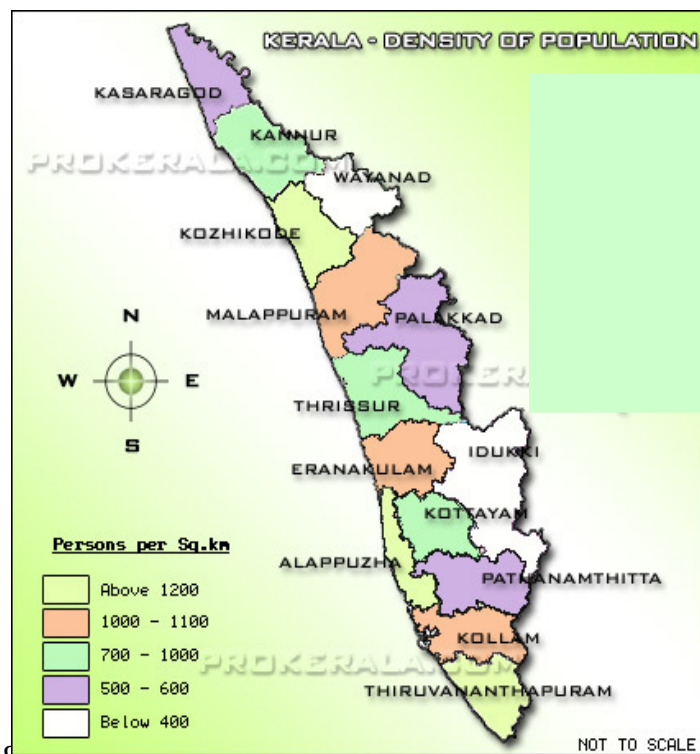
The empirical part of this study was conducted in the catchment area of six Primary Health Centers (PHCs) one each from *Palakkad, Malapuram, Kozhikode, Wayanad, Kannur, and Kasargod* districts of Kerala State. These districts constitute the erstwhile Malabar region.

With the help of district medical authorities one PHC area of each of districts of the region is randomly selected for the study. In this chapter the geographical and socio-economic characteristics of the districts are briefly portrayed.

Before coming to the specific study area it may be pertinent to highlight the overall socio-economic features of the state of Kerala and the six districts of Malabar region. To a large extent the ancient history of Kerala is shrouded in the mist of tradition. The total area of Kerala State is 38863 square km. The state stretches out between 8°18' and 12°18' north latitude and 74° 52' and 77° 22' east longitude. The area of the state is 1.27 per cent of the total area of the country. Among the districts, *Palakkad* is the largest with 4480 sq: km,

closely followed by *Iduki* with 4476sq km. The smallest district is *Alapuzha* with 1414sq km. of area.

The thick vegetation on the middle land makes the state an evergreen, “Gods own land”. The climate is pleasant with moderate temperature and sufficient rain. Coconut, paddy, aracnut and rubber are the major crops. Lengthy coastline of the state makes it famous for fishing industry. Traditional industries are handloom, cashew, coir, and handicrafts. In the rural area about 50 percent of the population depend upon agriculture.



The growth rate of population during 1991-2001 has declined in all the districts of the state as compared to the growth rate in 1981- 1991. The total population of Kerala is 31838619 persons with 15468664 males and 16369955 females according to 2001 census documents. *Kasargode, Wayanad, Kozhikode,*

*Malappuram, Palakkad, and Thiruvananthapuram* are the six districts having growth rate higher than the average growth rate of the state during 1991-2001. The urban population is 8266925 persons and rural 23574449 persons. The 2001 censuses reflect that the state of Kerala is the only state in India where sex ratio is above the equality ratio with 1058 female per 1000 males. The pattern of sex ratio is not uniform in all the districts.

Kerala is the most literate state in the country, 90.92 percent with 87.7 percent female literacy component. Literacy and the education reflect the social development of the community. The highest literacy is in *Kottayam* district (95.90 percent) and lowest in *Palakkad* district (84.31 percent).

Kerala is the home of many colourful festivals. Most of them are based on Hindu mythology. Onam is the typical Kerala Festival. The cultural scenario of the state is very attractive. 'Kathakali' is very popular in Kerala. In the matter of arts the state stands at the forefront.

The state is to be assessed as very good in social development. The health care system is as good as many other developed countries. There are six medical colleges, five Ayurvedic colleges and four Homeo colleges in the state. The rural people are upholding deep faith in the traditional and folk medicines.

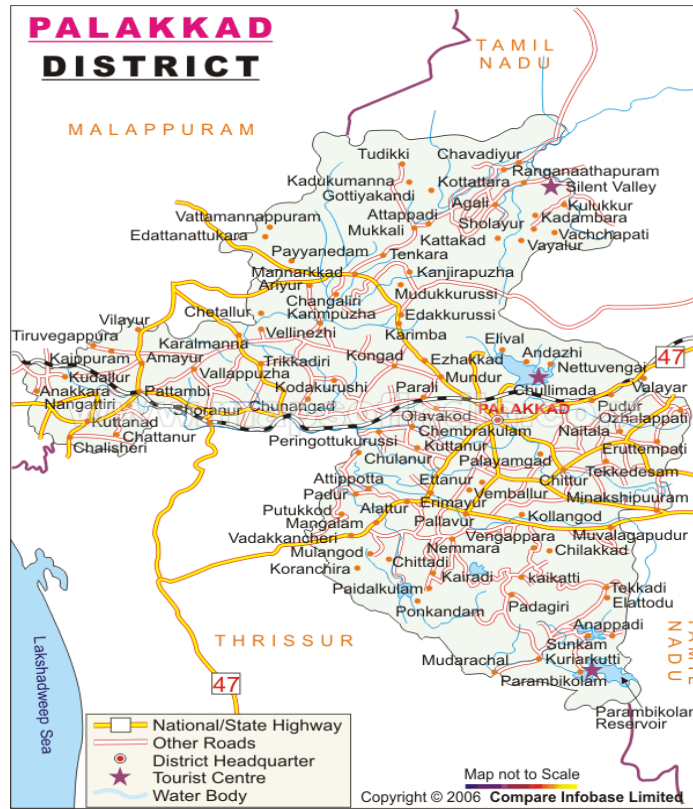
The socio-cultural and political atmosphere of the state also attracts our special attention. The population consists of mainly three religious groups, Hindus, Muslims, and Christians. Hinduism is predominant religion in the state. People believe in the traditional ways of life, system of treatment and health care. The literacy of the population is high but they still like the traditional system of health care. People have no time to stand in the queue to consult doctors. The rural people of Kerala state believe in black magic, superstition and evil spirits that cause disease and health.

## **THE SPECIFIC LOCALITIES OF THE STUDY**

### **1. PALAKKAD DISTRICT**

Palakkad is one of the 14 revenue districts of Kerala. Its geographical position, historical background, rural nature, educational status, tourist attraction and above all, the developmental activities that are carried out, are wide and varied. The district is situated almost in the centre of the state, has no coastal line. The district opens the state to the rest of the country through the Palakkad Ghat. The area of it is 4480 sq km. representing 11.5 percent of the state's geographical area. Palakkad is part of the erstwhile Malabar district of Madras Presidency. *Ottapalam*, *Alathur*, and *Mannarkad taluks* are having a climate similar to that of other districts of Kerala, whereas Palakkad and *Chittoor* are having rather a dry climate similar to that of *Tamilnadu*. However, the average rainfall is good for cultivation. There are 5 taluks, 163 villages 4 municipal towns and 90 Panchayath in the district. The district is divided into 13

community development blocks for the effective implementation of various developmental activities.



According to census 2001, the population of the district is 2617072. The sex ratio of the district is 1068 females per 1000 males. The district has achieved 34.31 percent literacy in 2001. The *Silent Valley* area, 40 kms away from Mannarkad town has the distinction of being a rain forest that is very rare in the world. It spreads over 9000 hectors.

Barathapuzha, with her tributaries, sprawls across the entire district. Agriculture is the main stay of the economy and more than 65 percent of workers and 88.9 percent of the district's population are rural in nature. It is a

land of palm trees and paddy fields. It is known to be rich in flora and fauna. The proximity and easy approach to Tamilnadu have created as admixture of Malayalam and Tamil cultures in the district. The great musicians like *Chempai Vaidyanatha Bagavathar* and *Palakkad Mani Iyer*, who have enriched Karnatic music by their contribution, hailed from this district. Palakkad district has a glorious cultural tradition. *Kunchan Nambiar* the founder of *the Thullal* and *Thunchathu Ramanujan Ezhuthachan*, the father of Malayalam literature spent their last days in Palakkad. *Kathakali* and *Chakiyarkoothu* are famous for Palakkad district. *Kalpathi Ratholsavam* is the famous festival in the district. *Nellyampathi*, *Malampuzha* and *Silentvalley* are the important tourist places of Palakkad district. *Parambikkulam* wild life sanctuary is in the district. The district is gifted with the beauty of virgin and verdiant *Nellyambathi* hills, the precious and unique *SilenValley* national park, the famous *Parambikulam wild life sanctuary*, *Attapadi hills* and more than half a dozen dams like *Malampuzha*, *Mangalam*, *Pothundi*, *Kanhirapuzha*, *Siruvani* and *Parambikulam*.

### **PIRAIRY PHC AREA**

Palakkad district consist of two revenue divisions, Palakkad and Ottapalam. There are 13 Development Block and 90 panchayaths in the district. The study area is *Pirairy* Primay Health Centre under the *Parali* Block P.H.C, in *Parali* Block Panchayath. *Pirairy* PHC is bounded by *Puthupady Grama panchayath* on the North, *Parali Gramapanchayath* on the west, Palakkad Nagarasabha on the east, *Kannady puzha* on the south. The total area comprises

130.25 sq.km. The population of the area is 37648 persons. The *Parali* block PHC consist of *Pirairy, Kalliyangad, Podipara, Variayamparamb, Kurichamkullam, Kodomtharapally* and *Muzhipalam*.

The religious composition is made up of Hindus, Christians and Muslims. Most of the area is inhabited by Hindu population.

Coming to health and sanitation of the area, it is to be pointed out that area is very backward in this regards. As the economic status of the people is very low, they depend much on the PHC for the medical support. There is no inpatient. 92 to 101 outpatients are treated in the PHC daily. The staff strength comprises of one Medical Officer, Three Junior Health Inspectors, One Staff nurse, six JPHN, one Pharmacist, one clerk, one nursing assistant, four class IV workers and one leprosy inspector.

Waste disposal method is insufficient in the area. Most of the households have their own wells. Palakkad district is blessed with irrigation facilities. Dams have been constructed across almost all the important tributaries of *Bharathapuzha* to provide irrigation facility.

There are two lower primary schools, two upper primary schools, one high school, and one higher secondary school in the area. The nearest college is Mercy College, which is 2 km away from Pirairy panchayath.



Electricity supply is not very satisfactory; especially voltage drop during peak time is a curse.

There are three Hindu temples, two Churches and two Mosques in this area.

## **2. MALAPURAM DISTRICT**

The location of Malappuram district is 75<sup>o</sup> to 77<sup>o</sup> east longitude and 10<sup>o</sup> to 12<sup>o</sup> north latitude, in the geographical map. Malappuram district was formed on 16<sup>th</sup> of June 1969. The *Nilgiris* of Tamilndu in the east, *Arabian sea* in the west, *Kozhikode* and *Wayanad* district in the north, and *Palakkad* and *Trissur* districts in the south constitute the boundary of the district. The district has a geographical area of 3550 Sq. kms, which is 9.13 percent of the total area of the state. Malapuram district ranks 3<sup>rd</sup> in the states in area. Malapuram consists of three natural topographical divisions, low land, midland and highland. The low land stretches along the seacoast.



The total population of the district is 3629640 persons with 1759479 males and 1870161 females. The sex ratio of the district is 1063 female for 1000 male. The district has achieved 88.61 percent literacy with 91.46 percent male and 85.96 percent female, literary components.

Four important rivers of Kerala flow through Malappuram district. They are *Chaliyar*, *Kadalundi puzha*, *Bharatha puzha* and *Tirur puzha*. The major forest area is concentrated in *Nilambur* and *Vandur* blocks and *Melattur* in the western ghat. Malappuram district is not rich in mineral wealth. Calicut airport situated at *Karipur*, which is 26 km away from Malappuram town. Two railway lines namely *Mangalore-Madras* and *Nilambur-Shornur* are passing

through the district. The first is through the coastal belt. The district has a good road network. The national highway 17 and 213 passes through the district.

Malappuram district has a good tradition in the field of art and culture. Many of the renowned writers and poets hail from this part of the land. It is a long chain, starting with *Thunjathu Ezhuthachan*, honoured as the father of modern Malayalam literature, *Melpathur Narayana Bhattathiri*, a Sanskrit scholar and the author of the 'Narayaneeyam' lived in *Ezhuthanchan's* period., *Poondanam Namboodiri*, *Achutha Pisharadi*, *Vallathol Narayana Menon*, *Kuttikrishna Marar*, *Moinkutty Vaidyar*, *V.C Balakrishana Paniker*, *Edassery Govindan Nair*, *Uroob*, *Cherukadu Govinda Pisharadi*, *K. Damodaran*, *Kuttipurath Kesavan Nair*, *P.V. Krishna Variar* were some of the great scholars enlightened the district.

Malappuram district, with its rich natural beauty and historic past has its own tourist attractions. Nilambur is famous for Teak plantation. Beautiful waterfall, *Adiyan Para* is 10 kms away from *Nilambur*, is a fast emerging main tourist centre. The famous *Kadambuzha* temple is not far from Kottakal, where devotees from in and out of Kerala come and pray to remove obstructions in life. Dry coconut is the main offering. *Thirunavaya* situated on the banks of *Bharathapuzha*, is a place of historical importance. *Navamukunda Temple* believed to be constructed by Nava Yogis on the right bank of *Bharatapuzha* is an important Vishnu Temple of Kerala. *Pithrutharpanam* is a

ritual, held here on the day of *amavasi* of *karkitaka* (July). '*Bali karma*' is offered by people in their wet clothes, after dip in the river, for the salvation of dead parents.

Tirur is one of the business centres of Malappuram district. It is 41 kms south of Kozhikode, on the Mangalore-Madrass railway route. *Thunchanparamba* in *Trikandiyur*, 3 kms from Tirur railway station, is sacred for all who speak Malayalam, and is the birth place of *Thunchath Ramanujan Ezhuthachan*, the father of Malayalam literature. Hundreds of people reach Thunjanparamba with their children, to initiate them into the world of letters on the *Vijayadashami day*. Tirur, witnessed the infamous *Wagon Tragedy* of the 1921 rebellion.

The University of Calicut, which is 23 kms south of Kozhikode city at Thenhipalam is in Malapuram district.

A good network of health care units is functioning under the government sector. Modern medicine, Ayurveda and Homeopathy services are available.

#### **THE VETTEM PHC AREA**

The Vettem PHC area comes in Tirur Block of Malappuram district. The area is bounded by *Tirur* and *Ponnani* rivers on the east, *Arabian sea* on the west, *Mangalam* panchayath on the south and Tharamaruthur

panchayath on the north. The area comprises of 15.13 sq. km with a population of 222682 persons.

The religious composition of the area shows the dominance of Muslims. Hindus are also present in good strength. Christians are negligible minority. Being a coastal area the population mainly depends on fishing to satisfy their economic needs.

Coming to the health and sanitation of the area it is to be pointed out that the area is very backward in the regards. As the economic status of the people is very low they depend much on the PHC for medical care. The PHC provides 50 beds for in-patient treatment. On an average 250 outpatients are treated in the PHC daily. The staff strength comprises of three doctors, one male health supervisor, five nurses, eight health inspectors, 20 junior health inspectors and 30 junior public health nurses. Waste disposal and water supply systems are deplorably insufficient and inefficient. The district as a whole is a water scarce area. Vettem being a coastal line area, drinking water scarcity is very acute. The problem is solved to a level by Tirur Urban Water Supply Scheme. The area avails the service of nine lower primary schools, six upper primary schools, one high school and one higher secondary school. However, for college education the students have to come down to Tirur (Tunchan Memorial Government College) nine km away from the Vettem area.

The area comes under the Kozhikode telephones district. For rail passage the residents have to come to Tirur. The area is connected to other places by road.

Electricity supply is not very satisfactory, especially voltage drops during peak hours.

There is a Hindu temple the *Vettathukavu* in this area. Mosques are many, but Churches are very few.

### **3. KOZHIKODE DISTRICT**

Calicut is the anglicized form of Kalikut, the Arabic for the Malayalam 'Kozhikode'. It is also called the Cock Fort. Topographically the district has three distinct regions, the sandy coastal belt; the rocky highlands formed the hilly portion of the western ghat and lactic middle land. The district stretches out in 2345 sq km on the north part of Kerala. The district has a coastal length about 80 kms. Calicut district is situated on the south west coast of India. The district is bounded on the north by Kannur district on the east by Wayanad district, on the south by Malappuram district and on the west by Arabian Sea. It is situated between north longitude 11° 0' and 11° 15' and east longitudes 75° 30' and 76° 08'. The district has the population of 2878498 persons with 1398674 males and 1479824 females. Of the total area of the district, 2004 sq kms. area rural and 341 sq km area urban. The district has an urban population of 1100946

and a rural population of 1777552. The population mainly consists of three religious groups; Hindus, Muslims, and Christians. Migrants from other North Indian states are also present in urban areas. Hindus constitute the majority of the population in the district. The Hindu community is organized on the basis of caste and sub caste. As elsewhere in the state they worship all the major Gods and Goddesses of the Hindu mythology. Vishnu and Siva are the major gods worshiped. Elaborate rules prescribed by the Sasthras are followed. The 'Kavu' dedicated to the Badrakali is a typical example of primitive religious centres. There are also temples devoted to such deities as Ayyappan, Hanuman, and Garuda. Serpent worship has been widely prevalent here. Ancestor worship is also practiced by the Hindus. The Muslims of the district are known as Mappilas.



There are reputed centres of learning and culture in Kozhikode district even in the early and medieval periods. One of the most important such centres was Kozhikode itself, under the rule of the enlightened *Zamorins*, it became famous all over south India as rendezvous of scholars and men of learning. Kozhikode district has a rich heritage in agriculture. Agriculture occupies a major role in the district's economy. According to the 2001 census total literate and educated persons are placed at 2351548 persons with break-up as 1182906 males and 1168642 females. Literacy rate is 92.45 per cent with male 96.30 percent and female 88.86 percent. The seat of the University of Calicut is 23 kms south of Kozhikode city at Thenhipalam in Malapuram district. There are arts and science colleges of which eight colleges are under private management. The district has four polytechnics and three industrial training institutions. Of the ten professional colleges in the district, one that is Feroke training college is run by private management.

Kozhikode districts now consist of one revenue division three Taluks, twelve blocks, seventy seven panchayath and one hundred and seventeen villages. There are twelve Community Development Blocks in the district. Kozhikode Corporation has a geographical area of 82.67 sq. kms.

Kozhikode city, known as the *Second Mecca* of football lovers has a fledgling stadium constructed by the Municipal Corporation. There are two urban water supply schemes being maintained by the Kerala Water Authority.



There are eleven government hospitals, ten community centres and seventy primary health centres in this district with total bed strength of 4747. In addition to this there is a government rural dispensary, a district TB centre and two government fisheries dispensaries. Family planning services are available in all the hospitals and health centres. School health services cover all the schools in the district. The district blindness control society is effective by functioning in Kozhikode district. To improve the health status of coastal people, Coastal Health Project was also introduced.

The temples and mosque of the district contains cultures and inscriptions, which are of considerable interest to the people of art. Kozhikode town itself has many temples; the most important one there is the Tali Temple. The district is famous for folk songs known as *Vadakkan pattu*. The people of the area seem to be more interested to keep alive their traditional socio-cultural practices. The fares and festivals of the district have an affiliation to the 'little tradition'. *Theyyam* and *Thira* are temple art forms staged in the festivals of 'Kavus' (temple dedicated to *serpant god*).

The district has 459049 km of good road and approximately 80 km of railway lines. Water supply and electricity are far from satisfactory. Educational facilities are developing. The *NIT*, *IIM*, *Medical College*, *Law College*, and *Arts and Science Colleges* are in countable numbers in the district.

Regarding the rural area, water supply and electricity are poor. Compared to the urban parts of Calicut the rural areas are very poor.

The district was a part of the erstwhile Malabar region, which was ruled by the *Zamorins* of Calicut with Kozhikode as the head quarters of their kingdom. The district has the significance that it was in *Kappad*, a place 16 kms away from Kozhikode city, Vasco Da Gama, the Portuguese navigator landed in 1498 which initiated the country's contact with the west. The urban Kozhikode is primarily commercial centre; industrialization is at lower ebb.

#### **THIRUVANGOOR PHC AREA**

The PHC area selected from Kozhikode district is Thiruvangoor. Thiruvangoor PHC area is bounded by *Anela*, *Ullur* and *Thoraipuzha* on the east, *Arabian Sea* on the west, *Korapuzha* on the south and *Moodadi panchayath* on the north. The total area comprises of 165.46 sq kms. The population of the area is estimated 113419 persons. The male female break-up is 56318 and 57101 respectively. The religious composition is made up of Hindus, Muslims, and Christians. The religious harmony is satisfactory. Agriculture is the main stay of the economy. Coconut is cultivated in a wide spread manner.

Regarding the social overheads available, let us take the health care system. The Thiruvangoor PHC has an in-patient capacity of twenty-five beds. The PHC is attached with a labour room. Around 300 outpatients are treated in the health centre daily. The manpower available in the PHC is three doctors,

three nurses, one health supervisor, four male and four female health inspectors, thirteen junior health inspectors and fourteen junior public health nurses.

Apart from the PHC there are Ayurvedic and Homeo dispensaries. The people of the area have Unani medical centres for their service. In the area there is a private hospital, which is capable of attending to the usual healthcare needs of the people. The Calicut Medical College is only 14 kms away from the PHC and the Taluk hospital Koyilandy is six kms. The area is provided with public water supply system. Most of the households have their own well. The area can avail of the benefits of 35 schools both government and private. (practice owned these schools also.). The government college, *Koyilandy* is six kms away. So the area is blessed with the services of sufficient number of educational institutions. The area is well connected with other places by road and railways.

There are sufficient number of commercial establishments to meet the needs of the people. Electricity supply is steady and sufficient.

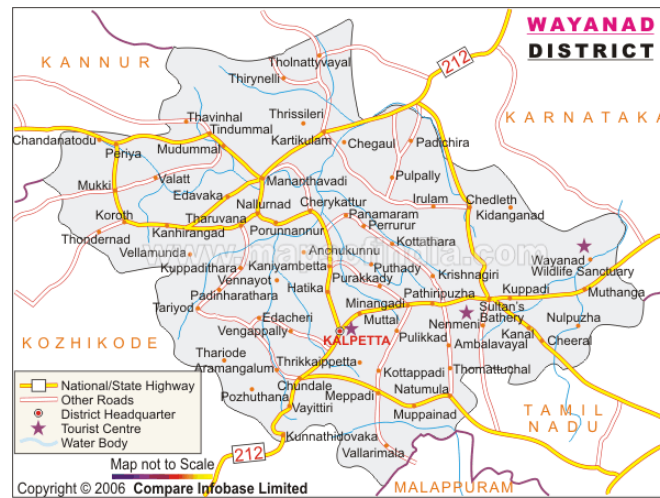
One significant matter is that just behind the PHC is the Kappad beach where the Portuguese Navigator *Vasc-Da Gama* landed. So the place has sufficient exposure to the outside world. An ancient temple on a hillock, facing the deep sea, is an added attraction.

The famous Pisharikavu in this area is a symbol of religious faiths and cultural maturity of the people. There are many mosques in the area. Further there is a Christian church in Koyilandy, a nearby place.

#### **4. WAYANAD DISTRICT**

Nestled among the mountain of the Western Ghats, lies Wayand, one of the loveliest hill stations of Kerala. This green paradise, located at a distance of 76 kms from the seashores of Kozhikode, lies at a height of 700 - 2100 mtrs above sea level, on the north-eastern part of the state. The district of Wayanad was carved out, from parts of Kozhikode and Kannur districts and came in to being on the 1<sup>st</sup> November 1980 as the twelfth district of Kerala. Wayanad lies between north latitude 11° 27' and 15° 58' and east longitude 75° 47' and 70° 37'. It is bounded on the east by Nilgiris and Mysore district of Tamil Nadu and Karnataka respectively, on the north by Coorg district of Karnataka, on the south by Malappuram and on the west by Kozhikode and Kannur. This district is perhaps one of the biggest foreign exchange earners of the state. A large percentage of the population in this region are tribal. The total area and population of Wayand are 2126 sq kms, and 672128 respectively which account for 5.48 percent and 2.1 percent of the state total. The male/female population are 341958 and 330170 respectively. The female-male sex ratio is 966 per 1000 males. The density of population is 369/sq km. The literacy in the

region is 85.52 percent, male literacy ratio is 90.28 and female literacy ratio is 80.80 per cent.



Its Geographical position is peculiar and unique. Agriculture in Wayanad is equally divided between Paddy and plantation crops except coconut. The hills, which is deep blue in bright sunlight and lie mist-covered most of the time, juxtaposes in the green of these paddy fields. This, in fact, is a splendid sight. East flowing rivers of Wayanad are in striking contrast to the various rivers of the rest of Kerala. The river Kabani of Wayanad is a perennial source of water to Cavery. The Panamaram rivulet, originating from Lakkidi, and the Manthavady rivulet originating from Thondarmodi peak meet six kms north of Panamaram town and after they confluence, the river is known as *Kabani*. Coffee is ubiquitous in Wayanad it is cultivated in every panchayath, both in the form of large plantation and small holdings.

Wayanad has the highest concentration of tribal population in Kerala. They form 17.1 per cent of the total population of the district. The

*Kurichas*, of Wayanad have a great marital tradition. No religion can be said to be predominant in this district. Different religious group of the state are more or less equally represented. A special aspect of Wayanad is the large Adivasi population. Though they are in the Hindu fold, primitive forms of worship still previle among them. Ancestral worship and offering to propitiate the spirits of ancestors are still prevalent. Two deities commonly worshiped by the Adivasis are Tamburati and Vetakorumakan. They are worshiped as the Hindu gods of various temples in the district. Adivasis do not have any temple of their own. The Thirunelli and Valliyurkavu temples, which are known outside Wayanad as the temples of the Adivasis, are in the fact, run by Hindu settlers with the help of Brahamin priests. Adivasis are allowed to worship and participate in the festivals of these temples. Almost all sections of Christianity are well represented. The Syrian Catholics have their bishop's houses at Sulthan Batheri and Roman Catholics have their own at Mananthavady. Muslims constitute another one fourth of the population. They are Mappilas who came from Malappuram and Kozhikode district. A large number of them are labourers.

Railway facility is not available in Wayanad. The nearest railway station is Kozhikode, about 70 kms away from Kalpatta. The only mode of transport of goods and commuters within the district is roadways. Bus services are available in all panchayath. Though there is no national highway touching Wayanad, the district has a network of road.

Wayanad district administration is aware of the varied health problems of the people especially Adivasis. With the support of various governmental agencies including tribal and health departments, a health action plan has already been implemented. The rural people and the tribes are following the traditional system of medicine like Ayurvedha and Unani.

For the purpose of revenue administration the district is divided into three Taluk namely *Sulthan Bathery*, *Vythiri* and *Mananthavadi*. The study area is in *Panamaram* PHC in Mananthavady Taluk.

#### **PANAMARAM PHC AREA**

Panamaram PHC is bounded in the north by Mananthavady Panchayath, south *Kottathara* Panchayath, west *Vellamada* Panchayath, the east two Panchayath *Kariyanpatta* and *Koothadi* Panchayath. Panamaram PHC consists of 6 sub centres and one main centre. The population of the area is 32162. The religious composition is made up of Hindus, Christians, and Muslims. Agriculture is the main stay of economy. Agriculture in Wayanad is based on paddy and plantation crops – Coffee, Tea, Pepper, and Cardamom.

The PHC has 25 beds for the in-patient treatment. Nearly 300 out-patients are treated in the PHC everyday. The manpower in the PHC consist of two Medical officers, four nurses, one health supervisor, four male and four female health inspectors, seven junior health inspectors and eight junior public

health nurses. There is one Veterinary hospital, one Homeo dispensary and one Ayurveda dispensary in the area. Near to the main centre there is one Junior Public Health Nurses Training Centre. The people of the area have Unani medical centres for their service. In the area there is one private hospital, which is capable of attending to the usual healthcare needs of the people.

The area is provided with public water supply system. Most of the householders have their own well.

The area avails the benefits of nine schools both government and private owned. The area is connected with other places only by roads.

There are sufficient numbers of commercial establishments to meet the needs of the people.

Electricity supply is steady and sufficient. The area comes under the Mananthavady telephone exchange.

*Pazhasi* tourist resort at Mananthavady is a good picnic centre in north Wayanad near to Panamaram. There is a good aquarium here. Coin operated toys for children and boating facilities for tourist are available here. *Pazhasi Raja*, the lion of Kerala, who organized gorilla type warfare against British East-India Company, was cremated here in 1805.



## 5. KANNUR DISTRICT

Kannur district derived its name from the location of its head quarters at Kannur town. The old name '*Kannannur*' is the anglicized form of the Malayalam word Kannur. Kannur district lies between latitudes 11° 40' to 12° 48' north and longitudes 74° 52' to 76° 07' east. The district is bounded by *Western Ghats* in the east (Coorg district of Karnataka state), Kozhikode and Wayanad districts in the south, *Arabian Sea* in the west, and the *Kasaragode*, in the north. The district can be divided into three geographical regions highlands, midlands and low lands. The total area of the district is 2966 sq. km. The density of population is 749/sq.km. The population of the area is estimated 2412365 persons with 1154144 males, and 1258221 females. The sex ratio of the district is 1090 females for 1000 males. The district has achieved 92.80 percent literacy in 2001 census (96.38 males and 89.51 percent female). The language spoken by the people of the district is Malayalam. Tamil, which is next in importance in most of the districts of Kerala, is not of much importance here. *Hindi, Gujarathi, Marathi* and *Kongani* are also spoken by the minorities.



The coastal region is a comparatively narrow zone characterised by secondary soil, which is rather loose and sandy. Kannur district is very rich in vegetation. Natural vegetation except in some coastal regions consists of different types of forest. Kannur district is endowed with a fine river system with a length of 110 kms. The Valapattanam River, which originates from the Western Ghats, is the longest river in the district. The main tributaries of the river are Valiyapuzha and Aralampuzha. Most of the rivers are navigable.

The Hindu community in the district, as elsewhere in the country, is organized on the basis of castes and sub castes. *Thiyas* form the majority among the Hindu community in the district. The Muslims, here known as Mappilas, form the second largest community. Christianity is believed to have been introduced in Kerala by the apostle St. Thomas in 52 AD. The major Scheduled Caste is Cheruman and the important tribe is *Kurichiya*.

Now Kannur district has three Taluks, *Kannur, Talipparamba, Thalassery*. It has 82 km. coastline from *Kavvayi* in the north of *Kurichiyil* in south. The west coast road from Mahe to *Thalappady* in Kannur district is a national highway. Railways play a vital role in the district in the transportation of men and materials.

Tourism potential for Kannur district is high. The Thalassery fort is an important tourist centre. Kannur beach and *Ezhimala* are known for scenic beauty. *Parassinikadavu Muthappan* Temple exhibits the Hindu tradition and belief of the rural people. *Kolathiri* Kingdom deserves special mention with regard to the cultural heritage of the area. The gift of the district in the field of art and culture is its folk art. The social situation that prevailed here, gave rise to various folk art forms. The cultural life of the folk remains unchanged. *Theyyam* is a highly ritualistic dance. It represents a glorious period of folk life in Kannur as well as in Kerala.

The rural people believe in gods and goddesses. *Vadakkan pattukal* and *Kalari* are most popular in Hindu community. The traditional Hindu in the district observes a number of religious festivals.

The long cherished dream of people of north Malabar region of Kerala is to have a super specialty hospital and Medical college at Pariyaram at Kannur district. In the district health facilities are very high. There are one

hundred and six Allopathic Hospitals, two hundred and sixteen Ayurvedic Hospitals, and one homeopathic hospital. Malabar cancer centre near Thalassery is in the district.

### **PAPPINISSERY PHC AREA**

In Kannur district 49.13 percentage of the population inhabit in villages. In the district there are nine development blocks comprising of eighty-two panchayaths. The development blocks are *Kannur, Edakkad, Irikkur, Irutty, Koothuparamba, Payyannur, Peravoor, Talipramba and Thalassery*. The study area Pappinissery panchayath come under Mangadavu block. The Pappinissery PHC is the main centre and a special grade panchayath. The sub centres of the Pappinissery PHC are *Narath, Parassinikadavu, Kaliyassery, Kurumathur, Cherukunnu, Mangadavu*. Total population of the PHC is 37819. The PHC has an inpatient capacity of 50 beds. Around 500-600 outpatients are treated in the health centre daily. The boundary of the PHC in the north *Kalliassery* panchayath, the south and the east Valapattanam River, in the west, *Talipparamba* municipality. The literacy rate of the area is above 90 per cent. The religious composition is made for Hindus, Muslims and Christians. The Christians are small in numbers.

The socio-cultural factors of the area are in a poor manner. The man power available in the PHC are six medical officers, one head nurse, six staff nurses, six junior public health nurses, three junior health inspectors, one

health inspector, one health supervisor, one lady health supervisor, one lady health inspector, two clerks, one peon, one pharmacist and a lab technician.

Apart from the PHC area there is one Ayurvedic clinic and one Homeo dispensary in the area. In the area there is a private hospital, which is capable of attending the usual health care needs of the people. The medical college is far away from Pappinissery panchayath. The area is provided by public water supply system. Most of the households have their own well. The area can avail the benefits of two high schools, two upper primary schools and two lower primary schools.

When we compare the other area of the study, the socio-economic and the cultural facility are high in Kannur district. The people of the rural area, practices traditional systems of beliefs and practice of treatment. Hence it is hoped that the effect of the overall development of the rural area of the people also can be assessed by conducting the study in these areas.

## **KASARAGOD DISTRICT**

Kasaragod is the one of the backward district of Kerala. Within the district, there are variations in natural conditions and socio-economic and demographic conditions. Some areas in the district are well developed and the

others are in poor condition. Kasaragod district lies between 11° 18' and 12° 14' north latitude and 74° 52' and 75° 26' east longitude. The district is bounded by Arabian Sea in the west, north and east Karnataka state and south Kannur district.

The district is the northern district of Kerala state. It has an area of 1961.30 sq km. with a population of 1203342 (census 2001). It has two taluks, four blocks, thirty-nine panchayaths and two municipalities. It has about eighty-two km in length and is more than the double of the east west axis; it is 40 km long at its broadest point.



Kasaragode district occupies the northern most part of Kerala state.

The area comprises of two taluks Kasaragod and Hosdurg. The districts have

four blocks namely Manjeswar, Kasaragod, Kanhangad and Nileswar. The district extends from the seacoast in the west to the Western Ghats in the east. The major portion of the district lies between 20m and 300 m above mean sea level. The district is drained by twelve rivers, the longest being Chandragiri. The temperature of the district ranges from 20° C to 26° C and the mean annual rainfall of 353 cm are mainly received during the southwest monsoon. Before Kerala state formation in 1956, Kasaragod was part of Malabar district of Madras Presidency. Many people have attained to identify backward area. It is found that the coastal region in the west is well developed, whereas, mid and highlands are less developed. The middle region is occupied by the hard laterite known as '*duricrust*'. People do not occupy these areas as they face water scarcity during summer. Moreover in this area cultivation is difficult.

Health facilities are found high in the coastal panchayath and municipalities. Cultural facilities are found high in the southern panchayath of Hosdurg taluk than the Kasaragod taluk. High density of population is found in coastal panchayaths. High literacy is found in all the panchayath in the southern taluk and coastal panchayath. A few panchayaths in the eastern part have low literacy. The panchayaths in Hosdurg taluk is more developed than Kasaragod taluk. The western coastal plain is well connected by roads and the railways. Kasaragod is less developed, due to the influence of the Port City of Mangalore situated in the north. The distance from the state capital Thiruvananthapuram is 575 Kms.

## **ANANDASRAMAM PHC AREA**

In the district the study area Anandasramam PHC comes in Kanhangad block of Karasagod district. The area of the PHC comprises 160 sq.km. The boundary of the PHC is, in the east Medikai panchayath in the north Pollorperie panchayath in the south Kanhangad Municipality and in the west Arabian Sea.

There is no inpatient facility in the PHC. Around 70 – 80 outpatients are treated in the health centre daily. The staff pattern of the PHC is one doctor, one pharmacist, one nursing assistant, one clerk, one peon, one health inspector, one lady health inspector, four junior health inspectors, and five junior public health nurses.

Agriculture is the main occupation of the population. The area is provided with public water supply system. Most of the householders have their own well and the area can avail the benefit of one LP school and one High school in government sector. The area is connected with other places by road. There is sufficient number of commercial establishments to meet the needs of the people. Electricity supply is steady and sufficient. The temples and the mosques of the district contain cultures and inscriptions, which are of considerable interest to the people of art. In the area there are three temples, one church, one mosque and a cultural centre Anandasramam. In Kanhangad block the National highway 47



crosses the area. Most of the rural people in Kasaragod district are coolies. Their socio-economic status is very poor. The rural people believe in folk medicine. Compared to all other districts of Malabar area Kasargod is the poorest district in Kerala state.

## **CHAPTER - V**

### **THE SANITATION SCENARIO OF THE STUDY AREA**

The study analysed the over all sanitation arrangements of the area. For this purpose eight indices were used, namely, type of house, care taken to keep the domestic environment clean, source of drinking water, care taken to keep drinking water uncontaminated, type of toilet facilities, care taken to prevent mixing of toilet water with drinking water, method of solid waste disposal and medical expense of household.

The disparity in the distribution of the facilities over the different geographical segments of the study area was also analysed. As mentioned in the chapter III, Methodology the study area comprised of six revenue districts of the Malabar region of Kerala state. The districts are, Palakkad, Wayanad, Kozhikode, Malappuram, Kasaragod and Kannur.

The details of the analyses are given under the different sections incorporated in the chapter.

#### **5.1. Type of Dwelling Unit**

Analysis of the collected data relating to the matter reveals that 15.17% of the respondents are residing in Pacca accommodation and 64% are in Kacha accommodation. The rest have no accommodation of their own and are residing with others or in rented portions or in temporary sheds. It is to be inferred

that though Kerala is one of the states which promotes building fine dwelling units, in the Malabar region the situation is not that much promising. Only 15.17% have good housing and 20.83% are virtually having no proper housing at all. It is a fact that house construction, by and large, is a result of foreign money inflow and relatively this region is not so blessed with very rich NRIs as the case in South Kerala.

As housing is one of the major factors, which decide health status of people, it is to presume that the condition shall be far from satisfactory.

#### **5.1.1. Location and Housing Facilities Available**

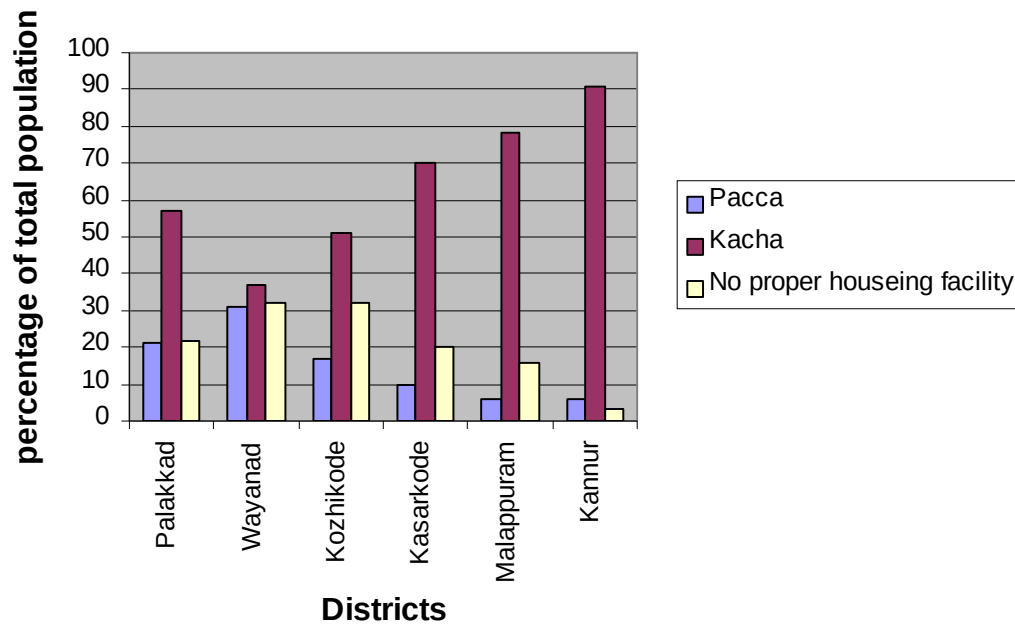
Coming to the housing conditions of different districts, which constituted the study area, Wayanad shows a special character. 31% have very good accommodation at the same time 32% have deplorable facilities. 37% have average facilities. This shows that Wayanad clusters at the two extremes compared to other localities. One prominent reason is the existence of large Christian population who are enjoying prosperity. The other side may be due to the concentration of tribal population in the district. Majority of them have no dwelling units. Kozhikode, Palakkad and Kasargode also face housing problem very much. Kannur district is significant in another way. 91% of the residences have average standard. Only 6% enjoy very good and 3% very bad housing facilities in Kannur. On the whole, we may come to the conclusion that rural

housing in Malabar region is not satisfactory. This will be telling upon the health and hygiene matters of the people.

**Table 5.1.1**  
**Location and Housing Facilities Available**

District Code	Pacca	Kacha	No Proper Housing Facilities	Total
Palakkad	21 (21.00%)	57 (57.00%)	22. (22.00%)	100 (100%)
Wayanad	31 (31.00%)	37 (37.00%)	32 (32.00%)	100 (100%)
Kozhikode	17 (17.00%)	51 (51.00%)	32 (32.00%)	100 (100%)
Kasarkode	10 (10.00%)	70 (70.00%)	20 (20.00%)	100 (100%)
Malappuram	6 (6.00%)	78 (78.00%)	16 (16.00%)	100 (100%)
Kannur	6 (6.00%)	91 (91.00%)	3 (3.00%)	100 (100%)
Total	91 (15.17%)	384 (64.00%)	125 (20.83%)	600 (100%)

**Figure 5.1.1. Location and Housing Facilities Available**



## 5.2. Habit of Keeping Domestic Environment Clean

A clean environment is a healthy environment and it is the creation of the people. How far healthy the study area will be was estimated by enquiring into the habit of people in keeping it clean. For a question relating to the matter we elicited two responses. 54% of the samples, according to the responses, are very careful to keep their surroundings clean and tidy. The other portion (46%) is not bothered about keeping the environment clean. If these responses are taken as representative of the total populations' habit we could only expect that the cleanliness of the environment will be average.

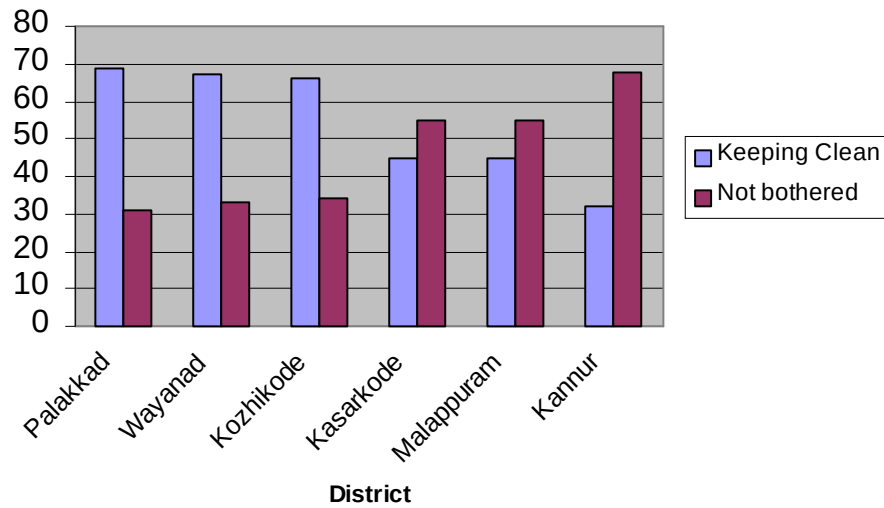
**Table 5.2.1**

**Geographical Locations and the Peoples' Habit of Keeping Domestic Environment Clean.**

District	Keep Clean	Not Particular	Total
Palakkad	69 (69.00%)	31 (31.00%)	100 (100%)
Wayanad	67 (67.00%)	33 (33.00%)	100 (100%)
Kozhikode	66 (66.00%)	34 (34.00%)	100 (100%)
Kasarkode	45 (45.00%)	55 (55.00%)	100 (100%)
Malappuram	45 (45.00%)	55 (55.00%)	100 (100%)
Kannur	32 (32.00%)	68 (68.00%)	100 (100%)
Total	324 (54.00%)	276 (46.00%)	600 (100%)

Geographical distribution of the habit indicates that Palakkad, Wayanad and Kozhikode show similar habit. Kasargode and Malappuram come under another cluster. Kannur is keeping aloof from both the previous categories. Majority of the respondents from Palakkad, Wayanad and Kozhikode (69%, 67% and 66% respectively) are very particular to keep their environment clean. 45% each of Kasargode and Malappuram are paying sufficient attention to keep their surroundings clean. The corresponding segment in the case of Kannur is constituted by 32% of the sample.

**Diagram 5.2. Geographical Locations and the Peoples Habit of Keeping Domestic Environment Clean**



### 5.3. Source of Drinking Water

Clean water prevents much of the diseases of rural population. So clean water is an indicator of good health. In this study an enumeration was carried out to conduct an analysis on the availability of drinking water in the different locales of the study. Data analysis revealed that 35.17% of the respondents depend on public well, 22.83% on their own pipe system, 21.67% on their own well and another 15.67% on the public tap. 4.17% have neighbour's well to depend on and 3 respondents have bore well (0.5%).

The analysis reveals that only 44.50% of the sample has their own arrangements for drinking water. Others are depending on other provisions. 35.17% depend on public well 15.67% on public tap and 4.17% as neighbour's well.

To conclude we must say that more than half of the population of the study area has no sufficient facilities for safe drinking water. This would naturally tell upon their health status.

### 5.3.1 Location-wise Distribution of Sources of Drinking Water

When we examine sources of drinking water, which the respondents depend on, we see that largest segments of all districts except Palakkad and Kannur depend on common well for their drinking water needs. In the case of Kannur the largest segment depends on public tap. In the case of Palakkad the situation is comparatively better. 40% of the respondents there have their own well. Regarding own pipe system Malappuram is little better. Kannur comes next. On the whole the drinking water situation is quiet grim in Malabar region if we generalize the findings of the sample study.

**Table 5.3:1**

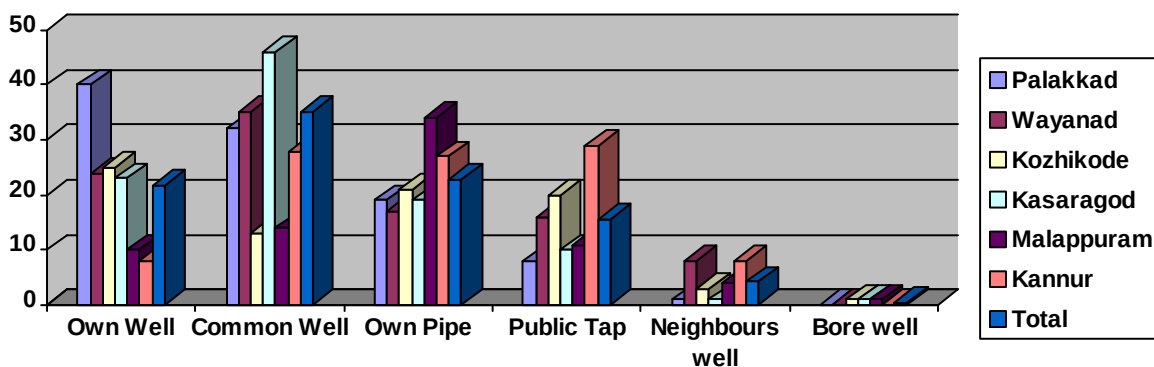
#### **Location-Wise Distribution of Sources Of Drinking Water**

<b>District</b>	<b>Own well</b>	<b>Common well</b>	<b>Own pipe system</b>	<b>Public tap</b>	<b>Neighbour's well</b>	<b>Bore Well</b>	<b>Total</b>
Palakkad	40 (40.00)	32 (32.00%)	19 (19.00%)	8 (8.00%)	1 (1.00%)	0 (0.00%)	100 (100%)



Wayanad	24 (24.00%)	35 (35.00%)	17 (17.00%)	16 (16.00%)	8 (8.00%)	0 (0.00%)	100 (100%)
Kozhikode	25 (25.00%)	30 (30.00%)	21 (21.00%)	20 (20.00%)	3 (3.00%)	1 (1.00%)	100 (100%)
Kasarkode	23 (23.00%)	46 (46.00%)	19 (19.00%)	10 (10.00%)	1 (1.00%)	1 (1.00%)	100 (100%)
Malappuram	10 (10.00%)	40 (40.00%)	34 (34.00%)	11 (11.00%)	4 (4.00%)	1 (1.00%)	100 (100%)
Kannur	8 (8.00%)	28 (28.00%)	27 (27.00%)	29 (29.00%)	8 (8.00%)	0 (0.00%)	100 (100%)
Total	130 (21.67%)	211 (35.17%)	137 (22.83%)	94 (15.67%)	25 (4.17%)	3 (0.50%)	600 (100%)

**Diagram 5.3.1. Location-wise Distribution of Source Of Drinking Water**



#### 5.4. Care Taken to Keep Drinking Water Uncontaminated

Taking account of the importance of drinking water in health maintenance further enquires regarding the facility was made. One of the queries was related to the protective wall maintained to the well. It is seen that only 33.83% of the well are protected by sidewalls and sweepage preventing basement. The rest are using water from well having no such protective structures.

The analysis indicates that the people are using water, which is prone to contamination.

#### 5.4.1. Location and Protection to Well.

Enquiry relating to the availability of protected well water in the locations revealed that 49% of the respondents from Palakkad have this facility. 46% of Kasaragode respondents also have protected well water. Wayanad and Kozhikode districts are very backward in this regard. Only 12% of the respondents from Wayanad are using water from protected well. Those who take water from unprotected wells, ponds and ditches come to 55%. The corresponding figures in respect of Kozhikode district are 20% and 38%. Kannur is distinguished itself in the sense that only 2% are using water from unprotected well. Another significance of Kannur is that 56% are not depending on well for their drinking water.

The pattern of responses indicates that fresh water is a problem in the rural area of Malabar region.

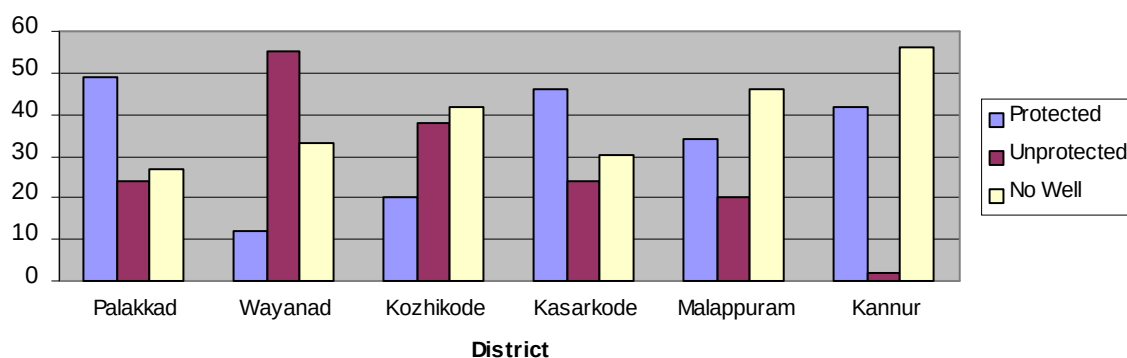
**Table 5.4.1**

Location and Protection to Well

District	Protected	Unprotected	No well	Total
Palakkad	49 (49.00%)	24 (24.00%)	27 (27.00%)	100 (100%)
Wayanad	12 (12.00%)	55 (55.00%)	33 (33.00%)	100 (100%)
Kozhikode	20 (20.00%)	38 (38.00%)	42 (42.00%)	100 (100%)

Kasarkode	46 (46.00%)	24 (24.00%)	30 (30.00%)	100 (100%)
Malappuram	34 (34.00%)	20 (20.00%)	46 (40.00%)	100 (100%)
Kannur	42 (42.00%)	2 (2.00%)	56 (56.00%)	100 (100%)
Total	203 (33.83%)	163 (27.17%)	234 (39.00%)	600 (100%)

Diagram 5.4.1. Locations and Protection to Well



## 5.5. Proximity of Leach Pit to Well

One of the major sources of contamination of well water is the sweepage from leach pit. Presence of bacteria like ecoli is a common problem of well water and this is due to the proximity of leach pit to well and bird's droppings received in the well.

In this study an enquiry was carried out to assess the proximity of leach pit to well. The analysis of data reveals that only 1.17% of the wells are more that of 50 feet away from leach pit. 18.67% are very closer to the leach pit. However 41.17% are not very closer but in any case will be with 50 feet. The minimum distance prescribed between leach pits and well is 50 ft. So we can guess the quality of water used by the rural people.

### 5.5.1 The Distance between Well and Leach Pit in Different Geographical Locations

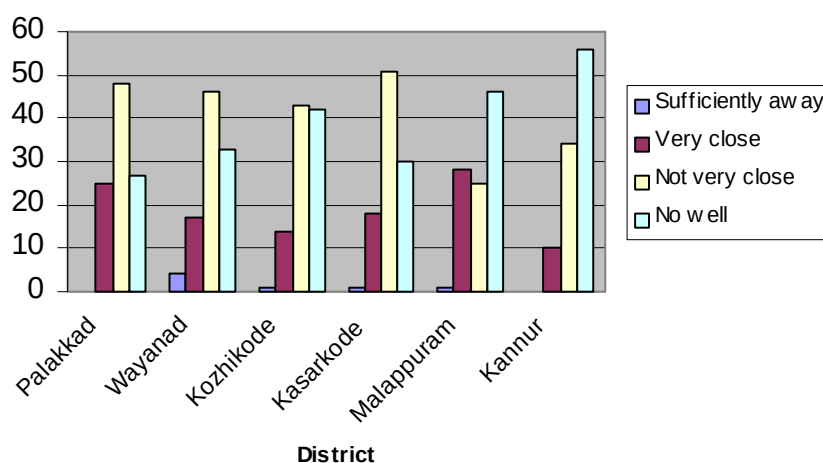
The respondents of Palakkad, Wayanad and Kasargode and also Kozhikode are having well some what away from leach pit. The analysis in table 5.5.1 indicates that there is pollution of well water or possibility for it due contamination from leach pit.

**Table 5.5.1**  
**Distance between Well and Leach Pit in Different Geographical Locations**

District	Sufficiently away	Very close	Not very close	No well	Total
Palakkad	0 (0.00%)	25 (25.00%)	48 (48.00%)	27 (27.00%)	100 (100%)
Wayanad	4 (4.00%)	17 (17.00%)	46 (46.00%)	33 (33.00%)	100 (100%)
Kozhikode	1 (1.00%)	14 (14.00%)	43 (43.00%)	42 (42.00%)	100 (100%)
Kasarkode	1 (1.00%)	18 (18.00%)	51 (51.00%)	30 (30.00%)	100 (100%)

Malappuram	1 (1.00%)	28 (28.00%)	25 (25.00%)	46 (46.00%)	100 (100%)
Kannur	0 (0.00%)	10 (10.00%)	34 (34.00%)	56 (56.00%)	100 (100%)
Total	7 (1.17%)	112 (18.67%)	247 (41.16%)	234 (39.00%)	600 (100%)

**Diagram 5.5.1. Distance between Well and Leach Pit**



## 5.6. Type Of Latrine Used

When we think about sanitation, type of latrine comes at the forefront. Human excreta, if not properly managed can let loose health the havoc in various ways. Air pollution, water pollution and diseases created by worms are very common in areas where open defecation is practiced by people.

Water closet with flushing system and leak proof pits may be ensuring personal and environmental hygiene. This study enquired about the type of latrine used by the rural households. Analysis of the data indicates that only

39.83% of the households are using water closet and the rest (60.17%) are using other types, which have no proper flushing system. Even water closets are very badly kept in many households. We can infer about the hygiene condition of other types of closets like pit latrine. So generally speaking on this index, the environmental sanitation of the study area may not be assessed as better.

### 5.6.1. Geographical Locations and Type of Latrine Used

On associating geographical locations with type of latrine used it is seen that there is wide disparity in the distribution of the facility. Kannur is having very good water closet density (70%). Kasargode and Palakkad also have satisfactory achievement in this regard (46% and 45% respectively). The case of Kozhikode is very deplorable with 8% respondents only having water closets in their households. 92% of the households of Kozhikode have only other types of latrine facilities. Majority of all households of the districts except Kannur have only non-flushing water closets. In Kannur only 30% present of the households are using non-water closets.

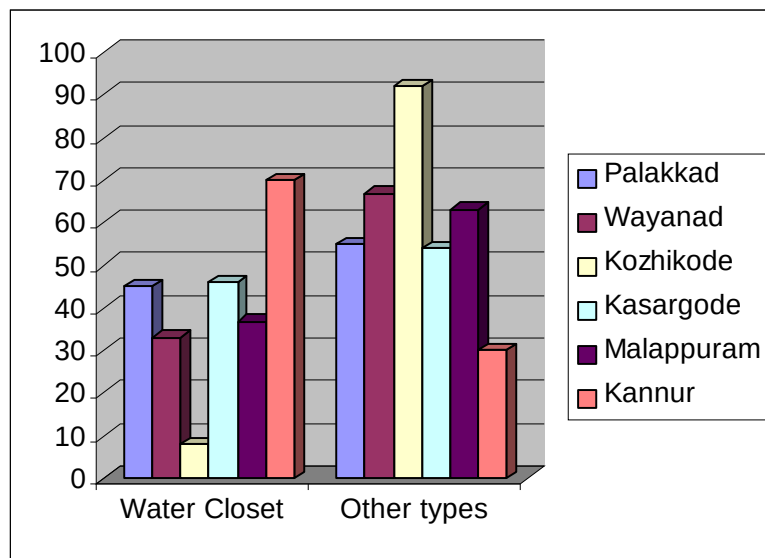
In this analysis also we witness a grim situation of environmental sanitation.

**Table 5.6.1**  
**Geographical Locations and Type of Latrine Used**

District	Water closet	Other types	Total
Palakkad	45 (45.00%)	55 (55.00%)	100 100%

Wayanad	33 (33.00%)	67 (67.00%)	100 100%
Kozhikode	8 (8.00%)	92 (92.00%)	100 100%
Kasarkode	46 (46.00%)	54 (54.00%)	100 100%
Malappuram	37 (37.00%)	63 (63.00%)	100 100%
Kannur	70 (70.00%)	30 (30.00%)	100 100%
Total	239 (39.83%)	361 (60.17%)	600 (100%)

**Diagram 5.6.1**  
**Geographical Locations And Type Of Latrine used.**



## 5.7. Solid Waste Management

Waste management is a burning problem of any society, rural or urban. Sub-standard and non-digestible plastic materials are the villains of the story of waste management. Improper disposal of waste creates health problem. So the method of waste disposal was selected as another index of environmental sanitation in this study. Accordingly, investigation was carried out to analyse the method of waste disposal practiced by the households. Analysis of the data indicates that 54.67% of the households are dumping waste materials on their courtyard. 32% burn out the waste and 12.50% use it for preparing manure for their farming activities.

By mere dumping, the practice resorted to by majority; waste may become breeding place for harmful insects and epicenter of epidemics. Similarly burning waste, now days, is not safe as it may contain plastic materials which generate toxic fumes and gases on burning. In short the handling of waste in the study area is not conducive for the maintenance of a healthy atmosphere.

**Table 5.7.1**

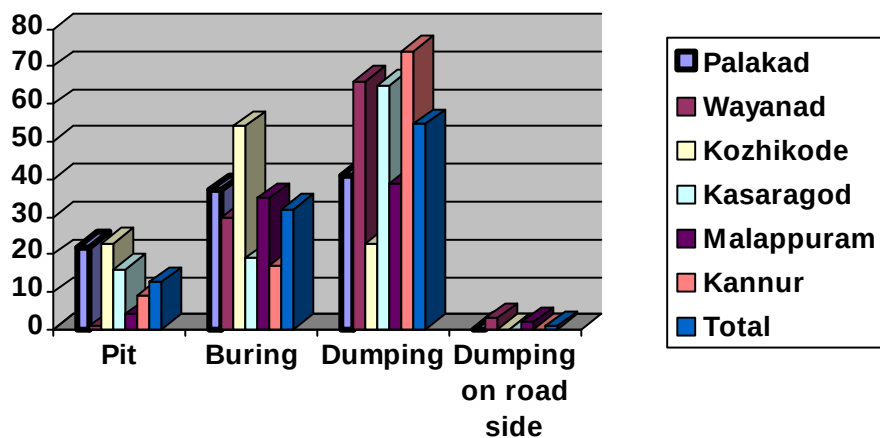
Geographical Location and Waste Management

District	Pit	Burning	Dumping	Dumping on road side	Total
Palakkad	22 (22.00%)	37 (37.00%)	41 (41.00%)	0 (0.00%)	100 (100%)
Wayanad	1 (1.00%)	30 (30.00%)	66 (66.00%)	3 (3.00%)	100 (100%)
Kozhikode	23 (23.00%)	54 (54.00%)	23 (23.00%)	0 (0.00%)	100 (100%)



Kasarkode	16 (16.00%)	19 (19.00%)	65 (65.00%)	0 (0.00%)	100 (100%)
Malappuram	4 (4.00%)	35 (35.00%)	59 (59.00%)	2 (2.00%)	100 (100%)
Kannur	9 (9.00%)	17 (17.00%)	74 (74.00%)	0 (0.00%)	100 (100%)
Total	75 (12.50%)]	192 (32.00%)	328 (54.67%)	5 (0.83%)	100 (100%)

**Diagram 5.7.1**  
**Geographical Location And Waste Management**



The analysis in Table 5.7.1 reveals that there are disparities in the methods of waste management between the households of different areas. Majority of households in Kannur, Wayanad, Kasargode, Malappuram dumping the waste somewhere in their courtyard. Among the burning groups, Kozhikode distinguished itself by the fact that majority of Kozhikode households resort to this practice. Kozhikode and Palakkad are to be mentioned due to the reason that a

sizable segments of the respective groups (23% and 22% respectively) use waste for manure preparation.

## **5.8 Expenditure For Medical Care**

An analysis of the medical expenditure of the households was also carried out as an index of the health status of the area. It is seen that (Table 5.8.1) 43.83% are spending on an average Rs.50 for medical care in a month. 21.83% spent Rs.50 – 100 a month for the purpose. 20.67% practically, do not spend anything for medical care of their family. 13.67% spend more than Rs.100 a month for the purpose. The analysis implies that health problems, which require medical attention, are not very severe in the study area.

### **5.8.1. Geographical Location And Expenditure On Medical Care**

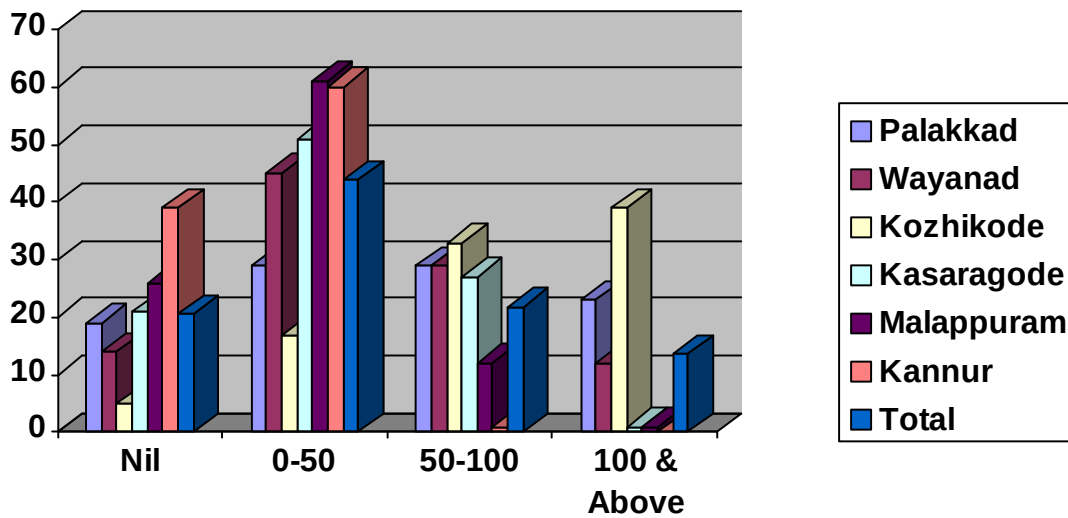
Location wise analysis of the spending indicates that there are wide disparities in it (Table 5.8.1). Majority of Malappuram, Kannur and Kasargode spend Rs.50 on an average for medical care monthly. But when we look at in extent of payment Kozhikode is more prone to health problem. 45% of the households spend more than Rs.100/- per month and 33%, Rs.50 – 100. That is 78% of the Kozhikode households spend above Rs.50. The rapid rate of urbanization of the district may be creating health problem for the rural people even.

**Table.5.8.1**

Geographical Location and Expenditure on Medical Care

District	Nil Rs. / Month	0-50 Rs./Month	50-100 Rs/Month	100 & above Rs/Month	Total
Palakkad	19 (19.00%)	29 (29.00%)	29 (29.00%)	23 (23.00%)	100 (100%)
Wayanad	14 (14.00%)	45 (45.00%)	29 (29.00%)	12 (12.00%)	100 (100%)
Kozhikode	5 (5.00%)	17 (17.00%)	33 (33.00%)	45 (45.00%)	100 (100%)
Kasarkode	21 (21.00%)	51 (51.00%)	27 (27.00%)	1 (1.00%)	100 (100%)
Malappuram	26 (26.00%)	61 (61.00%)	12 (12.00%)	1 (1.00%)	100 (100%)
Kannur	39 (39.00%)	60 (60.00%)	1 (1.00%)	0 (0.00%)	100 (100%)
Total	124 (20.67%)	263 (43.83%)	131 (21.83%)	82 (13.67%)	100 (100%)

**Diagram 5.8.1**  
**Geographical Location And Expenditure On Medical Care**



**Summary**

The analyses carried out give us a profile of the environmental sanitation of Malabar region where this study was conducted. The analyses show that the environmental sanitation is not satisfactory. Consequently the health status of the people may also be unsatisfactory. However, an analysis on the spending on medical care does not indicate that there are serious health problem for the population. May be the population depending on the free health delivery system of the government. Another possibility is that the people are negligent to attend to their genuine health care needs.



## **CHAPTER - VI**

### **BELIEF RELATED TO HEALTH & DISEASE**

Every society through experience has evolved ways to cope with illness and physical disorders. These ways are culture specific and vary greatly from one society to another (Dack, 1991:2).

For every disease human behaviours can become aggravating agencies. The other way round also is possible. Through proper behavioural patterns the risk of diseases can be reduced or even they can be kept at bay. Behaviours are the off springs of beliefs. Therefore, belief system of a community and its health and health maintenance are intimately related.

In this chapter analysis have been made on beliefs relating to health and disease and their variations according to the socio-cultural background of the rural people.

#### **6.1. Belief Relating to Mental Illness**

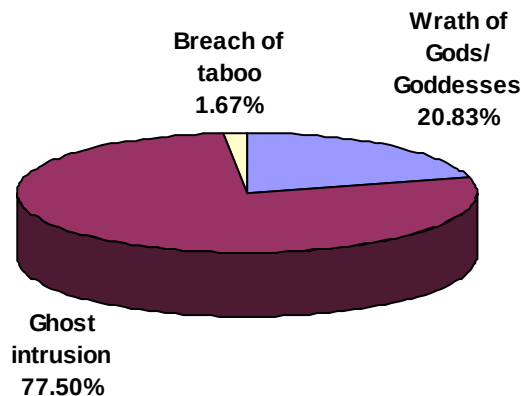
Health has three dimensions, namely, physical, mental and social aspects. Mental illness is one of the most disturbing and disabling conditions of life. It affects not only the person concerned but his/her family and the community as well. The situation is made worse by the social stigma attached to it.

An enquiry was conducted into the belief of the rural people regarding the cause of mental illness. The results of the analysis of the data are

very astonishing. 77.50 % of the sample believes that it is the intrusion of evil spirits that causes mental illness. Another 20.83% believe that it is the wrath of gods and goddesses that creates mental illness. 1.67% of the respondents believe that mental illness is the outcome of breach of taboo.

It is to be concluded that even in Kerala where the people are 100% literate there exist a strong conviction among the rural people that mental illness is the outcome of the deeds of evil spirits, which enter into human beings, or wrath of god and goddesses.

**Diagram 6.1.**  
**The Proportion of Belief Regarding Cause of Mental Illness**



### **6.1.1 Educational Status and Belief Relating to the Cause of Mental Illness**

Education creates rational thinking and belief relating to perceived phenomena. In this context it was assumed that educational attainment of the rural people and their belief regarding the cause of mental illness are associated.

Accordingly the collected data was analysed as shown in Table

6.1.1

**Table 6.1.1.**

Educational Status and Belief Regarding the Cause of Mental Illness

Educational Status	Wrath of Gods/ Goddesses	Ghost intrusion	Breach of Taboo	Total
No formal schooling	57 (21.51%)	204 (76.98%)	4 (1.51%)	265 (100%)
Primary	57 (18.33%)	249 (80.06%)	5 (1.61%)	311 (100%)
Secondary	11 (45.83%)	12 (50.00%)	1 (4.17%)	24 (100%)
Total	125 (20.83%)	465 (77.50%)	10 (1.67%)	600 (100%)

Chi-Square Value = 11.76, df = 4, Table Value =9.488,  $p \leq 0.05$

The association is significant.

The analysis (Table 6.1.1) reveals that the major portion of those who have no formal schooling and primary educated respondents are of strong opinion that the cause of mental illness is ghost intrusion. 50% of the secondary educated also come under this category. Among the secondary educated 45.83% believe that the cause of mental illness is wrath of gods or goddesses.

On a consolidation of the results it is to be concluded that rural people still uphold the belief that supernatural powers, particularly evil spirits,



are responsible for the occurrence of mental illness. The belief is stronger among the lesser educated.

### 6.1.2. Income Status and Belief Relating to the Cause of Mental Illness

Another analysis was carried out to find out the relationship, if any, existing between income status and belief related to mental illness. The analysis is shown in table 6.1.2

The analysis indicates that there is similarity in the belief of the lower and upper income groups (Rs. Up to 1000 per month and Rs. 2000 and above per month respectively). 80.18% and 83.55% respectively of the groups believe that it is the ghost intrusion that creates mental disorder. The corresponding figure in respect of the middle-income group (Rs.1000 – 2000) is 70.93%. Of the groups, the middle group subscribes more to the belief that mental illness is caused by the anger of Goddesses, and gods.

**Table 6.1.2.**  
Income Status and Belief Regarding the Cause of Mental Illness

Monthly Income (in Rs.)	Wrath of Gods/ Goddesses	Ghost Intrusion	Breach of Taboo	Total
Up to 1000 (Low)	20 (18.02%)	89 (80.18%)	2 (1.80%)	111 (100%)
1000 – 2000	70	183	5	258

(Middle)	(27.13%)	(70.93%)	(1.94%)	(100%)
2000 & above	35	193	3	231
(Upper)	(15.15%)	(83.55%)	(1.30%)	(100%)
Total	125	465	10	600
	(20.83%)	(77.50%)	(1.67%)	100%

Chi-Square Value = 11.86, df = 4, Table Value = 9.488,  $p \leq 0.05$ . The association is significant.

The concept of intrusion of spirits is that of black magic while wrath of Gods/Goddesses is that of pious religion. The income categories have misconception in the matter and the outlook of the lower and upper income groups is cruder than that of the middle-income category.

### 6.1.3. Occupational Status and Belief Relating to Cause of Mental Illness

Occupation and belief systems are closely related to each other. In this study the relationship is assumed and hence it was postulated that the occupational status of rural people and their belief regarding cause of mental illness are related. The analysis of the data to test the assumption reveals that it is true.

**Table 6.1.3**

Occupational Status and Belief Regarding the Cause of Mental Illness

Occupational Status	Wrath of Gods/Goddesses	Ghost intrusion	Breach of Taboo	Total
Manual Labour	60 (18.35%)	262 (80.12%)	5 (1.53%)	327 (100%)
Skilled Labour	22	107	3	132

	(16.67%)	(81.06%)	(2.27%)	(100%)
Salaried	21 (40.38%)	29 (55.77%)	2 (3.85%)	52 (100%)
Business	22 (24.72%)	67 (75.28%)	0 (0.00%)	89 (100%)
Total	125 (20.83%)	465 (77.50%)	10 (1.67%)	600 (100%)

Chi-Square Value = 19.28, df = 6, Table Value = 16.812,  $p \leq 0.01$

The association is significant.

The analysis (Table 6.1.3) highlights that salaried people considerably differ from other categories. While 80% each of the manual labourers and skilled workers and 75% of the business persons believe that it is the intrusion of ghost that creates mental illness, only 56% of the salaried group believe so. Similarly, the portion of all occupational groups except salaried people who believe that mental illness is the off-shot of the displeasure of Gods and Goddesses swing between 18% - 25%. The percentage of salaried group who comes under this category is 40.38%. 3.85% of them that stated breach of taboo as the reason for mental illness.

It is to be concluded that the salaried group has lesser faith in the dark forces' capacity to create this type of disorders in human beings.

#### **6.1.4 Socio-Economic Status and Belief Relating to Cause of Mental Illness**

To identify the relationship between the composite effect of the social and economic backgrounds of the rural population (socio-economic status) and their belief regarding the cause of mental illness an analysis as shown in Table 6.1.4 was conducted.

**Table 6.1.4**

**Socio Economic Status and Belief Regarding** the Cause of Mental Illness

Socio-Economic Status (Score)	Wrath of Gods/ Goddesses	Ghost intrusion	Breach of Taboo	Total
Low (below 20)	38 (23.60%)	120 (74.53%)	3 (1.87%)	161 (100%)
Medium (20 – 30)	69 (16.79%)	335 (81.51%)	7 (1.70)	411 (100%)
High (30 & above)	18 (64.29%)	10 (35.71%)	0 (0.00%)	28 (100%)
Total	125 (20.83%)	465 (77.50%)	10 (1.67%)	600 (100%)

Chi-Square Value = 37.05, df = 4, Table Value =13.277 ,  $p \leq 0.01$   
The association is significant.

The results reveal that the high socio-economic status group distinguishes itself from other two categories. While an overwhelming majority of the low and medium socio-economic status groups (74.53% and 81.51% respectively) believe in the involvement of ghost in the causation of mental illness. Majority of the high socio-economic status group (64.29%) believe in the role played by the displeased gods and goddesses in the matter. The belief regarding the role of evil forces is stronger among the lower socio-economic status groups. The power of the pious forces dominates in the belief of high socio-economic groups.

**6.1.5. Family Size and Belief Relating to Cause of Mental Illness**

The type of social interaction within the group can influence the belief system of individual and that in turn depends on the size of the group in which one lives. In this study, the size of the family in which the respondent

lives was assumed as a determinant of the belief regarding the cause of mental illness.

**Table 6.1.5**

Family Size and Belief Regarding the Cause of Mental Illness

Family size (Number of members)	Wrath of Gods/ Goddesses	Ghost intrusion	Breach of Taboo	Total
Smaller (Up to 5)	34 (15.04%)	187 (82.74%)	5 (2.21%)	226 (100%)
Medium (5–8)	82 (26.97%)	217 (71.38%)	5 (1.64%)	304 (100%)
Larger (8 & above)	9 (12.86%)	61 (87.14%)	0 (0.00%)	70 (100%)
Total	125 (20.83%)	465 (77.50%)	10 (1.67)%	600 (100%)

Chi-Square Value = 15.96, df = 4, Table Value = 9.488,  $p \leq 0.05$

The association is significant.

Analysis of the data supports the assumption. Results reveal that (Table 6.1.5.) a family having medium size (consisting of 5-8 members) differs from smaller and larger families. While faith in ghost intrusion is stronger among the smaller and larger families it is not so stronger in medium size families.

Analysis showed that other background variables namely, age, sex and religion are not associated with the belief. The details of the analysis are not given here.

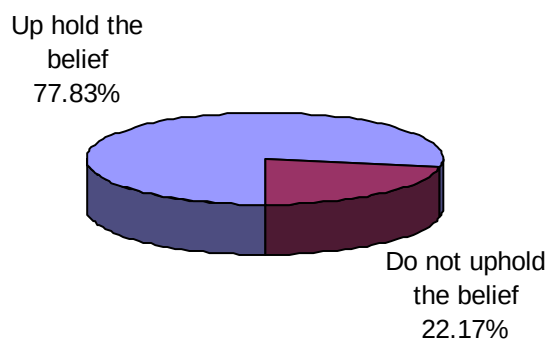
## 6.2. Belief Relating to Keeping Diseased Condition Confidential

Certain types of diseases attract social stigma and rural people are reluctant to disclose the occurrence of such diseases, particularly when the victim is a young female member. Insanity and sexually transmitted diseases are some such diseases.

In this study, the belief relating to keeping such diseases confidential was analyzed. Empirical analysis reveals that 77.83% of the respondents have such belief and the rest (21.17%) not. The results reveal that the ruralities are under the strong hold of belief of keeping the occurrence of such diseases undisclosed to others (Table 6.2.1).

Further analyses were carried out to identify the relationship between the faith and the background variables.

**Diagram 6.2.**  
**The Belief Regarding Keeping Diseased Condition Confidential**



### **6.2.1. Religious Affiliation and Belief Relating to Keeping Diseased Condition Confidential**

In primitive communities religious leaders were healers and the technique of healing was primarily *manthravada* (black magic). The trace of this curing technique still prevails among the priests of certain religious groups. Still now beliefs regarding occurrence, spread, cure etc. of the diseases are influenced by religion.

In this study, investigation was carried out to see whether religious affiliation is associated with the belief (Table 6.2.1)

**Table 6.2.1.**

Religious Affiliation and Belief regarding keeping diseased Condition Confidential

Religious Affiliation	Up hold the belief	Do not uphold the belief	Total
Hindu (Forward)	257 (88.32%)	34 (11.68%)	291 (100%)
Hindu (Backward)	96 (65.75%)	50 (34.25%)	146 (100%)
Christian	43 (76.79%)	13 (23.21%)	56 (100%)
Muslims	71 (66.36%)	36 (33.64%)	107 (100%)
Total	467 (77.83%)	133 (22.17%)	600 (100%)

Chi-Square Value = 39.09, df = 3, Table Value = 11.345,  $p \leq 0.01$

The association is significant.

The analysis reveals that the Hindu (Forward) group upholds the belief to the greatest extent, then comes, Christian group (88.32% and 76.79% respectively). Almost equal portions of Hindu (Backward) and Muslim come under the category (65.75 % and 66.36 % respectively). Hindu (Forward) is a tradition bound, status group. So they uphold traditional belief in every walk of life to the maximum extent possible. Moreover, the stigma brought about from being disclosed the occurrence is more felt by this status group. Hindu (Backward) and Muslim are not that much status seeking and they don't much mind in this kind of confidentiality. Christians of Kerala particularly of rural areas are rubbing shoulders with forward Hindus. This may be a possible explanation for the result elicited.

### **6.2.2. Educational Status and Belief Regarding Keeping Diseased Condition Confidential**

Education modifies the thoughts and beliefs of people. In the back drop this point of view it may be postulated that the educational attainment of rural people and their belief relating to keeping diseased condition confidential are associated. The collected data was analysed as shown in table 6.2.2. to test the validity of the postulate.

**Table 6.2.2**  
**Educational Status and Belief Regarding Keeping Diseased Condition Confidential.**

Educational Status	Up hold the belief	Do not uphold the belief	Total
No formal Schooling	196 (73.96%)	69 (26.04%)	265 (100%)



Primary	258 (82.96%)	53 (17.04%)	311 (100%)
Secondary	13 (54.17%)	11 (45.83%)	24 (100%)
Total	467 (77.83%)	133 (22.17%)	600 (100%)

Chi-Square Value = 14.83, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

Analysis of data pertaining to the issue reveals relationship between educational attainment and the belief. 73.96% of the respondents who have no formal schooling keep the occurrence of such diseases confidential and 82.96% of the primary educated also come under this category. However, among secondary educated respondents only 54.17 % believe that confidentiality must be kept in the matter. The necessity for keeping the matter confidential is more felt by the primary educated ruralites and least by the secondary educated group.

It is well known that in any group those who occupy the middle position will be more constrained by beliefs and practices. This is the truism here too.

### **6.2.3. Income Status and Belief Regarding Keeping Disease Condition Confidential**

Analysis 6.2.3 enquires into the nature of the relationship between income status and the belief regarding disclosing of diseased

condition. The analysis reveals that there is a patterned relationship between the variables. It is seen that as income increases the tendency to keep the occurrence of such diseased condition confidential increase.

**Table 6.2.3.**

Income Status and Belief Regarding Keeping Diseased Condition Confidential

Income (Monthly in Rs.)	Up hold the belief	Do not uphold the belief	Total
Up to 1000 (Low)	70 (63.06%)	41 (36.94%)	111 (100%)
1000 – 2000 (Middle)	183 (70.93%)	75 (29.07%)	258 (100%)
2000 & above (Upper)	214 (92.64%)	17 (7.36%)	231 (100%)
Total	467 (77.83%)	133 (22.17%)	600 (100%)

Chi-Square Value = 50.52, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

It is to be inferred that those from higher income groups are more conscious about the stigma attached to type of diseases and hence more reluctant to disclose the occurrence of the diseases in their families.

#### **6.2.4. Socio–Economic Status and Belief Regarding Keeping Diseased Condition Confidential**

Socio–Economic status of rural people is assumed to have association with the belief of keeping certain diseases confidential. Analysis of the data (Table 6.2.4) supports the assumption.

**Table 6.2.4**

Socio – Economic Status and Belief Regarding Keeping Diseased Condition  
Confidential

Socio-Economic status (Score)	Up hold the belief	Do not uphold the belief	Total
Low (below 20)	113 (70.19%)	48 (29.81%)	161 (100%)
Medium (20-30)	336 (81.75%)	75 (18.25%)	411 (100%)
High (30 & Above)	18 (64.29%)	10 (35.71%)	28 (100%)
Total	467 (77.83%)	133 (22.17%)	600 (100%)

Chi-Square Value = 12.09, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

It is seen in the analysis that the middle socio-economic status group is more reluctant to reveal the occurrence of stigma carrying diseases. 81.75% of the group comes under this category. The belief is a bit lesser among the low socio-economic status group and least among the high socio-economic status group. As we have highlighted in analysis 6.2.2., the middle category among the status groups usually shows more allegiance to the societal beliefs and social norms. This may be the reason here too for the difference in the responses.

### 6.2.5. Family Size and Belief Regarding Keeping Diseased Condition Confidential

Enquiry into the nature of relationship existing between family size and the belief revealed that the two dimensions are associated. It is seen that 85.40% of the small families (number of members below 5) try to keep stigma carrying diseases confidential. The other two categories almost uphold the same outlook. 73.03% of the medium sized and 74.29% of the larger families keep the matter concealed. Significance in the difference of relationship is indicated by the test statistic.

**Table 6.2.5.**

Family Size and Belief Regarding Keeping Diseased Condition Confidential

Family Size (number of members)	Up hold the belief	Do not uphold the belief	Total
Small Family (Below 5)	193 (85.40%)	33 (14.60%)	226 (100%)
Medium size Family (5-7)	222 (73.03%)	82 (26.97%)	304 (100%)
Large family (8 and above)	52 (74.29%)	18 (25.71%)	70 (100%)
Total	467 (77.83%)	133 (22.17%)	600 (100%)

Chi-Square Value = 12.08, df =2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

An interpretation of the results should take into account the higher social value of members when their number in the family, is few. We can understand that the news relating to stigma carrying diseases shall lower

the social value of the member who is suffering from it. Since the small size family is more concerned about keeping the social value of its members high, such family will be more reluctant to reveal the occurrence of such diseases to others. Analyses revealed that there exists no association between such background variables as sex, age, marital status and occupation with the belief. Hence details of the analyses are most given here.

### **6.3. Belief Relating to the Cause of Sexually Transmitted Diseases (STDs)**

Sexually Transmitted Diseases are major public health problem. STDs produce considerable wastage of manpower besides untold misery, brought directly and indirectly through the complications they produce (Guptha, 2003:225).

Another index selected to analyze the nature of belief of the rural people regarding health and disease was the one related to the cause of Sexually Transmitted Diseases (STDs).

Enquiry into the reason for the occurrence of STDs, according to the rural people brought forth four major responses, namely, breach of taboo, result of past sin, heredity and irresponsible sex (unprotected sexual relationship). Breach of Taboo includes marriage within prohibited degrees and disrespect shown to fertility gods & goddess. Past sin means pre-and extramarital sex and cheating the other party in a marriage settlement. Sex life without taking precaution against contagious diseases is considered as

irresponsible sex. Transmission from generation to generation comes under hereditary reason.

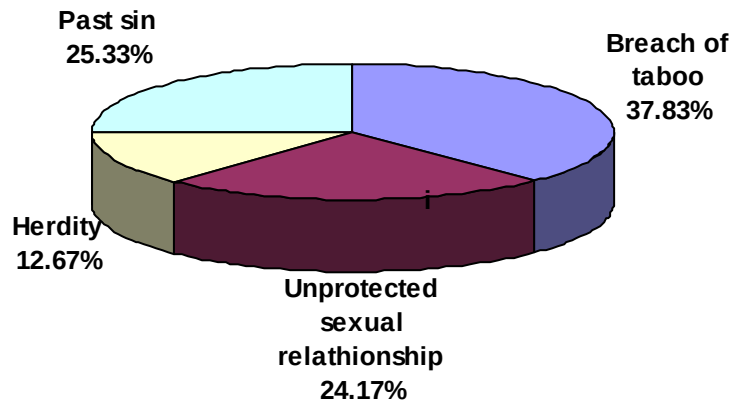
Analysis of the collected data reveals that 37.83% believe that it is the outcome of breach of taboos and 25.33% believe that it is the result of past sin. 24.17% have the belief that STDs occur as a result of unprotected sex relationships. A meager portion (12.67%) believes that the diseases occur due to hereditary reasons (Table 6.3.1).

This study concludes that the rural people of Kerala uphold the belief that STDs occur due to non-physical reasons. It is to be noticed that only about one fourth of the respondents stated that it is a contagious disease and mainly spread by unprotected sexual activities.

Kerala claims to have attained 100% literacy and have one of the best systems of Public Health Care. However, rural people who constitute around 70% of the state population do not know how STD occurs. Then how can we prevent sexually transmitted diseases including AIDS?

Subsidiary analyses were conducted to reveal the relationship of the belief with the background variable and are given in the ensuing sections.

**Diagram 6.3**  
**Belief relating to the Cause of STDs**



### 6.3.1. Religious Affiliation and Belief Relating to the Cause of STDs

The analysis carried out to find out the nature of relationship of the belief to the religious background of the people is shown in Table 6.3.1.

According to the analysis among Hindus (Forward) and Christians an equal proportions (44.67% and 44.64% respectively) uphold the belief that breach of taboo is the reason for the spread of the disease. They are the highest portions of the respective groups. Similarly, the highest portion of Muslims (30.84%) also believes that breach of taboo is the reason for the disease. Almost equal portions of the Hindu (Backward) community subscribe to the belief that past sin, breach of taboo and irresponsible sex are the reasons for the occurrence of the disease. The real channel of spread, namely, unprotected sex is not much emphasized by any of the groups, but their general faith is that the reason lies in the non permitted deeds of the individual concerned.

**Table 6.3.1**

Religious Affiliation and Belief relating to the Cause of STDs

Religious Affiliation	Breach of Taboo	Unprotected sexual	Herdity	Past Sin	Total
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	relation				
Hindu (Forward)	130 (44.67%)	64 (21.99%)	23 (7.90%)	74 (25.43%)	291 (100%)
Hindu (Backward)	39 (26.71%)	42 (28.77%)	24 (16.44%)	41 (28.08%)	146 (100%)
Christian	25 (44.64%)	18 (32.14%)	7 (12.50%)	6 (10.71%)	56 (100%)
Muslim	33 (30.84%)	21 (19.63%)	22 (20.56%)	31 (28.97%)	107 (100%)
Total	227 (37.83%)	145 (24.17%)	76 (12.67)	152 (25.33%)	600 (100%)

Chi-Square Value = 32.51, df = 9, Table Value = 21.66 ,  $p \leq 0.01$

The association is significant.

### 6.3.2. Educational Status and Belief Relating to the Cause of STDs

It is assumed that educational status of the rural people and their belief regarding the cause of STDs are associated. The collected data was analysed as shown in Table 6.3.2.

**Table 6.3.2**  
Educational Status and Belief Relating to the Cause of STDs

Education Status	Breach of Taboo	Unprotected Sexual relation	Hereditiy	Past Sin	Total
No formal schooling	96 (36.23%)	66 (24.90%)	42 (15.85%)	61 (23.02%)	265 (100%)
Primary	127	68	27	89	311



	(40.84%)	(21.86%)	(8.68%)	(28.62%)	(100%)
Secondary	4 (16.67%)	11 (45.83%)	7 (29.17%)	2 (8.33%)	24 (100%)
Total	227 (37.83%)	145 (24.17%)	76 (12.67%)	152 (25.33%)	600 (100%)

Chi-Square Value = 24.97, df =6, Table Value = 16.812,  $p \leq 0.01$   
The association is significant.

The analysis (Table 6.3.2) reveals that the major portions of the illiterate (no formal schooling) and primary educate respondents (36.23% and 40.84% respectively) are of the opinion that the cause of STDs is breach of taboo. 23.02% and 28.62% respectively of the groups believe that STDs are caused by past sin. Among the secondary educated respondents 45.83% believe that the cause of STDs is unprotected sexual relationship. They constituted the major section of the group. Among them only 16.67% and 8.33% respectively come under the categories of those who believe that the disease is the result of breach of taboos and past sin.

On a consolidation of the results it can be concluded that the lesser educated subscribes to blind faiths regarding the cause of the disease.

### **6.3.3. Income Status and Belief Relating to the Cause of STDs**

The data further analysed to test the relationship between income and belief relating to the cause of STDs. It is seen that majority of the middle and high income groups strongly expressed their opinion that cause of STDs is breach of taboo. A meager portion (13.51%) of the lowest income bracket (up

to Rs.1000) believes that breach of taboo is the reason for the disease. The analysis shown in Table 6.3.3.

**Table 6.3.3.**  
Income Status and Belief Relating to the Cause of STDs

Income (Monthly in Rs.)	Breach of Taboo	Unprotected Sexual relation	Heredity	Past Sin	Total
Up to 1000	15 (13.51%)	39 (35.14%)	20 (18.02%)	37 (33.33%)	111 (100%)
1000 – 2000	96 (37.21%)	56 (21.71%)	48 (18.60%)	58 (22.48%)	258 (100%)
2000 and above	116 (50.22%)	50 (21.64%)	8 (3.46%)	57 (24.68%)	231 (100%)
Total	227 (37.83%)	145 (24.17%)	76 (12.67%)	152 (25.33%)	600 (100%)

Chi-Square Value = 62.33, df =6, Table Value = 16.812,  $p \leq 0.01$

The association is significant.

Another important fact revealed in the analysis is that more than 50% of the middle and high-income groups find irrational factors ('Breach of taboo' and 'Past Sin' taken together) as the reasons behind the spread of STD. Those who subscribe to such reasons among the low-income groups come only below 50%. Further 35.14% of the low-income group believes that unprotected sex is the reason for STD. The corresponding figures in respect of the middle and high-income groups are only 21.71% and 21.64% respectively. That is, the low-income group recognizes the true reason for STD to a greater extent. The group may be more involving in unprotected sex and getting the

disease. Hence they may be consulting medical practitioners more and in this process they may be getting aware of the true reason.

#### 6.3.4. Occupational Status and Belief Relating to the Cause of STDs

Occupational situations are generative of beliefs and hence it may be postulated that occupational status and beliefs systems are associated.

This study enquired into the relationship between the occupational status and belief relating to the cause of STD.

Analysis (Table 6.3.4) reveals that the salaried respondents are more aware about the real cause of the diseases (34.62%). Though their responses have no scientific basis, the salaried group distinguished itself among those occupational groups who come under the response category, ‘Hereditary reasons’. While around 11% of other occupational groups highlighted this reason, 21.15% of the salaried group indicated this reason. It is to be again pointed out that the portion of the salaried group who come under the response group, ‘Breach of taboo’ is at par with other groups. However, the salaried group’s presence under ‘Past Sin’ category is rather very little.

**Table 6.3.4**

Occupational Status and Belief Relating to the Cause of STDs

Occupational Status	Breach of Taboo	Un protected Sexual relation	Heridity	Past Sin	Total
Manual Labour	117 (35.78%)	75 (22.94%)	40 (12.23%)	95 (29.05%)	327 (100%)
Skilled	53	34	15	30	132

				(22.73%)	
Labour	(40.15%)	(25.76%)	(11.36%)		(100%)
Salaried	20	18	11	3	52
	(38.46%)	(34.62%)	(21.15%)	5.77%	(100%)
Business	37	18	10	24	89
	(41.57%)	(20.22%)	(11.24%)	(26.97%)	(100%)
Total	227	145	76	152	600
	(37.83%)	(24.17%)	(12.67)	(25.33%)	(100%)

Chi-Square Value = 17.57, df = 9, Table Value = 16.919,  $p \leq 0.05$

The association is significant.

### 6.3.5. Socio-Economic Status and Belief Relating to the Cause of STDs

Another analysis was carried out to find out the relationship between the Socio-Economic Status and the belief patterns.

**Table 6.3.5.**

Socio-Economic Status and Belief Relating to the Cause of STDs

Socio Economic Status (Score)	Breach of taboo	Unprotected Sexual relation	Heredity	Past Sin	Total
Low (Below 20)	45 (27.95%)	42 (26.09%)	26 (16.15%)	48 (29.81%)	161 (100%)
Medium (20-30)	177 (43.07%)	87 (21.17%)	47 (11.44%)	100 (24.33%)	411 (100%)
High (30 & above)	5 (17.86%)	16 (57.14%)	3 (10.71%)	4 (14.29%)	28 (100%)
Total	227 (37.83%)	145 (24.17%)	76 (12.67)	152 (25.33%)	600 (100%)

Chi-Square Value = 29.36, df = 6, Table Value = 16.812,  $p \leq 0.01$

The association is significant.

It is identified from the analysis that the people who have medium SES are more prone to the unscientific faith that ‘breach of taboo’ is the cause of STD. Contrary to this, it is significant to point out that majority of the high SES group (57.14%) identify the true reason for the spread of STD, namely, unprotected sex. It is interesting to note that the low SES group is more aware about the real reason for STD spread than the middle SES group is. The higher awareness of the high SES group about the real reason may be due to the influence of the education component of the SES scores. Similarly, as already pointed out in the analysis No. 6.3.2, the low SES group may be consulting with medical practitioners frequently and this makes them more aware about the spread of the disease.

### **6.3.6. Family Size and Belief Relating to the Cause of STDs**

In small families members may be interacting one another to a greater extent. Therefore, it is to be inferred that the small family may be having more rational understanding about health and disease.

But an analysis undertaken scraps the assumption. The analysis (Table 6.3.6.) shows that members from larger families are more aware about the reason for the spread of STD. It is further seen that the scientific awareness increases with increase in the family size.

**Table 6.3.6**

Family Size and Belief Relating to the Cause of STDs

Family Size (No. of	Breach of Taboo	Unprotected Sexual relation	Hereditiy	Past Sin	Total
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members)					
Below 5 (Smaller)	111 (49.12%)	40 (17.70%)	19 (8.41%)	56 (24.77%)	226 (100%)
5 – 7 (Medium)	93 (30.59%)	84 (27.63%)	49 (16.12%)	78 (25.66%)	304 (100%)
8 & above (Larger)	23 (32.86%)	21 (30.00%)	8 (11.43%)	18 (25.71%)	70 (100%)
Total	227 (37.83%)	145 (24.17%)	76 (12.67)	152 (25.33%)	600 (100%)

Chi-Square Value = 24.91, df = 6, Table Value = 16.812,  $p \leq 0.01$

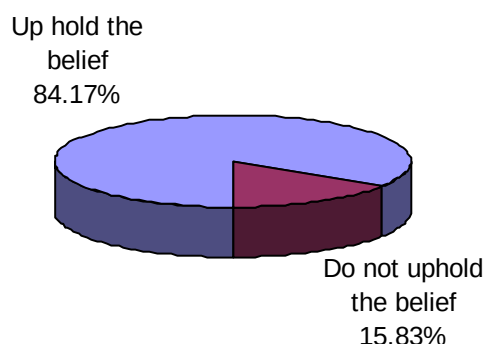
The association is significant.

The reason for this contradiction may be the communication ban on matters relating to sex among the family members. In Indian families talk and discussion about sex and related matters are prohibited. So, even when there are members who are competent to impart the awareness, the tradition blocks the dissemination of the knowledge. This is particularly true when the relationship is straight like father – son, brother – sister etc. In larger families the relationship may be indirect and more information exchange may be taking place on matters including sex life. Background variables such as sex, age, education, marital status, occupation and income are not indicated as association with the belief.

#### **6.4. Belief Relating to Auspicious Day for Beginning Treatment**

Rural society gives much emphasis on auspicious days to start with some important activities. In this study the perspectives of Kerala rural society on starting with medical treatments on particular days were analysed.

**Diagram 6.4**  
**Showing Specific Day for Beginning Treatment**



The respondents were asked to reveal, whether they select auspicious days to begin with medical treatments. The responses of 84.17% were affirmative and the rest (15.83%), negative. This indicates that the rural population is very much observing the significance of auspicious days in the matter (Table 6.4.1).

#### **6.4.1. Income Status and Belief Relating to Specific Day for Beginning Treatment**

Low-income status is a fertile ground for breeding irrational belief and activities. In this situation too, it was assumed that the principle remains true.

**Table 6.4.1**

Income Status and Belief Relating to Specific Day for Beginning Treatment

Income (Monthly in Rs.)	Uphold the belief	Do not uphold the belief	Total
Below 1000 (Low)	79 (71.17%)	32 (28.83%)	111 (100%)

1000-2000 (Middle)	223 (86.43%)	35 (13.57%)	258 (100%)
2000 & above (Upper)	203 (87.88%)	28 (12.12%)	231 (100%)
Total	505 (84.17%)	95 (15.83%)	600 (100%)

Chi-Square Value = 17.45, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

An analysis conducted (Table 6.4.1) questions the sustenance of the relationship. Table 6.4.1 indicates that 71.17% of the lowest income category (below Rs.1000) upholds the belief that it is good to observe auspicious day to start with medical treatment. The corresponding figures in respect of the middle and high-income groups are still higher than that of the low-income group (respectively 86.43% and 87.88%) Test statistic confirms the relationship.

The reason for the unexpected relationship may be that the low-income group has to work hard to satisfy their economic needs. So whichever day becomes convenient for them they initiate their treatment and do not wait for a particular day.

#### **6.4.2. Socio-economic Status and Belief Relating to Specific Day for Beginning Treatment**

Another analysis was carried out to find out the effects of the composites of the socio-economic factors (SES) as a whole on this belief.



The results show that income and SES have similar effects on the belief but with certain differences (Table 6.4.2 and 6.4.3). In the case of income the middle and high group indicate similar outlook. But in the case of SES, the low and high SES groups come closer in their belief. Comparing with the middle SES group, they are not so particular in observing auspicious days for beginning medical treatment.

**Table 6.4.2.**

Socio-economic Status and Belief Relating to Specific Day for Beginning Treatment

Socio-Economic Status (Score)	Uphold the belief	Do not uphold the belief	Total
Low (Score Below 20)	128 (79.50%)	33 (20.50%)	161 (100%)
Medium (20-30)	356 (86.62%)	55 (13.38%)	411 (100%)
High (30 & above)	21 (75.00%)	7 (25.00%)	28 (100%)
Total	505 (84.17%)	95 (15.83%)	600 (100%)

Chi-Square Value = 6.25, df = 2, Table Value = 5.991,  $p \leq 0.01$

The association is significant.

The explanation given in the previous section may be applicable in the case of low SES group too. In the case of high SES group it is to be presumed that their higher income coupled with higher education and better occupation, makes them more logical and rational in the matter. More over, they may be busy persons who have no time to observe omens and auspicious days.

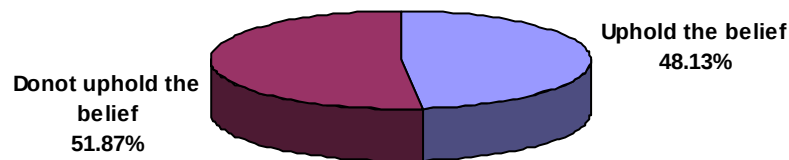
## **6.5 Belief in the Blessed Talent of Medical Practitioners for Curing Diseases. (*Kaippunnyam*)**

Rural people fondle many irrational ideas about health and disease. In this study another theme analysed by the investigator was the concept of blessed talent of a medical practitioner, in the local language (Malayalam) called *Kaippunnyam*. It is the belief that certain medical practitioners have a God ordained capacity to cure diseases of their patients. Whatever methodology or whatever medicine applied will be highly effective for their patients. The same approach and medicine resorted to by another practitioner who has no such blessings need not be effective.

The belief of the respondents relating to this capacity of the medical practitioner was analysed in details as an index of belief of rural people regarding health and disease.

On an enquiry 48.16% of the respondents revealed that they have faith in the blessed talent of the medical practitioner for treating (*Kaippunnium*) and the rest (51.84%) have no such faith. The statistical information inductively indicates that the rural population of Kerala have strong belief regarding the innate and blessed talent of medical practitioners for curing diseases (Table 6.5.1).

### **Diagram 6.5. Medical Practitioners Talent**



### 6.5.1. Religious Affiliation and Belief in the Blessed Talent of Medical Practitioners Curing Diseases. (*Kaippunnyam*)

Further analysis of the data revealed that religious affiliation of the respondents and their belief in *Kaippunnyam* are associated. The belief is strong among Backward Hindus and weak among Muslims. Christians come next to Backward Hindus. Forward Hindus are just below Christians in the hierarchical order. The Backward Hindus are closer to irrational religious faiths and this may be influencing them in this matter too. But followers of the rational semitic religion, Christians come next to the Backward Hindus and it is not very easy to explain the result without further enquiries.

**Table 6.5.1.**  
***Religious Affiliation and Belief in the Blessed Talent of Medical Practitioners for Curing Diseases*** (*Kaippunnyam*)

Religious affiliation	Uphold the belief	Do not uphold the belief	Total
Hindu (Forward)	123 (42.27%)	168 (57.73%)	291 (100%)
Hindu (Backward)	95 (65.07%)	51 (34.93%)	146 (100%)
Christian	28 (50.00%)	28 (50.00%)	56 (100%)
Muslim	43	64	107

	(40.19%)	(59.81%)	(100%)
Total	289	311	600
	(48.17%)	(51.83%)	(100%)

Chi-Square Value = 23.57, df = 3, Table Value = 11.345,  $p \leq 0.01$

The association is significant.

### 6.5.2. Income Status and Belief in the Blessed Talent of Medical Practitioners for Curing Diseases. (*Kaippunyam*)

Analysis in Table 6.5.2 was to enquire into whether there is association between economic status (income) and the belief regarding *Kaippunyam*. As revealed in the analysis majority of the low and middle-income groups have faith in the inexplicable curing capacity of medical practitioners (59.46% and 52.33% respectively). It is in the other way round in the case of the high-income group. 61.90% (majority) stated that they do not uphold the *Kaippunyam* proposition. The pattern of association between the variables is into the tune with the usual interconnection between the variable. That is, the higher income bracket has lesser faith in the irrational perspectives.

**Table 6.5.2.**  
***Income Status and Belief in the Blessed Talent of Medical Practitioners for Curing Diseases (Kaippunyam)***

Monthly Income (in Rs.)	Uphold the Belief	Do not uphold the belief	Total
Low (Below 1000)	66 (59.46%)	45 (40.54%)	111 (100%)
Medium (1000-2000)	135 (52.33%)	123 (47.67%)	258 (100%)
Upper (2000& above)	88 (38.10%)	143 (61.90%)	231 (100%)

Total	289	311	600
	(48.17%)	(51.83%)	(100%)

Chi-Square Value = 16.84, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

### 6.5.3. Socio- Economic Status and Belief in the Blessed Talent of Medical Practitioners for Curing Diseases (*Kaippunyam*)

While an analysis was carried out to discern relationship, if any, existing between SES and the belief, unexpected results are got. Usually, income and SES should have same pattern of relationship with the dependent variables. In the case of relationship between income status and the belief (Analysis Table 6.5.2.) it was seen that the lower and middle groups show strong faith in *Kaippunyam*. Regarding Socio-Economic Status a reverse relationship is revealed. 78.57% of the high SES group adhere to the belief while only 21.43% dissociate from the faith.

**Table 6.5.3.**

#### ***Socio-Economic Status and Belief in the Blessed Curing Quality of Medical Practitioners (Kaippunyam)***

Socio-Economic Status (SES) (Score)	Uphold the belief	Do not uphold the belief	Total
Low (Score blow20)	78 (48.45%)	83 (51.55%)	161 (100%)
Medium (20-30)	189 (45.99%)	222 (54.01%)	411 (100%)
High (30 and above)	22 (78.57%)	6 (21.43%)	28 (100%)
Total	289 (48.17%)	311 (51.83%)	600 (100%)

Chi-Square Value = 11.16, df = 2, Table Value = 9.210,  $p \leq 0.01$

The association is significant.

Education and occupation are the two strongest components added to income status to construct SES. So shall we conclude that higher education and better occupation are fostering the faith of *Kaippunyam*. Further enquiries are necessary to clarify the doubt.

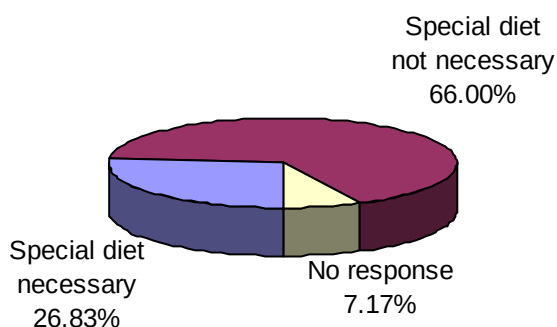
Other background variables such as sex, age, education and occupation are not associated with the blessed talent of medical practitioners for curing disease.

## **6.6. Diet of Pregnant Ladies**

Scientific knowledge reveals that a pregnant lady requires special treatments during the pregnancy and child rearing stages. Regarding the dietary of a pregnant lady the primary truth is that she requires more food to give proper nourishment to the foetus. Special foodstuffs are also to be included in her dietary. Considering all these aspects in this study the respondents were asked, whether they believe that pregnant lady requires special dietary. Their responses clustered under three categories, namely, she requires, do not think so and do not know. Analysis of the responses revealed astonishing results regarding their perspectives. A strong majority (66%) do not believe that a pregnant lady requires special dietary, only 26.83% believe so and 7.17% do not know whether such a need exist for woman during her pregnancy (Table 6.6.1). The result indicates that even though Kerala ruralities are literates their beliefs in health care matters are not very much in tune with scientific knowledge.

Secondary analyses showed that two background variables are associated with the dependent variable. Details of the association are discussed below:

**Diagram 6.6.**  
**Belief Relating to the Dietary of Pregnant Woman**



### **6.6.1. Sex Difference and Belief Relating to the Dietary of Pregnant Woman**

Belief regarding the necessity of special dietary for pregnant woman was assumed to have association with sex. As it is a matter connected with females the knowledge (belief) should be stronger among women.

However, the result of the analysis of data revealed that the females have lesser belief in the necessity of special dietary for pregnant woman. Table 6.6.1 indicates that while 63.56% of the male do not believe that special diet is necessary for pregnant woman, the corresponding figure in respect of female is as high as 78.95%.

**Table 6.6.1**

Sex Difference and Belief Relating to the Dietary of Pregnant Woman

Sex	Special diet necessary	Special diet not necessary	No response	Total
Male	146 (28.91%)	321 (63.56%)	38 (7.52%)	505 (100%)
Female	15 (15.79%)	75 (78.95%)	5 (5.26%)	95 (100%)
Total	161 (26.83%)	396 (66.00%)	43 (7.17%)	600 (100%)

Chi-Square Value = 8.57 df = 2, Table Value = 5.991,  $p \leq 0.05$

The association is significant.

It is the general impression of rural community that pregnancy, childbirth and related matters are not issues to be discussed in public. This outlook may be influencing the female folk to a greater extent and hence the result.

Since many of them had experienced enhanced hunger during pregnancy period, they naturally should know the necessity for more food, if do not know other details. Then the reason for not revealing those experiences at least may be the result of the restraints of the general outlook mentioned above.

### 6.6.2. Age Status and Belief Relating to the Dietary of Pregnant Woman



Another variable which showed association with the belief is age status of the respondents (analysis in Table 6.6.2.). There is a very systematic pattern discernable in the responses, viz., the younger age groups are stronger in their belief that pregnant woman should have special food habit. However, even among the youngest group (below 30 years) the largest portion comes under the category of those who do not believe in special diet pattern of pregnant woman.

**Table 6.6.2**

Age Status and Belief Relating to the Dietary of Pregnant Woman

Age Status (in years)	Special diet necessary	Special diet not necessary	No response	Total
Below 30	25 (41.67%)	26 (43.33%)	9 (15.00%)	60 (100%)
30-60	117 (25.71%)	307 (67.47%)	31 (6.81%)	455 (100%)
60 & above	19 (22.35%)	63 (74.12%)	3 (3.53%)	85 (100%)
Total	161 (26.83%)	396 (66.00%)	43 (7.17%)	600 (100%)

Chi-Square Value = 18.2 df = 4, Table Value = 13.277  $p \leq 0.01$   
The association is significant

This indicates that the rural community of Kerala is lacking proper perspectives on the matter.

### Summary

In this chapter the beliefs of the rural community relating to health and diseases were analysed by taking six indices. The indices selected

are beliefs regarding cause of mental illness, reason for the occurrence of STDs, confidentiality about certain types of diseases, observance of auspicious days for starting with treatment, *Kaippunyam* of medical practitioner and food requirements of pregnant woman. The analyses revealed that rural people are upholding wrong beliefs in the matters. Regarding the influence of the background variables, it is seen that income, socio-economic status and religious affiliation are strongly influencing the beliefs.

## **CHAPTER - VII**

### **AWARENESS ABOUT HEALTH AND DISEASE**

In the evolution of a society acquisition of knowledge and application of it in practical situation are key factors. Awareness is the first stage in the formulation of proper knowledge system. Health and disease are complex stages in the biological process of human beings. The knowledge level of common people, especially rural people, in these matters may not be very high. So in this study emphasis was given on the awareness of rural people about health and disease. Hence enquiries were conducted and the responses analysed relating to the awareness of the people. The details of the analyses are discussed in the following sections.

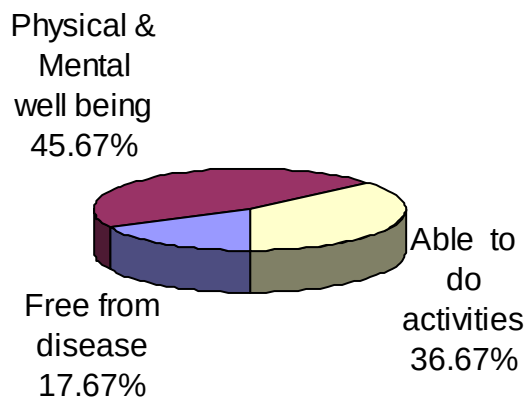
#### **7.1. Concept of Health**

The concept of health is defined in terms of the physical, mental and social well – being of human beings. However, by and the large, understanding of the phenomenon is usually based on the physical dimension only. In this study an enquiry was conducted to know, how the rural people visualize the matter.

The analysis of the collected data reveals that 17.67 % of the respondents consider health as a state where in there is no disease. 45.67% consider health as the total well being and the rest (36.67%) as the capability to do day-to-day activities (Refer to Table 7.1.1.).

The analysis reveals that the largest portion of the respondents is aware of the true dimension of the matter. So we have to conclude that rural peoples' understanding of health is, by and large, realistic. However, it is to be remembered that a very substantial portion of them only takes into consideration the bodily aspect.

**Diagram 7.1**  
**The Concept of Health**



### **7.1.1 Religious Affiliation and Understanding of the Concept of Health**

Religious background of people tells upon their knowledge and practice. Here it was assumed that the understanding of the people on the matter is associated to the religious affiliation.

Analysis reveals (Table 7.1.1) that the assumption is sustainable. It is seen that 50% of the Christians and 47.42% of the Forward Hindus conceive

health in the true prospective. Hindu (Backward) comes just below the two groups in the context (45.21%). Only 39.25% of the Muslims understand the phenomenon in its entity.

**Table 7.1.1**

**Religions Affiliation and Understanding of the Concept of Health.**

Religious Affiliation	Free from disease	Physical & Mental well being	Able to do activities	Total
Hindu (Forward)	29 (9.97%)	138 (47.42%)	124 (42.61%)	291 (100%)
Hindu (backward)	35 (23.97%)	66 (45.21%)	45 (30.82%)	146 (100%)
Christian	12 (21.43%)	28 (50.00%)	16 (28.57%)	56 (100%)
Muslim	30 (28.04%)	42 (39.25%)	35 (32.71%)	107 (100%)
Total	106 (17.67%)	274 (45.67%)	220 (36.67%)	600 (100%)

Chi-Square = 27.04, df = 6, Table Value = 16.812,  $p \leq 0.01$

The association is significant.

In health related matters Christian community had been showed a deep interest and understanding. The backwardness of the Muslim community in health and hygiene is well recognized in our society. However, it is a matter of concern that have stand below even the backward classes of the Hindu community.

**7.1.2. Educational Status and the Understanding of the Concept of Health**

Education is the processes of gathering knowledge on matters that come across to humans. So those who have better education will have good knowledge about various matters and here the relationship between educational background of rural people and their understanding of the concept of health was assumed; the better educated have more perfect knowledge of the concept of health. To establish the relationship empirically the collected data was analysed as shown in Table 7.1.2.

**Table 7.1.2**

Education Status and Understanding of the Concept of Health				
Education status	Free from disease	Physical & Mental well being	Able to do activities	Total
No formal schooling	44 (16.60%)	116 (43.77%)	105 (39.62%)	265 (100%)
Primary	48 (15.43%)	151 (48.55%)	112 (36.01%)	311 (100%)
Secondary	14 (58.33%)	7 (29.17%)	3 (12.50%)	24 (100%)
Total	106 (17.67%)	274 (45.67%)	220 (36.67%)	600 (100%)

Chi-Square = 30.21, df = 4, Table Value = 13.277,  $P \leq 0.01$

The association is significant.

The analysis in the table reveals that the proposition is true in the case of those who have informal schooling and primary educated group. 48.55% of the primary educated group and 43.77% of the first category have proper conceptualisation of the theme. However, the data relating to secondary educated category contradicts the postulate. In the case of the group it is seen that only 29.17% have proper understanding of the concept. Majority of them (58.33%)

conceptualise health as physical fitness. It seems that analytical approach is in capable of explaining the contradiction seen in the results regarding this group. Further empirical enquiries are necessary to reveal the underlying reality of the contradiction.

### 7.1.3. Occupational Status and the Understanding of the Concept of Health

Occupational status has an influence on the knowledge level of individual. In this study an analysis was carried out to find out whether the background variable has any influence on the understanding of the rural people on the concept health. Accordingly an analysis as shown in Table 7.1.3 was carried out.

The analysis reveals that 52.27% of the skilled workers, 46.15% of salaried people and 44.34% of Manual labourers have correct understanding of the concept. The Business community stands at the lowest range in the accurate understanding. Only 4.45% know properly what health is.

**Table 7.1.3**  
**Occupational Status and the Understanding of the**  
**Concept of Health**

Occupational status	Free from disease	Physical and mental activity	Able to do activities	Total
Manual Labour	50 (15.29%)	145 (44.34%)	132 (40.37%)	327 (100%)
Skilled	19	69	44	132

labour	(14.39%)	(52.27%)	(33.33%)	(100%)
Salary	18	24	10	52
person	(34.62%)	(46.15%)	(19.23%)	(100%)
Business	19	36	34	89
Men	(21.35%)	(40.45%)	(38.20%)	(100%)
Total	106	274	220	600
	(17.67%)	(45.67%)	(36.67%)	(100%)

Chi-Square = 18.89, df = 6, Table Value =16.812 ,  $P \leq 0.01$

The association is significant.

It is to be inferred that the skilled workers might have got some sort of awareness about occupational hazards and industrial health, which give a correct understanding of the concept. An explanation to the extreme backwardness of business community in the matter may be that, rural business people are, by and large, lower educated, probably illiterate, and not having any professional training. Those who have industrial or professional training will have proper perspectives on the concept.

#### **7.1.4. Income and the Understanding of the Concept of Health**

Investigation carried out into the relationship between income status and the awareness indicates that there is intimate association between the variables. Here too the concept is properly understood by the medium category to the greatest extent. 49.22% of them have proper understanding of the concept. The corresponding figures in respect of the high income (Rs.2000/-and above per month) and low-income (up to Rs.1000) categories are respectively 45.02% and 38.74%. The dominant segments of these groups understand 'health' as



conditions were in the individual is capable of carrying out their daily functions appropriately.

**Table 7.1.4**  
**Income and the Understanding of the Concept of Health**

Monthly Income (Rs)	Free from disease	Physical and mental well being	Able to do activities	Total
Up to 1000	19 (17.12%)	43 (38.74%)	49 (44.14%)	111 (100%)
1000-2000	67 (25.97%)	127 (49.22%)	64 (24.81%)	258 (100%)
2000 & above	20 (8.66%)	104 (45.02%)	107 (46.32%)	231 (100%)
Total	106 (17.67%)	274 (45.67%)	220 (36.67%)	600 (100%)

Chi-square = 40.06 df = 4, Table value=13.277,  $P \leq 0.01$

The association is significant

#### **7.1.5. Socio-Economic Status and the Understanding of the Concept of Health**

In order to reveal the combined effect of the Socio-Economic factors of the rural people on the understanding SES score was taken as the background variable and analysis of the understanding of the concept were carried out as shown in Table 7.1.5. The result was in tune with the findings of analysis 7.1.4. In this analysis it was revealed that the medium socio-economic status group has proper understanding of the concept than the other two groups have.

In this analysis it is also revealed that the high SES group lags behind the low SES group regarding correct understanding of the concept.

**Table 7.1.5**  
**Socio-Economic Status and the Understanding of the Concept of Health**

Socio-economic status (score)	Free from disease	Physical and mental Activity	Able to do activities	Total
Below 20 (Low)	25 (15.53%)	69 (42.86%)	67 (41.61%)	161 (100%)
20-29 (Medium)	66 (16.06%)	194 (47.20%)	151 (36.74%)	411 (100%)
Above 29 (High)	15 (53.57%)	11 (39.29%)	2 (7.14%)	28 (100%)
Total	106 (17.67%)	274 (45.67%)	220 (36.67%)	600 (100%)

Chi-square = 28.92 , df = 4, Table value=13.277,  $p \leq 0.01$   
The association is significant.

It may be realistic to say that the medium category (based on social and economic criteria) is particular to be closer to the normative living, whether it be relating to food, health or any thing else. This would maximize the return for their action or spending. This particular approach of the category is reflected in this analysis also.

#### **7.1.6. Family size and the Understanding of the Concept of Health**

Another analysis attempted the establishment of association between family size and the nature of understanding of the concept of health. Analysis carried out for the purpose is given in Table 7.1.6.

**Table 7.1.6**  
**Family size and the Understanding of the Concept of Health**

Family	Free from	Physical	Able to do	Total
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size	disease	and mental well being	activities	
Up to 5	28 (12.39%)	115 (50.88%)	83 (36.73%)	226 (100%)
Medium 5-8	68 (22.37%)	133 (43.75%)	103 (33.88%)	304 (100%)
Larger 8 and above	10 (14.29%)	26 (37.14%)	34 (48.57%)	70 (100%)
Total	106 (17.67%)	274 (45.67%)	220 (36.67%)	600 (100%)

Chi square = 13.87, df = 4, Table value = 9.488,  $P \leq 0.05$

The association is significant

50.88% of the small families, 43.75% of the medium size families and 37.14% of the larger size family have correct understanding of what health is. That is, the patterns is that the smaller the family size, the accurate the understanding of the meaning of health.

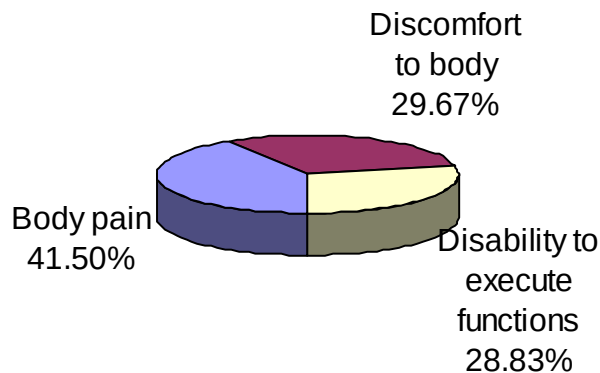
In fact, the correct understanding of the meaning of health and knowledge about the methods by which health and welfare of the family are maintained may be the causal factor of small family. That is the directions of relationship may be reversible. However, it is certain that the variables are associated very intimately.

## 7.2. Understanding of the Meaning of Disease

A second index, selected to analyse the rural peoples knowledge about health was their understanding of disease. Disease is not defined by WHO. Definitions by authors referred to on pages 12 and 13 of Chapter II, literature review reveal that, it is a condition which disable the individual to execute the normal vital functions.

In this study it was revealed that the lion's shares of the respondents understand disease as bodily discomfort (41.50%). 29.67% consider it as a discomfort to either body or mind. Finally, 28.83% of them consider it as a disability to execute the normal vital functions of individual. Inductively, it is to be understood that rural people of Kerala have a concept of disease, which is based on body pain (physical pain). Only one third of them look upon disease as a state, which disrupt the vital functions of the body, that is, in a wider perspective. Details of the analysis are shown in Table 7.2.1.

**Diagram 7.2**  
**Understanding of the Meaning of Disease**



### 7.2.1. Age and Understanding of the Meaning of Disease

An enquiry was conducted to know whether the understanding is related to the age status of the population. The data relating to the respondents was analysed as indicated in table 7.2.1.

The analysis reveals that the variables are associated. It is interesting to see that a higher portion of the upper age group (60+) has understood health in its wider meaning (32.94%). The figure corresponding to the middle age group is 29.45% and lower age group is only 18.33%. That is as age increases rural people consider the condition a broader meaning. Their impression among people especially rural that aging and disease are associated. So elderly people will take whatever deviation occurs to their normal life as disease. This may be the reason for the relationship between the variables.

**Table 7.2.1**

Age Status and Understanding of the Meaning of Disease.

Age in Years	Body pain	Discomfort To body	Disability to execute functions	Total
Up to 30 (Lower)	34 (56.67%)	15 (25.00%)	11 (18.33%)	60 (100%)
30 – 60 (Medium)	176 (38.68%)	145 (31.87%)	134 (29.45%)	455 (100%)
60 & above (Upper)	39 (45.88%)	18 (21.18%)	28 (32.94%)	85 (100%)
Total	249 (41.50%)	178 (29.67%)	173 (28.83%)	600 (100%)

Chi square value 10.69, df=4, Table Value = 9.488,  $p \leq 0.05$

The association is significant.

### 7.2.2. Educational Status and Understanding of the Meaning of the Disease

Knowledgeable persons will have correct understanding on any phenomenon. In this context it is rational to assume that the higher educated rural population have more accurate understanding about the meaning of disease.

Analysis of the data (Table 7.2.2.) shows that the assumption requires some modification. It is seen that those respondents who have no formal schooling are as good as, or better than those who have secondary education in this regard. Those who have primary education are far behind other two groups. In the case of those who have no formal schooling the figure is 33.58%, primary educated is 24.76% and secondary educated is 29.17 %. The rubbing of shoulders of the two polar groups may be due to different reasons. The illiterates do not feel any deviation in the normal state as disease and they conceptualized disease accordingly knowingly or unknowingly. In the case of more educated group their perception may be the result of rational understanding of the phenomena.

**Table 7.2.2.**

Educational Status and Understanding of the Meaning of Disease

Educational Status	Body pain	Discomfort to Body and Mind	Disability to Execute Functions	Total
No formal Schooling	91 (34.34%)	85 (32.08%)	89 (33.58%)	265 (100%)
Primary	147 (47.27%)	87 (27.97%)	77 (24.76%)	311 (100%)

Secondary	11 (45.83%)	6 (25.00%)	7 (29.17%)	24 (100%)
Total	249 (41.50%)	178 (29.67%)	173 (28.83%)	600 (100%)

Chi square 10.74, df=4, Table Value = 9.488,  $P \leq 0.05$

The association is significant.

### 7.2.3. Income Status and Understanding of the Meaning of Disease

Income wise distribution of the responses and its implications are to be interpreted as the association between the variables is confirmed. Table 7.2.3 contains the details of the distribution.

**Table 7.2.3**

Income Status and Understanding of the Meaning of Disease

Monthly Income (Rs)	Body pain	Discomfort to Body and Mind	Disability to Execute Functions	Total
Up to 1000 (Low)	23 (20.72%)	39 (35.14%)	49 (44.14%)	111 (100%)
1000-2000 (Medium)	112 (43.41%)	79 (30.62%)	67 (25.97%)	258 (100%)
2000 & above (Higher)	114 (49.35%)	60 (25.97%)	57 (24.68%)	231 (100%)
Total	249 (41.50%)	178 (29.67%)	173 (28.83%)	600 (100%)

Chi square 28.61, df=4, Table Value = 13.277,  $P \leq 0.01$

The association is significant.

It is seen that the highest segment of the low-income group (44.14%) understands disease as a condition in which the individual is incapacitated to

execute the normal functions. In the case of the other two groups, around 25% each of them come under this category and their highest segments come under the category, which considers disease as bodily discomfort (43.41% of the middle and 49.35% of the upper income groups). The analysis reveals that the low-income group consider disease as the condition, which interferes with the capacity to do vital function. That is, the group is closer to the rational explanation of disease. Usually the economically well off groups, are more closer to the rational understanding of phenomena.

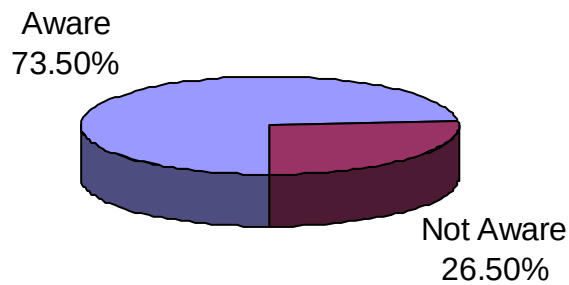
The other background variables and the perceptions are not seen associated and hence the details of the analysis are not given here.

### **7.3. Awareness Relating to Water Born Diseases**

Water is essential for the existence of life. At the same time water can become agents of health hazards, if its role is not known to us. In this study, in order to understand how far our rural population is aware about water born diseases, a question was asked to the respondents.

**Diagram 7.3.**  
**The Awareness of Water Born Disease**





Analysis of the responses reveals that 73.50% of the respondents know that many diseases can spread due to contaminated water. However, the rest of the sample (26.50%) very innocently responded that they don't know the role of water in the matter. Though an overwhelming portion of the respondents is properly aware about water born diseases it is a matter of concern that more than 25% of them do not know the role of water in spreading diseases. In a state where high literacy and health standard are prevalent the result is not expected.

### **7.3.1. Religious Affiliation and Awareness About Water Born Diseases**

Religion is an important component of culture and it is well known that culture structures human knowledge. In this study the role of religious background of rural people in the structuring of their knowledge about water born diseases was enquired into (Table 7.3.1) shows that the two variables are related. The knowledge level of Christians is the highest (80.36%) and that of Muslims the lowest (59.81%). Hindu (Forward) comes next to Hindu (Backward) in the hierarchy and those of them are below the Christian in that order.

The result follows the pattern shown in earlier analyses. The Christians are at the forefront in health care and hygiene maintenance matters. The Muslims due to their backwardness in various spheres are lagging behind other communities. But it is surprising to see that their knowledge level is even below that of backward sections of Hindus who were victims of various deprivations.

**Table 7.3.1**

Religious Affiliation and Knowledge about Water Born Diseases			
Religious Affiliation	Aware	Not Aware	Total
Hindu (Forward)	229 (78.69%)	62 (21.31%)	291 (100%)
Hindu (Backward).	103 (70.55%)	43 (29.45%)	146 (100%)
Christian	45 (80.36%)	11 (19.64%)	56 (100%)
Muslim	64 (59.81%)	43 (40.19%)	107 (100%)
Total	441 (73.50%)	159 (26.50%)	600 (100%)

Chi-Square = 16.33, df = 3, Table value =11.345,  $P \leq 0.01$

The association is significant.

### 7.3.2. Educational status and knowledge about water born disease

The analysis conducted under 7.3.1 was repeated to see how the educational status of the rural people affects their knowledge level in the matter (Table 7.3.2).

**Table 7.3.2**

Educational Status and Knowledge about Water Born Disease

Education status	Aware	Not Aware	Total
No formal Schooling	178 (67.17%)	87 (32.83%)	265 (100%)
Primary	244 (78.46%)	67 (21.54%)	311 (100%)
Secondary	19 (79.17%)	5 (20.83%)	24 (100%)
Total	441 (73.50%)	159 (26.50%)	600 (100%)

Chi-Square = 9.77, df = 2, Table value =5.991,  $P \leq 0.05$

The association is significant.

Very systematic relationship is seen to exist between the variables. The knowledge level increases from that category who has no formal schooling to the secondary educated group through the primary educated category. That is, as the level of schooling increases the knowledge level in the matter also increase. This result indicates the necessity of improving educational status of rural population.

### 7.3.3. Occupational Status and Awareness about Water Born Disease

Occupational status and awareness about water born diseases are associated variables-analysis 7.3.3 reveals. The pattern of relationship highlights that the knowledge level decreases from salaried group.86.54% of them know unclean water in an agent of spreading disease. Business category stands just below salaried group (79.78%). The lowest rung is occupied by manual labourers (68.50%) and just above them comes technically skilled employees (76.52%). The rest of the groups have no awareness about water born disease.

The awareness level of manual labourers, when they enter in to the vocation, may be rather low and the opportunity for exposing themselves to new information is also almost nil in our context. This might be the reason for their lower level of knowledge in the matter. Similar reasoning is applicable to other categories too. In the case of salaried group, their opportunity for education is higher. Hence their greater knowledge.

**Table 7.3.3**

Occupation Status and Knowledge about Water Born Disease

Occupational Status	Aware	Not Aware	Total
Manual Labourers	224 (68.50%)	103 (31.50%)	327 (100%)
Skilled Labourers	101 (76.52%)	31 (23.48%)	132 (100%)
Salaried Persons	45 (86.54%)	7 (13.46%)	52 (100%)
Business Men	71 (79.78%)	18 (20.22%)	89 (100%)
Total	441 (73.50%)	159 (26.50%)	600 (100%)

Chi-Square = 11.15, df = 3, Table value =7.815,  $P \leq 0.05$

The association is significant.

#### 7.3.4. Income Status And Awareness About Water Born Disease

An analysis to find out relationship between if any income status and the knowledge indicated association between them. There is a systematic pattern in the relationship, as the income status increases the knowledge level also increase (Table 7.3.4).

The awareness level is 53.15% in the case of low-income group and 85.71% in the case of high-income group. The figure in respect of the middle-income group is 71.32%. The higher the income the greater the knowledge level is a general principle discernable in human life. This is applicable in this context too.

**Table 7.3.4**

Income Status and Awareness about Water Born Disease

Monthly Income (Rs)	Aware	Not Aware	Total
Upto 1000 (Low)	59 (53.15%)	52 (46.81%)	111 (100%)
1000-2000 (Medium)	184 (71.32%)	74 (28.68%)	258 (100%)
2000 & above (Higher)	198 (85.71%)	33 (14.29%)	231 (100%)
Total	441 (73.50%)	159 (26.50%)	600 (100%)

Chi-Square = 41.92, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant.

### 7.3.5 Socio-Economic Status and Awareness Relating to Water Born Disease

**Table 7.3.5**

Socio-Economic Status and Knowledge Relating to Water Born Disease

Socio-economic status	Known	Not known	Total
Below 20 (Low)	96 (59.63%)	65 (40.37%)	161 (100%)
20-29 (Medium)	320 (77.86%)	91 (22.14%)	411 (100%)
Above 29 (High)	25 (89.29%)	3 (10.71%)	28 (100%)
Total	441 (73.50%)	159 (26.50%)	600 (100%)

Chi-Square = 23.50, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant.

Analysis on the basis of the consolidated measure of socio-economic status shows that it is a deterrent of the knowledge level in the matter (Table 7.3.4.). Similar pattern of association between the variables as revealed in analysis No.7.3.3 is seen in this context too. That is, the knowledge level at the low SES is lower and it increases through medium SES to high socio-economic status. This analysis is supporting the additive property of the three major components of socio-economic status viz, education, income and occupation. In the respective analyses with these background variables positive relationship is revealed. The

association is very firmly revealed in this analysis when the composite index of SES is taken as the background variable. Hence confidently we may state that the knowledge regarding health and disease of rural Keralites is much depending on their socio-economic background.

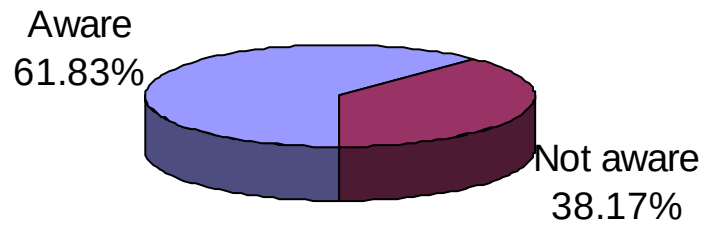
#### **7. 4. Awareness about Vector Born Disease**

Chickungunia, Dengue fever, Elephantiasis, Malaria etc. are vector born diseases. Different breeds of mosquitoes are acting as the carrier of these diseases. Though malaria is almost eradicated and elephantiasis is confined to certain pockets of Kerala state the other two are new comers that threaten the health scenario of the community, particularly in the rural areas. In this study rural people's awareness about the role of mosquitoes in spreading diseases was analysed. They were asked to reveal their knowledge about the agents which spread the disease.

When the data was analysed it was seen that 61.83% of the respondents are aware about the vectors and the after effect of the diseases. The rest of the respondents stated that they are ignorant about the vectors and their role in creating the malady. The results indicate, majority of the rural community have awareness about the role of mosquitoes in spreading the diseases. However, those who are ignorant about the matter constitute a sizable group. This should be a matter of concern for those who monitor the community health of Kerala rural population. (See table 7.4.1.)

Further analyses had been carried out to establish relationship, if any, between the background variables and the awareness. Analyses indicated that relationship exists between the awareness and such background variable as sex, religious affiliation, education, income and socio-economic status. The details of the analyses are given in the following sections

**Diagram 7.4**  
**Awareness about Vector Born Disease**



#### **7.4.1. Sex and Awareness about Vector Born Diseases**

Analysis on the relationship between sex difference and the knowledge shows that male population have an upper hand in the matter. Table 7.4.1 reveals, the known group among males is constituted by 63.56% of the sample and the corresponding figure in respect of female is 52.63%. Chi-square test indicates that there is significant association between the variables. The comparatively reduced exposure of the female rural population to these types of health hazard makes them ill informed about the matter. However, being female



members the hub of community health the revelation is to be seriously taken into account by the appropriate authorities.

**Table 7.4.1**

Sex and Knowledge about Vector Born Disease

Sex	Known	Do not known	Total
Male	321 (63.56%)	184 (36.44%)	505 (100%)
Female	50 (52.63%)	45 (47.37%)	95 (100%)
Total	371 (61.83%)	229 (38.17%)	600 (100%)

Chi-Square = 4.05, df = 1, Table value =3.841,  $P \leq 0.05$

The association is significant.

#### 7.4.2 Religious Affiliation and Knowledge about Vector Born Diseases

Religion is a component of culture, which is affecting awareness of any community relating to various themes whether traditional or current. In this context, the analysis carried out to test the relationship reveals that the background factor is firmly associated with the awareness. Hindu (Forward) community is highly aware about the role of vectors like mosquitoes in spreading diseases (69.42%). Muslims and Christians are on the same footing and come below Hindu (Forward) (57.94% and 57.14% respectively). The awareness level of Hindu (Backward) is the lowest among that of the communities.

**Table 7.4.2**

Religious Affiliation and Knowledge about Vector Born Disease

Religious	Know	Do not know	Total
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affiliation			
Hindu (Forward)	202 (69.42%)	89 (30.58%)	291 (100%)
Hindu (Backward)	75 (51.37%)	71 (48.63%)	146 (100%)
Christian	32 (57.14%)	24 (42.86%)	56 (100%)
Muslim	62 (57.94%)	45 (42.06%)	107 (100%)
Total	371 (61.83%)	229 (38.17%)	600 (100%)

Chi-Square = 15.07, df = 3, Table value = 11.345,  $p \leq 0.01$

The association is significant.

The ***Sudham-asudham*** concept of Hindu (Forward) group is very crucial in the religious ideologies of the group. So they may be acquiring knowledge about all agencies, which cause ***asudham*** to their households. This inquisitive search enabled them to identify such insects, it is to be inferred.

#### 7.4.3. Educational Status and Awareness about Vector Born Disease

Education based analysis in unequivocal terms revealed that the higher the educational attainment of the rural people the greater their awareness about harmful vectors like mosquitoes. Analysis in table 7.4.3 indicates systematic increase of knowledge level from 54.72% to 70.83% through 67.20% when move from the category of respondents who have no formal schooling to

secondary educated category through primary educated group. No further interpretation of the results is necessary, as it is well established that education is the energy behind enhancing over all knowledge of the individual.

**Table 7.4.3**

Educational Status and Awareness about Vector Born Disease

Education status	Know	Do not known	Total
No formal Schooling	145 (54.72%)	120 (45.28%)	265 (100%)
Primary	209 (67.20%)	102 (32.80%)	311 (100%)
Secondary	17 (70.83%)	7 (29.17%)	24 (100%)
Total	371 (61.83%)	229 (38.17%)	600 (100%)

Chi-Square = 10.31, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant.

#### 7.4.4 Income Status and Awareness about Vector Born Disease

The study enquired into the nature of influence of income level of the people on their awareness level. An analysis as shown in Table 7.4.4 was devised. The result shows that the awareness of the respondents and their income status are increasing in the same direction. When income increases from low-income group to high-income group the awareness level increase from 43.24% to 73.16%. The in between group (Rs. 1000-2000) indicates an awareness level of 59.69%. Statistical test confirms the significance of the association between the

variables. The result is generalized as the sample is sufficiently large (N=600). The result support the general norm that development is the panacea for awareness inculcation and inducing action based on the awareness.

**Table 7.4.4.**

Income Status and Awareness about Vector Born Disease

Income (in Rupees)	Known	Unknown	Total
Up to 1000	48 (43.24%)	63 (56.76%)	111 (100%)
1000-2000	154 (59.69%)	104 (40.31%)	258 (100%)
2000 & Above	169 (73.16%)	62 (26.84%)	231 (100%)
Total	371 (61.83%)	229 (38.17%)	600 (100%)

Chi-Square = 29.32, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant

#### **7.4.5. Socio-Economic Status and Awareness about Water Born Disease**

Socio-Economic Status (measured in terms a score) is an indicator of a composite of different components that pushes one to progress. So a similar results to the one got from the previous analysis (7.4.4.) is expected in this section. The expectation is almost fulfilled in the analysis. It is seen that the awareness improves from low SES to high SES. There is no much difference between the awareness level of the medium and high SES groups; not only that it is seen that the medium SES group has slight edge over the high SES group. The results

confirm the role of over all development in inculcating right knowledge relating to health and hygiene maintenance of rural population.

**Table 7.4.5**

Socio-Economic Status and Knowledge about Water Born Disease

Socio-economic Status (score)	Aware	Not Aware	Total
Below 20 (Low)	79 (49.07%)	82 (50.93%)	161 (100%)
20-29 (Medium)	274 (66.67%)	137 (33.33%)	411 (100%)
Above 29 (High)	18 (64.29%)	10 (35.71%)	28 (100%)
Total	371 (61.83%)	229 (38.17%)	600 (100%)

Chi-Square = 15.26, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant

## **7.5 Awareness about the Importance of Foot Ware in Health and Hygiene Maintenance**

Another index to assess the awareness of health and hygiene maintenance of rural population was the importance of using foot ware. Traditional rural society had certain unfounded notions about the importance of keeping certain parts of our body clean and healthy. One such part was leg, particularly feet. The concept was that the feet are for walking and walking anywhere. People used to walk in dirt and mud whether infected with dangerous

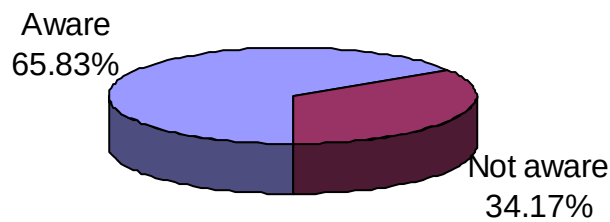
micro-organisms. People would get wounded by stones and thistles. Inflamated wounds were common on the leg, particularly of children.

Now things have changed for the better. It is the modern perception that leg and feet are to be protected as we do in the case of face. One method suggested by community medical practitioners and extension workers is the use of footwear. When you go outside your house, use convenient and suitable foot wares.

In this study an enquiry was carried out to assess how far the rural people are aware about the importance of foot wares.

The data when analysed reveals that 65.83% of the samples are quiet aware about the importance of using foot ware. However, more than 1/3<sup>rd</sup> are ignorant about the matter. This result indicates that rural people of Kerala are not up to the mark in the matter. Intensive extension work is to be conducted among ruralities, who are away from the modern health care systems.

**Diagram 7.5**  
**Awareness about Importance of using Foot Ware**



### 7.5.1 Age Status and Awareness about the Importance of using Foot Wares

An analysis (Table 7.5.1.) carried out to find out the relationship between age status and the awareness revealed an interesting result. It shows that among the old age group the awareness is greater and among the middle age group it is comparatively the least. The proportion of the known groups of the respective categories are 78.82% and 63.30%. The low age group comes in between the other two groups. 66.67% know that foot wares are very important to keep infected diseases away and to protect feet from wounds and cuts.

Contrary to the expectation the old age group stands far ahead of the two other groups. The old groups may be always in search of methods and medicines to prevent their health from unduly drawn out since they know old age is prone to health hazards. More over they may be more attended to by health practitioners. These are opportunities for them to gather information on proper health care practices.

**Table 7.5.1**

Age status and Awareness about the Importance of using Foot Wares

Age	Aware	Not aware	Total
Up to 30	40 (66.67%)	20 (33.33%)	60 (100%)
30 to 60	288 (63.30%)	167 (36.70%)	455 (100%)
60 & Above	67 (78.82%)	18 (21.18%)	85 (100%)
Total	395 (65.83%)	205 (34.17%)	600 (100%)

Chi-Square = 7.70, df = 2, Table value = 5.991,  $P \leq 0.05$

The association is significant

### 7.5.2. Educational Status and Awareness about using Foot Ware

Education is an awareness as well as knowledge inculcation programme. The awareness and knowledge shall not be confined to theoretical matters situated away from day to day empirical life. Education should prepare people to survive materially, morally and socially.

**Table .7.5.2**

Educational Status and Awareness about Importance of using Foot ware

Educational status	Aware	Not aware	Total
No formal schooling	179 (67.55%)	86 (32.45%)	265 (100%)
Primary	195 (62.70%)	116 (37.30%)	311 (100%)
Secondary	21	3	24



		(12.50%)	
	(87.50%)		(100%)
Total	395	205	600
	(65.83%)	(34.17%)	(100%)

Chi-Square = 6.71, df = 2, Table value = 5.991,  $p \leq 0.05$

The association is significant.

How far present day education equips rural people to keep themselves healthy? The present analysis may be an answer to this question too. The analysis was conducted by taking education as the independent and awareness about the importance of using foot wares as a health care measure as dependent variables (Table 7.5.2.).

The analysis shows that the realities having no formal schooling are better aware of the importance of using foot wares to prevent diseases than the primary educated are. However, the secondary educated are far ahead of the 'no schooling' and primary educated categories. The first group may gather information about basic rules of living from many sources including media. The primary educated may be remaining non inquisitive for the reason that they have formal schooling. The difference between the primary and the secondary in the matter is very great. Probably basic education may be getting started at the secondary level. Our primary level is made unnecessarily theory oriented and this incapacitates out individuals from getting informed about basic principles of healthy living.

### 7.5.3. Income Status and awareness about importance of using foot wares

The third background variable which revealed association with the dependent association with the dependent variable was income status.

The analysis of the data reveals expected pattern up to high-income group and abnormal pattern in the case of high-income group. 63.06% of the low-income category and 71.32% of the middle-income category are well aware about the necessity of wearing foot wares. However, only 61.04% of the high-income group come under the 'aware of group' showing a decline in the awareness level from the middle-income group.

**Table 7.5.3**

Income Status and Awareness about Importance of using Foot Wares			
Monthly Income (In Rupees)	Aware	Not Aware	Total
Up to 1000 (Low income)	70 (63.06%)	41 (36.94%)	111 (100%)
1000-2000 (Middle income)	184 (71.32%)	74 (28.68%)	258 (100%)
2000 & above (High income)	141 (61.04%)	90 (38.96%)	231 (100%)
Total	395 (65.83%)	205 (34.17%)	600 (100%)

Chi-Square = 6.19, df = 2, Table value = 5.991,  $P \leq 0.05$

The association is significant.

So we have to conclude that at the lower and higher income brackets the awareness is relatively less than that at the middle-income level. Further analyses maybe necessary to identify the latent facts if any, that creates anomaly in the results.

## **7. 6. Awareness about the Adverse Impact of Washing Cloth Near the Well**

In rural people follow the practice of washing clothes near well by pounding them against a granite stone arranged for the purpose. When washing is carried out dirty water splash into the well contaminating water. Many of the wells in rural area are not properly guarded with fencing wall and in such situation the contamination due to the wastewater will be very high.

In this study the awareness of the people regarding the adverse impact of washing cloths near well was considered as an index to assess their awareness about health and diseases. The responses to the question investigating into the awareness were grouped as aware of the impact and do not aware of the impact.

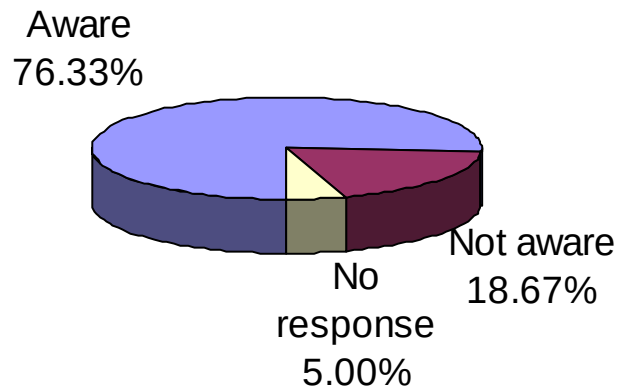
It is revealed in the analysis that 76.33% of the respondents are aware of the adverse impact and 18.67% are not aware of the health hazard. Of the respondents aware of the matter the unaware group is not insignificant. It is to be remembered that this study shows, 27.17% of the respondents have not

protected their wells with side walls (Table 5.4.1). So this ignorance has serious dimensions. Kerala community distinguishes itself very much in health and hygiene matters. But when we go deep into the issue we feel that situations are not that much fine (Table.7.6.1).

Subsidiary analyses revealed that the awareness is associated with religious background, income status and Socio-Economic Status of the rural people. Other background variables have no association with the awareness.

**Diagram 7.6**

**Impact of Washing Cloths near the Well.**



**7.6.1. Religious Affiliation and Awareness about the Adverse Impact of Washing Clothes near the Well**

An enquiry into the relationship between the religious affiliation and the awareness indicates that the Hindu (Forward) are the fore front in the

awareness. The ‘aware of’ group is constituted by 82.13% of the respondents of the group. The Backward Hindus and Christians have almost the same awareness level. 72.60% of the Hindu Backward and 71.43% of the Christians come under the category. In the case of Muslims the figure is only 68.22%. Chi-square test applied reveals that the variables are associated.

**Table 7.6.1**  
**Religious Affiliation and Awareness about the Adverse Impact of Washing Cloth near the Well.**

Religious affiliation	Known	Un known	No response	Total
Hindu (Forward)	239 (88.19%)	32 (11.00%)	20 (6.87%)	291 (100%)
Hindu (Backward)	106 (72.60%)	40 (27.40%)	0 (0.00%)	146 (100%)
Christian	40 (71.43%)	13 (23.21%)	3 (5.36%)	56 (100%)
Muslim	73 (68.22%)	27 (25.23%)	7 (6.54%)	107 (100%)
Total	458 (76.33%)	112 (18.67%)	30 (5.00%)	600 (100%)

Chi-square =30.74, df = 6, Table value =16.812,  $P \leq 0.01$

The association is significant is significant.

### **7.6.2. Income Status and Awareness about the Adverse Impact of Washing Cloth near the Well.**

A very systematic pattern is revealed when the data was analysed on the basis of the economic background of the respondents. The awareness increases with the income status (Table 7.6.2). 87.45% of the high-income group are aware of the impact. The figure in respect of the low-income group is far below at 55.86%. 75.19% of the middle-income category are also aware of the matter. The analysis reveals that the income status is associated with the awareness.

**Table 7.6.2.**

Income Status and Awareness about the Adverse Impact of Washing Cloth Near the Well

Income	Known	Un known	No response	Total
Up to 1000 (Low)	62 (55.86%)	45 (40.54%)	4 (3.60%)	111 (100%)
1000-2000 (Middle)	194 (75.19%)	52 (20.16%)	12 (4.65%)	258 (100%)
2000 and Above (High)	202 (87.45%)	15 (6.49%)	14 (6.06%)	231 (100%)
Total	458 (76.33%)	112 (18.67%)	30 (5.00%)	600 (100%)

Chi-square = 57.99, df = 4, Table value =13.277,  $P \leq 0.01$

The association is significant.

### **7.6.3. Socio- Economic Statement and Awareness about the Adverse Impact of Washing Cloth near the Well**

The combined effect of the socio-economic factors also shows that they are influencing the awareness about health and hygiene maintenance of rural

people (Table 7.6.3.). Almost similar pattern is seen in the behaviour of the dependant variable with the independent variable. However, one difference is that at the higher level of SES there is no much difference in the influence of the variable. The awareness level of the middle and high SES groups are respectively 79.08% and 82.14%. But the gap between the lower and the upper groups is very significant. The awareness of the lower category is 68.32%.

**Table 7.6.3.**

Socio-Economic Status and Awareness about the Adverse Impact of Wash Cloth Near Well

Socio-Economic Status (score)	Known	Un known	No response	Total
Below 20 (Low)	110 (68.32%)	45 (27.95%)	6 (3.73%)	161 (100%)
20 – 29 (Medium)	325 (79.08%)	62 (15.09%)	24 (5.84%)	411 (100%)
Above 29 (High)	23 (82.14%)	5 (17.86%)	0 (0.00%)	28 (100%)
Total	458 (76.33%)	112 (18.67%)	30 (5.00%)	600 (100%)

Chi-square = 14.65, df = 4, Table value =13.277,  $P \leq 0.01$

The association is significant.

The fore gone analyses clearly reveal that socio-economic and cultural backgrounds of rural population influence their awareness of health related matters.

### **7.7. Awareness about the importance of maintaining mental hygiene**

The well being of human being depends on three dimensions, body, mind and intellect. Bodily fitness not only is sufficient for considering an individual as healthy. But mental health and intellectual alertness are also a sine-qua-non.

In this study the outlook of the ruralites towards mental hygiene was enquired into. The respondents were asked, do they consider mental hygiene an important dimension of health of an individual.

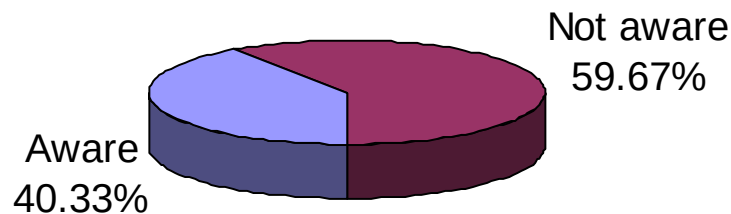
The responses elicited reveal that only 40.33% are aware about the fact that mental health is an important component of total health of an individual in an informal chat with four respondents that talked about the importance of keeping mind free from unnecessary anxiety, unwanted desires and unnecessary hostilities towards others and so on. They also highlighted that true spiritualism will be enabling to maintain good mental health.

The remaining portion of the respondents is unaware about the concept of mental health even (59.67%). On generalization we include that rural people of North Kerala are not properly aware about the importance of mental hygiene for keeping an individual healthy (Table 7.7.1).



Secondary analysis indicates that two-background variables income and socio-economic status are correlated with the independent variable. The others have influence on the awareness in the matter. Analysis related to the two variables are given in sections 7.7.1 and 7.7.2

**Diagram 7.7**  
**Awareness about the Importance of Maintaining Mental Hygiene**



### **7.7.1. Income status and awareness about the importance of maintaining mental hygiene**

Analysis based on income status shows that it is a deciding factor of the awareness we can see that (table 7.7.1) the awareness about the importance of hygiene increases with increase in the income status. Only 21.62% of the lower income bracket is aware about the role of mental hygiene in keeping an individual hail and hearty. The awareness increases to 40.70% in the case of middle-income group and 48.92% in the case of high-income group. Chi-square test shows the existence of very good relationship between the variables.

**Table 7.7.1**

Income Status and Awareness about the Importance of Maintaining Mental Hygiene

Monthly Income (in Rs)	Known	Un known	Total
Up to 1000 (Low)	24 (21.62%)	87 (78.38%)	111 (100%)
1000- 2000 (Medium)	105 (40.70%)	153 (59.30%)	258 (100%)
2000 & above (High)	113 (48.92%)	118 (51.08%)	231 (100%)
Total	242 (40.33%)	358 (59.67%)	600 (100%)

Chi-square = 56.67, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant

**7.7.2. Socio Economic Status and Awareness about Importance of Maintaining Mental Hygiene**

Very similar pattern of relationship to the one seen in section 7.7.2 is revealed in the analysis with the socio economic status. The awareness is very feeble among the low socio-economic category (29.19%). In the case of middle SES group the aware of group comes to 42.34%. The gap between these two groups and the higher SES group is very high. 75% of the high SES group are aware that a sound mind only will keep a person healthy.

In the case of the income group the gap was not as high as the case here. We know that education is a strong component in the SES and it may be

giving leverage to the awareness of this high socio-economic status group in the awareness. It is to be pointed out that education by itself is not an awareness indication agency as we have seen that when the data was analysed on the basis of education no association was seen. Education when coupled with other components like income, occupation and material possessions the awareness is very much enhanced.

**Table 7.7.2**

Socio Economic Status and Awareness about Importance of Maintaining Mental Hygiene

Socio Economic Status	Known	Un known	Total
Below 20 (Low)	47 (29.19%)	114 (70.81%)	161 (100%)
20 – 29 (Medium)	174 (42.34%)	237 (57.66%)	411 (100%)
Above 29 (High)	21 (75.00%)	7 (25.00%)	28 (100%)
Total	242 (40.33%)	358 (59.67%)	600 (100%)

Chi-square = 22.97, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant

### Summery

In this chapter the analysis highlights the awareness about health and hygiene of rural people. The awareness is analysed in seven sessions, namely, concept of health, meaning of disease, awareness relating vector borne disease, awareness relating to water born disease, importance of using foot ware, impact of washing cloths near the well, importance of maintaining mental hygiene. The

analyses revealed that the rural people are not much aware about the various profiles of health and hygiene. Regarding the influence of background variables, education, income and socio-economic status are strongly influencing the awareness of the people.

## **CHAPTER - VIII**

### **PRACTICES RELATNG TO HEALTH AND DISEASES**

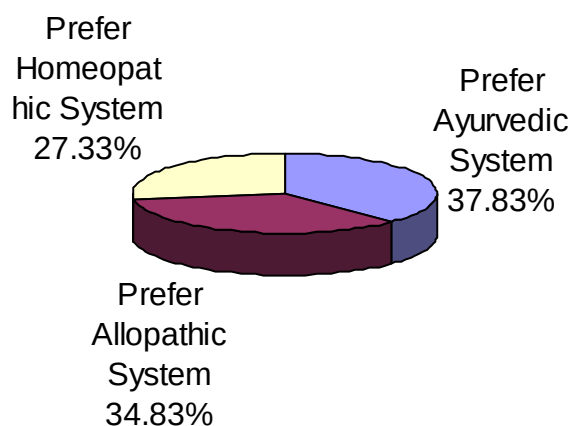
In this chapter, analyses have been done to reveal the profiles of practices of the people relating to health care. Further attempts are also made to establish relationship between socio-cultural backgrounds of rural people under investigation and their practices relating to health care and disease management.

#### **8.1 Preference for System of Medicine and Treatment**

The first analysis enquired into the preference of the people for the systems of medicine and treatment. The respondents were asked to reveal their preference for Ayurvedic, Allopathic and Homeopathic systems of treatment and medicine. The analysis of the elicited data reveals that (Table 8.1) the highest portion of them (37.83%) prefers Ayurvedic system. 34.83% prefer Allopathic system and the rest (27.34%) homeopathic system.

The result shows that Ayurvedic system has a slight edge over Allopathic system Homeopathic system is the least preferred one by rural Keralites.

**Diagram 8.1. Preference for System of Medicine and Treatment**



As every body knows, when there arises the question of tradition vs. modernity rural people frequently support the former one. In the present case we know that Ayurveda is the traditional system of treatment of Indian society. The rural people are favouring the traditional medicines and methods of treatment.

The study further investigated into the relationship between the socio – cultural parameters of the people and their preference in the matter.

### **8.1.1 Religious Affiliation and Preference for System of Medicine and Treatment**

In the past religion and medical treatment were intimately related to each other. Still now religious values and ethic have strong influence on the curing processes of diseases. In this study, based on this insight, it was postulated that religious affiliation of the people and their preference for the systems of

medicine and treatment are associated. The analysis carried out to test the validity of the perspective is given in Table 8.1.1.

**Table 8.1.1**

Religious Affiliation and Preference for System of Medicine and Treatment

Religious affiliation	Prefer Ayurvedic System	Prefer Allopathic System	Prefer Homeopathic System	Total
Hindu (Forward)	126 (43.30%)	109 (37.46%)	56 (19.24%)	291 (100%)
Hindu (Backward)	36 (24.66%)	51 (34.93%)	59 (40.41%)	146 (100%)
Christian	21 (37.50%)	14 (25.00%)	21 (37.50%)	56 (100%)
Muslim	44 (41.12%)	35 (32.71%)	28 (26.17%)	107 (100%)
Total	227 (37.83%)	209 (34.83%)	164 (27.33%)	600 (100%)

Chi-square =29.85, df=6, Table value=16.812,  $P \leq 0.01$

The association is significant

The analysis reveals that the variables are associated. The preference of Hindu (Back ward) is somewhat different from that of the other groups. Their preference for systems of medicine and treatment gets slackened from Homeopathy to Ayurveda through Allopathy. The preference of Hindu (Forward) and Muslim is in the other way round. However, Christians have equal preference for Ayurveda and Homeopathy and a lesser preference for Allopathy.

The Hindus (Backward) may be more spirited to show their adaptability to the most modern trend in the matter. As we know, Homeopathy is getting more popular among the two systems of modern medicine. The Christians being a more informed group might have known more about the adverse impact of allopathic treatment and medicines. And that may be prompting them to go for lesser harmful treatments, namely, Ayurveda and Homeopathy. It is to be inferred that the traditional outlook of Hindu (Forward) and Muslim attracts them to the Ayurvedic system to a greater extent.

### **8.1.2. Educational Background and the Preference for system of Medicine and Treatment**

In order to analyse the relationship between educational attainment and the preference of the people the data was analyzed as shown in Table 8.1.2

The analysis (Table 8.1.2) indicates that the preference of the respondents for Ayurvedic and Allopathic traditions increases with increase in the educational status. A reverse order of preference is seen in the case of Homeopathy.

Homeopathy, though claims to have the capacity of curing any type of disease, may not be able to convince the better educated the claimed capacity. Better education increases one's faith in Ayurveda and Allopathy. It is revealed in the analysis that the better educated prefer Ayurveda to Allopathy even.

#### **Table 8.1.2.**

Educational Background and the Preference for system of Medicine and Treatment



Educational Status	Prefer Ayurvedic System	Prefer Allopathic System	Prefer Homeopathic System	Total
No Formal schooling	81 (30.57%)	87 (32.83%)	97 (36.60%)	265 (100%)
Primary	135 (43.41%)	112 (36.01%)	64 (20.58%)	311 (100%)
Secondary	11 (45.83%)	10 (41.67%)	3 (12.50%)	24 (100%)
Total	227 (37.83%)	209 (34.83%)	164 (27.33%)	600 (100%)

Chi -square =22.87 df=4, Table value =13.277, P<0.01

The association is significant.

### 8.1.3 Income and Preference for System of Treatment and Medicine.

In order to find out the nature of relationship between income status and the preference the analysis shows in Table 8.1.3 was conducted.

Analysis in Table 8.1.3 reveals a general pattern that, as the income status increases, the preference for both Ayurveda and Allopathy increase. The reverse trend is seen in the case of Homeopathic treatment and medicine. Hence it is to be inferred that Homeopathic system is preferred more by the poor. During informal discussions with the respondents the fact was highlighted by many of them. They say that in the past the most inconvenient part of following Ayurvedic treatment was the preparation of the medicines from the ingredients. This was overcome because now all the medicines are available in a ready-to-use form, just like Allopathic medicines. However, the cost of Ayurvedic treatment, according to

them, is as high as allopathic system. Homeopathic medicines and treatment are comparatively cheaper and affordable for poor people – the respondent’s opined.

**Table 8.1.3**

**Income Status and Preference for Systems of Medicine and Treatment**

Income (Monthly in Rs)	Prefer Ayurvedic System	Prefer Allopathic System	Prefer Homeopathy System	Total
Up to 1000	27 (24.32%)	37 (33.33%)	47 (42.34%)	111 (100%)
1000 - 2000	107 (41.47%)	79 (30.62%)	72 (27.91%)	258 (100%)
2000 & above	93 (40.26%)	93 (40.26%)	45 (19.48%)	231 (100%)
Total	227 (37.83%)	209 (34.83%)	164 (27.33%)	600 (100%)

Chi –square=24.35, df =4, Table value = 13.27, P ≤0.01  
The association is significant.

Further analyses revealed that other background variables, namely, sex, age, occupation and socio-economic status are not associated with the preference for systems of treatment and medicine. Hence the details of the analysis are not included in the report.

## **8.2 Keeping the Surroundings Hygienic**

Environment affects our life mentally, spirituality and physically. It can also influence the health and disease of human beings.

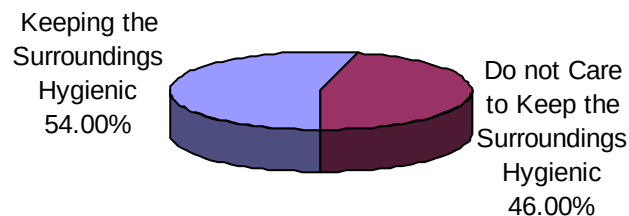
Physical environment begins from the house. Many houses of rural people lack the minimum resources for a healthy lodging. Housing of poor quality

often fails to protect against insects and rodents, which are capable of creating health and hygiene hazards.

In this study the Practice of rural people relating to hygiene maintenance in their surroundings was analysed. They were asked as to how careful they are to maintain their surroundings clean and tidy.

The data collected were analysed as shown in Table 8.2.1. The analysis reveals that 54% are very careful to keep their surroundings clean and tidy so that proper hygiene is maintained and health hazards are arrested. But a very disturbing fact is that 46% of the respondents are not very careful to maintain their surrounding areas clean and hygienic. It is to be inferred from this analysis that a large portion of rural people are not bothered about keeping proper hygiene in their living environment. This is the condition of Kerala where the sense of health and hygiene is very high.

**Diagram 8.2 Keeping the Surroundings Hygienic**



### 8.2.1. Educational Background and the Practice of Keeping the Surroundings Hygienic

Subsidiary analyses were carried out to find out the nature of influence of the sociological variables on the behaviour. The first analysis established a relationship between educational background and the behavioural pattern (Table 8.2.1).

The relationship unambiguously states that the higher the educational standard of the rural people the greater their care for keeping their surroundings clean and hygienic. 52.08% and 53.70% respectively of those who have no formal schooling and have primary education are careful to keep their surroundings clean. The corresponding figure in respect of the Secondary educated is 79.19%. Improving the general educational standard of rural people is very crucial in enhancing their health and hygiene standards.

**Table. 8.2.1.**  
**Educational Background and the Practice of Keeping the Surroundings Hygienic**

Educational Status	Keeping the Surroundings Hygienic	Do not Care to Keep the Surroundings Hygienic	Total
No Formal Schooling	138 (52.08%)	127 (47.92%)	265 (100%)
Primary	167 (53.70%)	144 (46.30%)	311 (100%)
Secondary	19	5	24

	(79.17%)	(20.83%)	(100%)
Total	324	276	600
	(54.00%)	(46.00%)	(100%)

Chi- square value =6.53, df =2, Table value =5.991,  $p \leq 0.01$

The association is significant.

### 8.2.2 Socio-Economic Status and Keeping the Surroundings Hygienic

An investigation into the relationship between Socio-Economic Status and the practice revealed fairly strong association. The type of association revealed is similar to the one seen in the case of educational background and the practice – lower Socio-Economic Status groups have lesser commitment to keeping their surroundings clean.

**Table 8.2.2**  
**Socio- Economic Status and Practice of Keeping the Surroundings Hygienic**

Socio- Econ- Status (in score)	Keeping the Surroundings Hygienic	Do not Care to Keep the Surroundings Hygienic	Total
Below 20 (Low)	86 (53.42%)	75 (46.58%)	161 (100%)
20-30 (Medium)	216 (52.55%)	195 (47.45%)	411 (100%)
30 and above (High)	22 (78.57%)	6 (21.43%)	28 (100%)
Total	324	276	600

(54.00%)	(46.00%)	(100%)
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Chi –square value=7.17, df =2, Table value =5.991,  $p \leq 0.05$

The association is significant.

Speaking in terms of statistics, 52.55% and 53.42% respectively of the lower and middle Socio-Economic Status groups take into account the importance of keeping their surroundings clean. This figure shoots up to 78.57% when we come to the high socio-economic layer.

No explanation is necessary for the exhibited relationship between the variables.

### 8.2.3. Marital Status and Practice of Keeping the Surroundings Hygienic

Marriage is a turning point in social life of an individual. It brings about basic changes in the ideologies and practices of the parties to it. The practice of up keeping environmental cleanliness and hygiene also is amenable to the general principle. On the basis of this insight an analysis was carried out to reveal relationship, if any, existing between marital status and the practice.

**Table 8.2.3**

#### **Marital Status and Practice of Keeping the Surroundings Hygienic**

Marital – Status	Keep the Surroundings Hygienic	Do not Care To Keep the Surroundings Hygienic	Total
Single	9 (56.25%)	7 (43.75%)	16 (100%)

Married	265 (54.30%)	223 (45.70%)	488 (100%)
Divorced	6 (26.09%)	17 (73.91%)	23 (100%)
Widow / Widower	44 (60.27%)	29 (39.73%)	73 (100%)
Total	324 (54.00%)	276 (46.00%)	600 (100%)

Chi- square value =8.42, df=3, Table value=7.815, P<0.05

The association is significant.

The analysis indicates that the marital status and the practice are closely associated.

The Analysis of data shows that the widow/widower category is at the forefront in keeping the surroundings clean (60.27%). Majority of the single and married respondents follow the practice (56.25% and 54.30% respectively). In the case of divorced the rule is in the other way round. Only a meager (26.09%) portion of them are paying heed to follow the practice.

The widow/widower being free from much household responsibilities may be getting more time to keep their surroundings clean. The divorced may be much dejected and this may adversely affect his/her practices. The other background variables such as sex, age, religion, income and occupation are not associated with the practice of keeping the surroundings hygiene.

### **8.3. Method of Waste Disposal**

In rural households' large quantity of waste materials are daily produced. Left-over of prepared food, vegetable peels, garden waste, agricultural waste, plastic materials are the usual items of waste, generated. Conventionally, rural households dump the bio-degradable waste in the pit dug around coconut tree, aracanut tree, jackfruit tree etc. At present there are novel methods of waste disposal, which can be followed in rural households – like making composite, using them as biogas plant input. Preparation of vermi composite is very popular now.

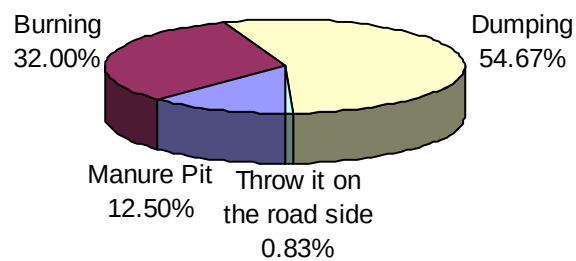
In this study an analysis was made into waste handling by rural household as it is intimately related to health and disease of rural people. The major methods of waste handling by rural respondents are using as manure, dumping somewhere in the courtyard, burning and throwing on the road side (Table 8.3.1).

It is seen from the analysis in the table that majority of the respondent (54.67%) dump the waste some where in the courtyard, 32% burn them out, only 12.5% convert waste into manure, a meager portion 0.83% throw them carelessly on the road side. The results show that a negligible portion (12.5%) of them handles the waste properly by converting them into manure under controlled conditions. Dumping waste here and there will attract mosquitoes, rodents' flies



and other harmful insects and by this it is a health hazard method. Burning also generate harmful fumes as the waste of even rural households, now-a-days, contain plastic refuses in considerable quantity. The habit of a few (5 respondents) is quiet anti social because by throwing away the waste on the roadside they are prompting others to adopt a very unhealthy habit. In short the waste handling methods of rural people according to this study are not conducive for maintaining good health and preventing diseases.

**Diagram 8.3. Method of Waste Disposal**



Further analyses were conducted to find out the relationship of background variables with the habit. It was revealed that background variables namely, age, income, occupation and socio-economic status associated with the habit. The association is discussed the details.

### **8.3.1. Age and Method of Waste Disposal**

An analysis was carried out to find out relationship, if any, existing between age and the method of disposing of waste. The details of the analyses are given in Table 8.3.1. The analysis reveals that there are certain patterns in the method adopted by the respondents. One of the patterns is that as age increases the method of disposal by dumping waste in the courtyard decreases. This is the most popular method of waste disposal resorted to by the respondents. The record popular method is burning out the waste. This method is more popular among the older people and the habit decreases as we go from older group to the younger category. Both these methods are defective from the point of health care. In the past burning of waste materials was not hazardous because there was practically no plastic waste, which on burning will produce hazardous fumes.

**Table 8.3.1**

Age and Method of Waste Disposal

Age (in years)	Manure Pit (1)	Burning (2)	Dumping (3)	Throw it on the road side (4)	Total
Up to 30	8 (13.33%)	13 (21.67%)	38 (63.33%)	1 (1.67%)	60 (100%)
30 –60	52 (11.43%)	142 (31.21%)	257 (56.48%)	4 (0.88%)	455 (100%)
60 & above	15 (17.65%)	37 (43.53%)	33 (38.82%)	0 (0.00%)	85 (100%)
Total	75 (12.50%)	192 (32.00%)	328 (54.67%)	5 (0.83%)	600 (100%)

**Note : Column (4) was not considered for the calculation of Chi-square Value**

Chi Square Value = 12.81      df=4,      Table Value=9.458,      p<=0.05  
The Association is significant

### **8.3.2. Income and Method of Waste Disposal**

Income and the pattern of waste disposal were assumed to be associated as income is strong factor that influence personal habits. The analysis relating to the behaviour is given Table No. 8.3.2. It is revealed that significance of the association between the variables is statistically confirmed. It can be seen that though minor portions, the lower and medium income groups are more interested in producing manure from waste materials, the safest method of waste handling. The high-income group is small in proportion under this category (9.52%). They might be considering that it is economical to purchase manure than produce it from the tedious process of decomposing waste into manure form. The burning of waste is more popular among the medium income group (40.31%). Almost an equal proportion of the group dump waste materials in the courtyard (44.57%). Only one-fourth each of the low and high income brackets resort to this method of waste disposal. Another prominent feature in the disposal patterns is that the low and high-income groups are more in the habit of dumping waste (59.46% and 63.64% respectively). The low-income group may be using the decomposed dump as manure later. The high-income group may not be even having such an intention as they can spare for purchasing manure. However, dumping waste unattended to be not a healthy practice. The dump will be breeding place harmful organisms.

**Table 8.3.2**

## Income and Method of Waste Disposal

Income (in Rs.)	Manure Pit (1)	Burning (2)	Dumping (3)	Throw it on the road side (4)	Total
Up to 1000	15 (13.51%)	27 (24.32%)	66 (59.46%)	3 (2.70%)	111 (100%)
1000-2000	38 (14.73%)	104 (40.31%)	115 (44.57%)	1 (0.39%)	258 (100%)
2000 & above	22 (9.52%)	61 (26.41%)	147 (63.64%)	1 (0.43%)	231 (100%)
Total	75 (12.50%)	192 (32.00%)	328 (54.67%)	5 (0.83%)	600 (100%)

**Note : Column (4) was not considered for the calculation of Chi-square Value**

Chi Square Value = 21.22      df=4,      Table Value=9.458,      p<=0.05

The Association is significant

### 8.3.3 Socio-Economic Status and Method of Waste Disposal

Similar pattern of behaviour is expected of SES groups as revealed in section 8.3.3 as income is a strong composition of SES score. An analysis of the collected data as shown in Table 8.3.3 was carried to confirm the proposed relationship. It is seen that in the case of the high SES group, a different pattern of

behaviour is discernible. Majority of them (53.57%) burn the waste. 25% convert the waste into useful manure. They might believe that burning out waste is a healthy practice in this regard. However, if they do not contain plastic materials it may be a safe practice. But now-a-days waste produced in rural households contains plastic refuses in large quantities. In the case of majority of the low and middle SES groups, majority (68.32% and 51.58% respectively) dump their household waste in the courtyards. Contradictory to the results relating the high income groups, in this analysis only a meager portion (21.43%) of the high SES group dump their household waste in their courtyards. Their practice may be prompted by the outlook that waste dumps are health hazards. So it is to be concluded that the practice of the high SES group is more conducive for health maintenance in rural area.

**Table 8.3.3**

Socio-Economic Status and Method of Waste Disposal

Socio-Economics Status (Score)	Manure Pit (1)	Burning (2)	Dumping (3)	Throw it on the road side (4)	Total
Below 20 (Low)	7 (4.35%)	41 (25.47%)	110 (68.32%)	3 (1.86%)	161 (100%)
30 –29 (Medium)	61 (14.84%)	136 (33.09%)	212 (51.58%)	2 (0.49%)	411 (100%)
Above 29 (High)	7 (25.00%)	15 (53.57%)	6 (21.43%)	0 (0.00%)	28 (100%)
Total	75 (12.50%)	192 (32.00%)	328 (54.67%)	5 (0.83%)	600 (100%)

**Note : Column (4) was not considered for the calculation of Chi-square Value**

Chi Square Value = 32.13                  df=4,                  Table Value=9.458,                  p<=0.05

The Association is significant

### 8.3.4 Occupational Status and Method of Waste Disposal

The study again undertook an analysis to establish relationship between occupational status of rural people and their waste disposal pattern. The collected data was analysed as shown in Table 8.3.4.

**Table 8.3.4**  
Occupational Status and Method of Waste Disposal

Occupational Status	Manure Pit (1)	Burning (2)	Dumping (3)	Throw it on the road side (4)	Total
Manual Labour	37 (11.31%)	102 (31.19%)	186 (56.88%)	2 (0.61%)	327 (100%)
Skilled	15 (11.36%)	41 (31.06)	73 (55.30%)	3 (2.27%)	132 (100%)
Salaried Men	13 (25.00%)	25 (48.08%)	14 (26.92%)	0 (0.00%)	52 (100%)
Business	10 (11.24%)	24 (26.97%)	55 (61.80%)	0 (0.00%)	89 (100%)
Total	75 (12.50%)	192 (32.00%)	328 (54.67%)	5 (0.83%)	600 (100%)

**Note : Column (4) was not considered for the calculation of Chi-square Value**

Chi Square Value = 20.38      df=6,      Table Value=16.812      p<=0.01

The Association is significant

The analysis reveals that the salaried group keep themselves as a distinct group in the matter. 48% of them burnout waste and 25% convert it into useful manure. Another interesting pattern revealed in the analysis is that overwhelming majority of other occupational groups except salary drawers

consider dumping of waste as the method of handling it. In the case of salaried group it is only 26.92%. It is to be again pointed out that equal proportion of the occupational group (around 11% each) here also, except salaried group, produce manure from domestic waste.

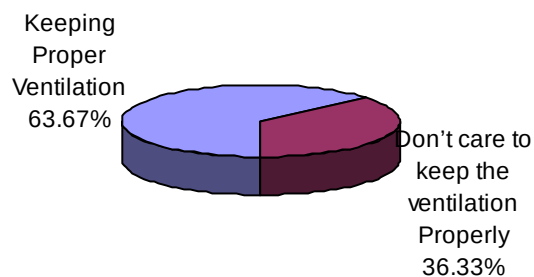
All these factors highlights that the waste handling habit of salaried section of rural population is more health oriented. However, the risk in burning plastic materials along other household waste materials is there in the case of the group too.

#### **8.4. Practice of Keeping Proper Ventilation**

Ventilation enables exchange of vitiated air inside the room, which is hot, humid and stagnant with atmospheric air out side the room that is cool, dry, and moving. The aim of ventilation is to ensure air supply inside the work place or living space, which is free from harmful agents and is conducive for health. The analysis enquired in to the practice of keeping proper ventilation.

The data was analyzed as shown in Table 8.4.1. The analysis reveals that 63.67% of the respondents keep proper ventilation. But 36.33% of the respondents' state that they are not paying attention to keep the ventilation properly.

#### Diagram 8.4. Practice of Keeping Proper Ventilation



The results indicate that a sizable portion of the rural population is not much concerned about the importance of ventilation in their living space. They are exposing themselves to the hazards of repeated inhalation of polluted air

##### 8.4.1. Religious Affiliation and the Practice of Keeping Proper Ventilation

An enquiry was carried out to identify the relationship if any, existing between religious affiliation and the practice of keeping proper ventilation in their living space.

Accordingly an analysis was carried out as shown in Table 8.4.1 and it reveals that the variables are associated. In this connection the Hindu (Forward) & Christians may be grouped together. Muslims and the Hindu (Backward) show similar behaviours. The former two groups pay much heed to proper ventilation to the living arrangement (70.79% and 64.29% respectively). Though majority of the other groups also give attention to the matter they lag behind the former categories (53.27% and 56.85% respectively).



**Table 8.4.1**

Religious Affiliation and the Practice of Keeping Proper Ventilation

Religious affiliation	Keeping Proper Ventilation	Don't care to keep the ventilation Properly	Total
Hindu Forward	206 (70.79%)	85 (29.21%)	291 (100%)
Hindu Backward	83 (56.85%)	63 (43.15%)	146 (100%)
Christian	36 (64.29%)	20 (35.71%)	56 (100%)
Muslim	57 (53.27%)	50 (46.73%)	107 (100%)
Total	382 (63.67%)	218 (36.33%)	600 (100%)

Chi- square value=14.33, df= 3, Table value=11.345, P<0.01

The association is significant.

#### 8.4.2. Income Status and the Practice of Keeping Proper Ventilation

It was assumed that economic prosperity has a strong influence on behaviour of keeping proper ventilation. Accordingly, income, which is the typical index for economic advancement and the practice were examined as the independent and dependent variables respectively.

The analysis (Table 8.4.2) reveals that the variables are very systematically associated. At the lower income level majority do not pay attention for keeping ventilation (52.25%). But at the middle and high income levels overwhelming majority pay proper attention to the matter (64.34% and 70.56% respectively). Proper dwelling units and even non-essential amenities are built by

economically well off people, both in the rural and urban areas. So the logic of the association between the variables is self-explanatory.

**Table 8.4.2**  
**Income Status And The Practice of Keeping Proper Ventilation**

Income (Monthly in Rs)	Keeping ventilation Properly	Do not keeping ventilation Properly	Total
Up to 1000 (Low)	53 (47.75%)	58 (52.25%)	111 (100%)
1000-2000 (Middle)	166 (64.34%)	92 (35.66%)	258 (100%)
2000 & above (High)	163 (70.56%)	68 (29.44%)	231 (100%)
Total	382 (63.67%)	218 (36.33%)	600 (100%)

Chi-square value 16.96, df= 2, Table value =9.210,  $P < 0.01$ .

The association is significant

#### **8.4.3. Socio-Economic Status and the Practice of Keeping Proper Ventilation**

In fact, socio-economic status is a composite of social and economic variables and by attempting to find out relationship between it and the practice under investigation is an analysis for reinforcing the relationship revealed in analysis 8.4.2. The present analysis, gives positive result, the variables are strongly associated. Comparatively, the low socio-economic status group lags behind the middle and the high status groups (54.66% of low SES group pay attention to the practice). It may be interesting to note that the middle Socio-

Economic Status group has slight edge over the high Socio-Economic Status group (67.15% and 64.29 % respectively).

**Table 8.4.3**  
**Socio-Economic Status and the Practice of Keeping Proper Ventilation**

Socio-Economic status (in score)	Keeping Ventilation Properly	Do not keep Ventilation Properly	Total
Below 20 (Low)	88 (54.66%)	73 (45.34%)	161 (100%)
20-29 (Medium)	276 (67.15%)	135 (32.85%)	411 (100%)
Above 29 (High)	18 (64.29%)	10 (35.71%)	28 (100%)
Total	382 (63.67%)	218 (36.33%)	600 (100%)

Chi-square value =7.81, df= 2, Table value =5.991, P< 0.05

The association is significant.

Sex, age, education, occupation are not related variables of the practice keeping proper ventilation.

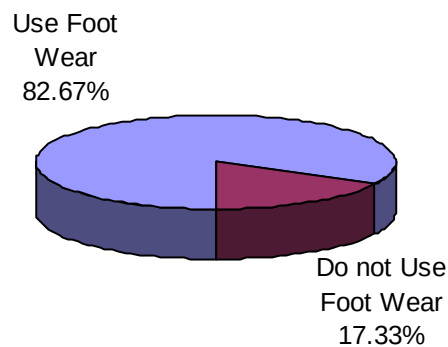
The analysis revealed that other background variables (education and occupation) and the practice are not associated.

### **8.5. The Practice of Using Footwear**

Rural area is more prone to certain types of diseases particularly those caused by worms and other microorganisms. So extension workers stress on necessity of using footwear by rural people.

In this study an investigation was carried out to find out the practice of using footwear by rural population and the influence of cultural backgrounds on the practice. The data collected was analyzed as shown in this section.

**Diagram 8.5. The Practice of Using Footwear**



The first analysis, relating to religious affiliation and the practice of using footwear, indicates that only a meager portion of the rural population is indifferent to this practice (17.33%). 82.67% use footwear whenever they go out of their house. This is a very good indicator of good health care habit of the people. People use slippers manufactured from rubber latex, which are available at low cost in Kerala. The State is at the forefront of rubber cultivating

regions. Analysis 8.5.1 revealed that the practice of using footwear is a stabilized one among rural people of Kerala. (Table 8.5.1)

### 8.5.1. Religious Affiliation and the Practice of Using Footwear

**Table 8.5.1**

#### **Religious Affiliation and the Practice of Using Footwear**

Religious Affiliation	Use Foot Wear	Do not Use Foot Wear	Total
Hindu (Forward)	252 (86.60%)	39 (13.40%)	291 (100%)
Hindu (Backward)	104 (71.23%)	42 (28.77%)	146 (100%)
Christian	48 (85.71%)	8 (14.29%)	56 (100%)
Muslim	92 (85.98%)	15 (14.02%)	107 (100%)
Total	496 (82.67%)	104 (17.33%)	600 (100%)

Chi square value = 17.64, df = 3, Table value = 11.345,  $p \leq 0.01$

The association is significant.

Further analysis was carried out to find out relationship between religious affiliation of the ruralites and the practice. The analysis reveals (Table 8.5.1) that religious background has influence on the practice. It is seen that around 85% of all the religious group except Hindu (Backward) adhere to this practice whole heartedly. But in the case of Hindu (Backward) the figure is 71.23%. A considerable portion of them (28.77%) is keeping themselves away from the main stream.

### 8.5.2 Socio Economic Status and the Practice of Using Footwear

Socio- economic status and the practice were assumed to be associated and an analysis was carried out to test the sustenance of the assumption (Table 8.5.2). The analysis revealed that there is a systematic pattern in the relationship between the variables the higher the socio economic status the greater the use of footwear by the despondence .It is interesting to note that 100% of the high socio economic status group use footwear. The corresponding figure in the case of middle and low socio economic status groups are 85.16% and 73.29% respectively. Inductively it is possible to generalize the results to the rural population of Kerala as a whole.

**Table 8.5.2**  
**Socio Economic Status And The Practice Of Using Footwear**

Socio- Economic Status (score)	Use footwear	Do not use footwear	Total
Below 20	118 (73.29%)	43 (26.71%)	161 (100%)
20-30	350 (85.16%)	61 (14.84%)	411 (100%)
30 and above	28 (100.00%)	0 (0.00%)	28 (100%)
Total	496 (82.66%)	104 (17.33%)	600 (100%)

Chi-square value =17.53, df = 2, Table value = 9.210, P<0.01  
The association is significant.

Further analysis revealed that other variables, namely, sex, age, education, income and occupation have no association with the behaviour and the details of the analysis become irrelevant here.

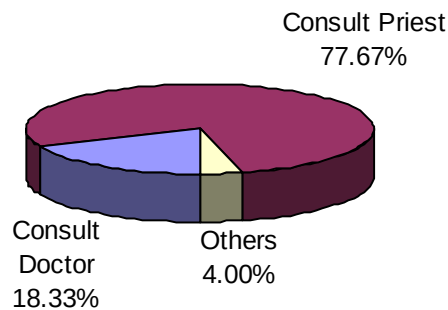
## **8.6. Patterns Attempted for Curing Disease**

From time immemorial people have been practicing various methods for curing diseases. Both medicine and magic are groomed together for this purpose. In the past priests were the custodians of these practices. Later formal medicine men emerged and medicine detached from occult practices. Still then the priests are not completely thrown out of the field of treating diseases. People at least belonging to certain sections have faith in priest in matters relating to curing disease or getting advice as to how to go about when disease is occurred. The faith is firmer among villagers.

In the study the Kerala rural communities' approach in treating disease was analysed. The data pertaining to the matter was analysed as shown in Table 8.6.1. As per the analysis 77.67% of the sample consult first a priest whenever there occur disease in a family, only a minority approach a doctor directly to get advice regarding the treating of the disease. A meager portion of them (4% only) resort to self-treatment, prays etc. whenever such contingency arises. (They are labelled in the table as 'others').

The results show that Kerala Rural Community still now (even after achieving so many advances in the field of health care and literacy standard) falls back in priests for getting relief from diseased conditions.

#### **Diagram 8.6. Patterns Attempted for Curing Disease**



Subsidiary analyses with the background variables were carried out and they are given in the following sections.

### 8.6.1. Educational Status and Pattern of Treating Disease

Association between educational status and patterns of treating disease was confirmed when an analysis was carried out for the purpose (Table 8.6.1). The behaviour of respondents who belong to the illiterate group and primary educated is almost the same, a major chunk of them consult their priest whenever disease occurs (76.60% and 81.31% respectively). The fact that the strength of the group is greater under the primary educated than that under the 'No Formal Schooling' group. Another important result is that majority of the (51.17%) Secondary educated group consult a medical practitioner first whenever there occurs a disease.

**Table 8.6.1**

Educational Status and Pattern of Treating Disease

Educational	Consult	Consult	Others	Total
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Status	Doctor	Priest		
No formal	49	203	13	265
Schooling	(18.49%)	(76.60%)	(4.91%)	(100%)
Primary	48	253	10	311
	(15.43%)	(81.35%)	(3.22%)	(100%)
Secondary	13	10	1	24
	(54.17%)	(41.67%)	(4.17%)	(100%)
Total	110	466	24	600
	(18.33%)	(77.67%)	(4.00%)	(100%)

Chi-Square Value = 23.85, df = 4, Table Value = 13.277,  $p \leq 0.01$

The association is significant.

Therefore, the conclusion we arrive at is, rural community of Kerala by and large, gives greater emphasis on the role of religious men in curing diseases. Analysis based on religion revealed lack of association between the variable and hence it is to be concluded that all religious groups are equally upholding this practice. However, education is a strong variable which influences the behaviour, the better the education the more scientific the approach in curing disease.

### 8.6.2. Occupation Status and Pattern of Treating Disease

In the making of the personality of an individual ones occupation plays an important role. In this study the behaviour of treating diseases is presumed to have an association to the occupational background of individual. Analysis of data (Table 8.6.2) supports the assumed relationship. The manual labourers are more prone to the influence of religious men in the matter. Then

come the technically skilled persons. The behaviour of the salaried persons and business people is almost the same, around 1/3 of the groups consult medical doctors first when diseases occur in their families.

**Table 8.6.2**  
**Occupational Status and Pattern of Treating Disease**

Occupational Status	Consult doctor	Consult priest	Others	Total
Manual Labour	47 (14.37%)	267 (81.65%)	13 (3.98%)	327 (100%)
Skilled	21 (15.91%)	102 (77.27%)	9 (6.82%)	132 (100%)
Salaried Men	15 (28.84%)	35 (67.31%)	2 (3.85%)	52 (100%)
Business	27 (30.34%)	62 (69.66%)	0 (0.00%)	89 (100%)
Total	110 (18.33%)	466 (77.67%)	24 (4.00%)	600 (100%)

Chi- square = 21.66, df = 6, Table value = 16.812,  $p \leq 0.01$

The association is significant.

### 8.6.3. Socio-Economic Status and Pattern of Treating Disease

Another background variable, which is related to the behaviour, is the Socio-Economic Status (composite of social and economic factors). The details of the analysis are given in Table 8.6.3.

**Table 8.6.3**  
**Socio-Economic Status and Pattern of Treating Disease**

Socio -	Consult	Consult	Others	Total
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Economic Status (Score)	doctor	priest		
Below 20 (Low)	22 (13.66%)	132 (81.99%)	7 (4.35%)	161 (100%)
20 - 29 (Medium)	72 (17.52%)	323 (78.59%)	16 (3.89%)	411 (100%)
29 and above	16 (57.14%)	11 (39.29%)	1 (3.57%)	28 (100%)
Total	110 (18.33%)	466 (77.67%)	24 (4%)	600 (100%)

Chi-Square value = 30.88, df = 4, Table value = 13.277,  $p \leq 0.01$

The association is significant.

One important result that is to be emphasized in the analysis is that in the case of those who consult medical practitioners, there is a gradual increase in the strength of association between the variables as we move from low socio-economic status to high socio-economic status. While 13.66% of the low socio-economic status and 17.52% of the middle socio-economic status groups consult medical doctor for curing disease, majority of the high socio-economic group (57.14%) resort to this method of curing. A reverse relationship exists between the variables when we consider the case of those who consult priest. Among rural people the socio-economically well off, follow rational method of treating disease – it is to be concluded.

#### **8.6.4. Family Size and Pattern of Treating Disease**

Another analysis was carried out to find out relationship between family size and pattern of the treating disease, if any, gave positive result. The pattern of responses reveals that the small family and large family have similar approach to the power of medical practitioners and religious men. However, we see that their faith in occult practitioners (religious men) is highly firm than that of the middle size family (Table 8.6.4). More of the middle size family (23.68%) go to medical practitioners when disease occurs in the family. Corresponding figures in respect of small size and large size families are 12.39% and 14.29% respectively. The data analysis shows that the middle size family of the rural population (5-8 members) has more modern outlook in health care practice. A rational explanation for the result is not possible without making further enquires.

**Table 8.5.4.**  
**Family Size and Pattern of Treating Disease**

Family Size (no. of members)	Consult Doctor	Consult Priest	Others	Total
Up to5 (Low)	28 (12.39%)	188 (83.19%)	10 (4.42%)	226 (100%)
5 - 8 (Medium)	72 (23.68%)	223 (73.36%)	9 (2.96%)	304 (100%)
8 and above	10 (14.29%)	55 (78.57%)	5 (7.14%)	70 (100%)
Total	110	466	24	600

(18.33%)	(77.67%)	(4.00%)	(100%)
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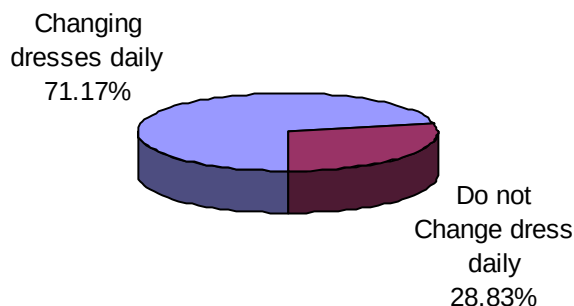
Chi-Square value = 14.00, df = 4, Table value = 9.488,  $p \leq 0.05$   
The association is significant.

### 8.7. The Practice of Changing Dresses Daily

The chance of rural people being exposed to environmental forces is rather higher in comparison with that the urban population. So they have to protect their body from dust, mud, and severe heat waves etc. For this they have to dress properly and change it at the appropriate time. In this study enquires had been made to analyze the habit of changing dress by the people.

The enquiry reveals that 71.17% of the respondents are in the habit of changing their dress daily and the rest (28.83%) not. The results imply that Kerala rural population is very careful to maintain personal hygiene and avoid diseases.

**Diagram 8.7. The Practice of Changing Dresses Daily**



Subsidiary analyses were also carried out to explain the relationship between the practice and the background variables.

### **8.7.1 Religious Affiliation and the Practice of Changing Cloths Daily**

The most important component of culture, namely, religion was assumed to have association with the practice of changing cloths daily. Analysis shows (Table 8.7.1) that Hindu (forward) is very strict in this practice followed by Muslim. 81.44% of the Hindu (forward) and 72.90% of the Muslims very systematically observe this practice. In the case of Christians the figure comes only to 66.07%. The situation of the Hindu (backward) is still below (51.37% of them follow this practice). The behaviour of backward Hindu may be easily explained on the basis of historical reasons. As we know, many of the groups were designated as unclean castes and the dictates of the clean castes were being followed by them till the early 20<sup>th</sup> century. This lagging in the behaviour is to be seen only as a hangover of the past conditions. The case of the Christians who are at the forefront of health and hygiene maintenance may be explained from another angle. They are very judicious in spending resources. This is the very thesis of Max Weber. It is to be doubted that they may be thinking – changing clothing daily and cleaning them are unnecessary and create reckless behaviour in spending money.

**Table 8.7.1**

Religious Affiliation and the Practice of Changing Cloths Daily.

Religious affiliation	Changing dresses daily	Do not Change dress daily	Total
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Hindu (Forward)	237 (81.44%)	54 (18.56%)	291 (100%)
Hindu (Backward)	75 (51.37%)	71 (48.63%)	146 (100%)
Christian	37 (66.07%)	19 (33.93%)	56 (100%)
Muslim	78 (72.90%)	29 (27.10%)	107 (100%)
Total	427 (71.17%)	173 (28.83%)	600 (100%)

Chi-square value =43.70, df =3, Table value =11.345,  $p \leq 0.01$

The association is significant.

### 8.7.2. Educational Status and the Practice of Changing Cloths Daily

Analysis on the relationship between educational status and the habit of changing cloths daily revealed that there is significant difference between those who have no formal schooling and those who have it. While 64.91% of the former category changes their clothing daily the figure shoot up to 76.21% and 75% respectively in case of primary and secondary educated groups.

The results indicate that schooling has a positive effect on the rural population in the matter. It is a consoling fact that even an over whelming majority of the ruralites who have no formal schooling even are in the habit of maintaining personal hygiene by changing unclean cloths.

**Table 8.7.2**  
**Educational Background and the Practice of Changing Dresses Daily**

Educational Status	Changing dresses daily	Do not change Dress daily	Total
No Formal Schooling	172 (64.91%)	93 (35.09%)	265 (100%)
Primary	237 (76.21%)	74 (23.79%)	311 (100%)
Secondary	18 (75.00%)	6 (25.00%)	24 (100%)
Total	427 (71.17%)	173 (28.83%)	600 (100%)

Chi –square =9.08,df =2 ,Table value = 5.991 , $P \leq 0.05$   
The association is significant.

### 8.7.3. Income Level and Practice of Changing Dresses Daily

A very systematic pattern in the habit has been revealed when the data was analysed to find out relationship, if any, existing between the variables. It is seen that as income increases the practice of changing clothing daily become more habitual.

The explanation for this finding is crystal clear. To resort to this practice one should have more number of dresses, to spend more on washing, ironing etc. That is, a thick purse is necessary for this practice to be carried out.

**Table 8.7.3**  
**Income Status and the Practice of Changing Dresses Daily.**



Income (monthly in Rs)	Changing dresses daily	Not changing Dresses daily	Total
Up to 1000 (Low)	43 (38.74%)	68 (61.26%)	111 (100%)
1000-2000 (Middle)	183 (70.93%)	75 (29.07%)	258 (100%)
2000 & above (High)	201 (87.01%)	30 (12.99%)	231 (100%)
Total	437 (71.17%)	173 (28.83%)	600 (100%)

Chi square = 85.16, df =2, Table value =9.210 , P <=0.01

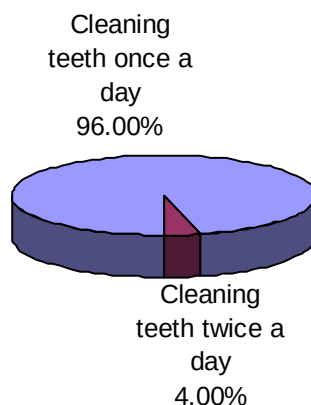
The association is significant.

The practice is unrelated to other background variables, namely, sex, age, occupation, socio-economic status and family size.

### **8.8. Dental Hygiene**

Lack of dental care is often seen as a problem among rural population. Presently science has indicated that lack of dental hygiene is not only to create such problems as dental decay, intestinal disorders, bad breath etc, but it can be casual for such fatal disorders like heart disease. Taking these facts into consideration dentists insist on cleaning teeth at least twice a day - in the morning and at bedtime. In this study the practice of dental cleaning was chosen as a typical index for the health practice of rural people, recognizing its importance.

**Diagram 8.8. Dental Hygiene**



Analysis of the elicited data indicates very grim situation (Table 8.8.1). It is seen that 96% of the respondents are in the habit of cleaning teeth once a day – in the morning. Only 4% of them practice cleaning teeth twice daily in the morning and evening. It is a truism that bacteria grow from decayed food particles remaining on the gum and teeth. After many times of eating in a day the chances for food particles to stick on the teeth and gum are very high at bedtime. So cleaning teeth at bedtime is more important than doing so in the morning. So we have to measure the health habits of Kerala rural people as very low on this scale.

### **8.8.1. Age and the Practice of Cleaning Teeth**

Age wise analysis of the data reveals that the practice is associated with the variable. 96.67% and 96.92% respectively of the low and middle age group pay heed only to clean their teeth once a day – in the morning. The corresponding figure in the case the elderly is 90.59%. But the positive aspect in

the case is that 9.41% clean their teeth twice a day in the morning and at bedtime. It is to be noticed that only 3.33% and 3.08% respectively of the low age and middle age groups resort to this habit. Generally, we expect that the younger age groups are more careful to follow modern methods of health care practices. But the observed results contradict our expectations. An explanation may be that every type of health problem is more during old age. Dental problems are not exceptions. This experience may be prompting them to pay more attention in keeping their teeth clean and hygienic.

**Table 8.8.1**  
**Age and the Practice of Cleaning Teeth**

Age (in years )	Cleaning Teeth once a Day	Cleaning Teeth Twice a Day	Total
Up to 30	58 (96.67%)	2 (3.33%)	60 (100%)
30-60	441 (96.92%)	14 (3.08%)	455 (100%)
60& above	77 (90.59%)	8 (9.41%)	85 (100%)
Total	576 (96.00%)	24 (4.00%)	600 (100%)

Chi-square value =7.56, df = 2, Table value =5.991, P<0.05

The association is significant.

### 8.8.2. Educational Status and the Practice of Cleaning Teeth

Though the strength of those who followed the practice of cleaning teeth twice a day is insignificantly small attempts were made to find out its association with the background variables. This would reveal the trend of the behaviour of the different social categories.

The association between education and the pattern of the behaviour is very significant. It is seen that the behaviour of the illiterate and the primary educated is almost the same. But at the secondary level the behaviour becomes more health friendly. Between the two first groups (illiterates and Primary Educates) those who clean teeth twice a day come to only 3.77% and 3.22% respectively. But in the case of the secondary educated group the practice exists among 16.67%. That is, education is a determinant of good health care practices.

**Table 8.8.2**

Educational Status and Practice of Cleaning Teeth

Educational Status	Cleaning Teeth once a day	Cleaning teeth twice a day	Total
No formal Schooling	255 (96.23%)	10 (3.77%)	265 (100%)
Primary	301 (96.78%)	10 (3.22%)	311 (100%)
Secondary	20 (83.33%)	4 (16.67%)	24 (100%)
Total	576	24	600

(96.00%)                      (4.00%)                      (100%)

Chi-square value =10.56, df = 2, Table value =5.991, P≤0.05

The association is significant.

### 8.8.3. Income and Practice of Cleaning Teeth Daily

Income is a supporting factor for the practice of modern life style, especially when it requires financial commitment. In the case of cleaning teeth, even in rural area, it has become a spending matter. Ruralites have detached themselves from the practice of using carbon powder for cleaning their teeth and switched over to brush and toothpaste. The new method requires spending. The economically better off may be having the practice in a more systematic manner.

**Table .8.8.3**

Income And Practice Of Cleaning Teeth Daily

Monthly Income (Rs)	Cleaning teeth once a day	Cleaning Teeth twice a day	Total
Up to 1000 (Low)	110 (99.10%)	1 (0.90%)	111 (100%)
1000-2000 (Middle)	250 (96.90%)	8 (3.10%)	258 (100%)
2000 & above (High)	216 (93.51%)	15 (6.49%)	231 (100%)
Total	576 (96.00%)	24 (4.00%)	600 (100%)

Chi-square value =7.06, df =2, Table value =5.991, P≤ 0.05

The association is significant.

In the backdrop of this assumption, the data was analyzed as shown in Table 8.8.3. The analysis reveals that the assumption is true 6.49% of the high income group (Rs 2000 and above) clean their teeth at least twice a day while the practice is followed by only 0.90% of the low and 3.10% of the middle income groups.

#### 8.8.4. Socio-Economic Status and the Practice of Cleaning Teeth

A similar way of reasoning as stated in section 8.8.4 helps to formulate the postulate that socio-economic status and the practice of changing teeth are interrelated. Empirical analysis of the data gives support to the presumption.

**Table 8.8.4**

Socio- Economic Status and the Practice of Cleaning Teeth

Socio-Economic Status (in same)	Cleaning Teeth Once a day	Cleaning Teeth Twice a day	Total
Below 20 (Low)	158 (98.14%)	3 (1.86%)	161 (100%)
20- 29 (Medium)	395 (96.11%)	16 (3.89%)	411 (100%)
Above 29 (High)	23 (82.14%)	5 (17.86%)	28 (100%)
Total	576 (96.00%)	24 (4.00%)	600 (100%)

Chi-square = 15.93, df = 2, Table value =9.210,  $p \leq 0.01$

The association is significant.

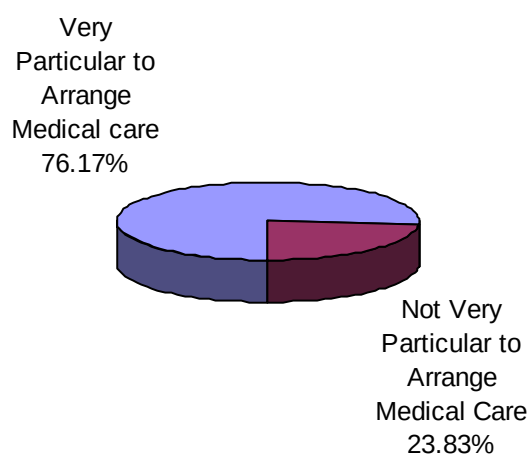
The pattern of relationship revealed in the analysis is that as the Socio-Economic Status increases the practice is more normative. It is seen in the

analysis that only 1.86% of the low socio-economic status group and 3.89% of the middle socio-economic status group follow the two time cleaning norm. The figure is comparatively very significant in the case of the high socio-economic status group (17.86%). The background variables sex, occupation, and family size are not associated with the analysis.

### 8.9. Medical Care to Expectant Mother

All communities pay much attention to the bodily and mental welfare of the expectant mothers. Caring expectant mother is not only beneficial to the individual concerned rather it will build up a healthy future generation. So this was taken as another index for analyzing rural community's health care practices. The practice of pre-natal attention given to pregnant ladies is discussed in this section.

**Diagram 8.9. Medical Care to Expectant Mother**



Analysis in Table 8.9.1 indicates that rural Keralites are very careful about the health condition of expectant mothers. 76.17% of the respondents

indicated that they arrange pre-natal medical attention to pregnant ladies whenever situation arises. Only 23.83% are careless in the matter.

Subsidiary analyses were carried out to find out the influence of the Socio-Cultural variables and it was revealed that all the prominent variables have influence on the practice.

### **8.9.1. Age and Practice of Arranging Medical Care to Expectant Mother in the Family**

Age wise analysis of the practice revealed that 75% of the younger age group (below 30 years), 78.90% of the middle age group (30-60 years) and 62.35% of the upper age group take care to arrange pre-natal medical care for ladies when ever such situation arises. That is, the middle age groups stands ahead of the other groups in the matter. It is to be again pointed out that the older group (60 years and above) is comparatively, the most careless in the matter. We know that the senior persons especially from the rural area will not be so much attracted by modern health care practices as the youngsters are, and this is reflected in this analysis also. The middle age group (30-60 years) will be more facing the medicare situation of expectant mothers compared to the other two groups and that may be the reason for the higher strength of this category.



**Table. 8.9.1**

Age and Practice of Arranging Medical Care to Expectant Mother in the Family

Age (in years)	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Up to 30 (Lower)	45 (75.00%)	15 (25.00%)	60 (100%)
30 –60 (Medium)	359 (78.90%)	96 (21.10%)	455 (100%)
60 & above (Higher)	53 (62.35%)	32 (37.65%)	85 (100%)
Total	457 (76.17%)	143 (26.83 %)	600 (100%)

Chi –square value = 10.85, df= 2, Table value=9.210,  $p \leq 0.01$

The association is significant.

### **8.9.2 Religious Affiliation and Practice of Arranging Medical Care to Expectant Mother in the Family**

Enquiry into the influence of religious affiliation on the practice reveals that different religious groups have different approaches to the issue of arranging medical care to expectant mother. The Hindus show utmost care in the matter. The Christians come second in the line. The Muslims and the Hindu (Backward) are coming in the same compartment, and they are below the Christians.

Hindu community, particularly, the forward groups, is a mother centred one and they give very much importance to the welfare of mothers. By

and large, the pregnancy and childbirth are considered as happy events in the family; particularly if the newborn is a girl child. This vision of the community is seen reflected in their practice. ‘Humanism and modernity’ is the logo of Christian community and they never allow chance to play in the health care matter. This ethic may be prompting them to pay proper attention to the matter. The general moorings of the rural society are seen in the practice of the Hindu (Backward) and Muslim communities.

**Table. 8.9.2**

Religious Affiliation and Practice of Arranging Medical Care to Expectant Mother in the Family.

Religious Affiliation	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Hindu (Forward)	257 (88.32%)	34 (11.68%)	291 (100%)
Hindu (Backward)	90 (61.64%)	56 (38.36%)	146 (100%)
Christian	44 (78.57%)	12 (21.43%)	56 (100%)
Muslim	66 (61.68%)	41 (38.32%)	107 (100%)
Total	457 (76.17%)	143 (23.83%)	600 (100%)

Chi –square value = 53.17, df= 3, Table value=11.345,  $p \leq 0.01$

The association is significant.

### **8.9.3. Educational Status and Practice of the Arranging Medical Care to Expectant Mother in the family**

The relationship between the practice and educational background of the people is rather unusual. It is seen that 69.43% of the respondents who have

no formal schooling follow the practice. In the case of the primary educated it is as high as 82.96%. But it is against our expectation that the figure relating to the secondary educated is only 62.50%. An interpretation of the behaviour cannot be given with out further probing. Generalization of the results may be possible only after such probing.

**Table 8.9.3**  
**Educational Status and Practice of Arranging Medical Care to Expectant Mother in the Family**

Educational Status	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
No Formal Schooling	184 (69.43%)	81 (30.57%)	265 (100%)
Primary Educated	258 (82.96%)	53 (17.04%)	311 (100%)
Secondary Educated	15 (62.50%)	9 (37.50%)	24 (100%)
Total	457 (76.17%)	143 (23.83%)	600 (100%)

Chi –Square value =16.99, df=2, Table value=9.210,  $p \leq 0.01$

The association is significant.

#### **8.9.4. Income and Practice of Arranging Medical Care to Expectant Mother in the Family**

Another subsidiary analysis was carried out as shown in Table 8.9.4 and it enquired into the relationship between the practice and the income status of the people. The analysis shows that a definite pattern in the relation is

discernible – as the income status increases the behaviour also become more and more normative. Only 45.95% of the low-income group adheres to the practice. The corresponding figures in respect of the middle and high-income groups are respectively 74.42% and 92.64%. So the conclusion one arrives at is, income status of rural people in Kerala is a basic variable in determining their behaviour relating to health (and disease). Of course, there are lots of controversies regarding Kerala’s development processes. It is a fact that many regions in the country, which are economically more advanced, are not showing such development hunger as Kerala shows. The presence of other parameters also may be necessary for progressing on the path of development. This study also would like to high light this fact – income sufficiency coupled with other background factors creates more normative behaviour of paying special attention to expectant mothers.

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**Table 8.9.4**  
**Income and Practice of Arranging Medical Care to Expectant Mother in the Family**

Monthly Income (Rs)	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Up to 1000	51	60	111

		(54.05%)	
(Low)	(45.95%)		(100%)
1000-2000	192	66	258
(Middle)	(74.42%)	(25.58%)	(100%)
2000 & above	214	17	231
(High)	(92.64%)	(7.36%)	(100%)
Total	457	143	600
	(76.17%)	(23.83%)	(100%)

Chi-square value =90.18, df =2, Table value =5.991,  $P \leq 0.01$

The association is significant.

#### **8.9.5. Occupational Status and Practice of Arranging Medical Care to Expectant Mother in the Family**

So far analysis have shown that occupational background of the respondents is a weak variable to influence the healthcare practices. However, in this context it is seen that occupation is influencing the practice of giving pre-natal care to pregnant women.

**Table 8.9.5**

Occupational Status and Practice of Arranging Medical Care to Expectant Mother in the Family

Occupational Status	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Manual	237	90	327

Labour	(72.48%)	(27.52%)	(100%)
Skilled	111	21	132
Labour	(84.09%)	(15.91 %)	(100%)
Salaried	37	15	52
Person	(71.15%)	(28.85%)	(100%)
Business	72	17	89
Person	(80.90%)	(19.10%)	(100%)
Total	457	143	600
	(76.17%)	(23.83%)	(100%)

Chi Square value = 8.84, df =3, Table value =7.815,  $P \leq 0.05$

The association is significant.

As seen in Table 8.9.5 skilled labourers are very much concerned about the matter. Then come business groups, Manual labourers and salaried respondents in the order. The percentages of respondents who show positive inclination in the matter are respectively 84.09%, 80.90%, 72.48% and 71.15%. It is to be presumed that persons who are engaged in skilled jobs are more systematic and normative. Business people also are systematic in their vocation. The quality may be influencing them to be normative in this matter too. Manual workers including small farmers, agricultural labourers and salaried people may not be very serious and systematic in their activities and this may be reflecting in their role as guardian / parents of expectant mother.

#### **8.9.6. Socio-Economic Status and Practice of Arranging Medical Care to Expectant Mother in the Family**

Analysis on the basis of Socio–Economics Status indicates that Middle Socio-economic status groups are more concerned about the welfare of the expectant mothers in the family.82% of the group arranges periodical care to pregnant women, while the fraction among the low socio-economic status group is 60.87% and that among the high Socio-Economic Status groups is 78.57%. The latter two groups may be respectively consisting of the ignorant and the knowledgeable. Both the categories may be neglecting their responsibility in the matter and hence comparatively low strength of these groups. The middle socio-economic status group may be more anxious to look after the welfare of pregnant ladies properly.

**Table 8.9.6.**  
**Socio-Economic Status and Practice of Arranging Medical Care to Expectant Mother in the Family.**

Socio Economic Status (Score)	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Below 20 (Low)	98 (60.87%)	63 (39.13%)	161 (100%)
20-29 (Medium)	337 (82.00%)	74 (18.00%)	411 (100%)
Above 29	22	6	28

(High)	(78.57%)	(21.43%)	(100%)
Total	457	143	600
	(76.17%)	(23.83%)	(100%)

Chi square value = 28.53, df =2 , Table value =9.210, P ≤ 0.01

Association is significant.

### 8.9.7. Family Size and Practice of Arranging Medical Care to Expectant Mother in the Family

A significant result has been highlighted when the data was analyzed on the basis of family size. As seen in Table 8.9.7 small family is more careful to provide their expectant mothers with medical care. 84.07% of families comprising of below five members promptly arrange medical care to expectant mothers. Then come the larger families (77.14%). The medium sized families (5-8 members) are relatively backward in the matter. Delivery of one or two children is looked upon very seriously and prompt medical attention is arranged. This may be the reason for the greater concern of small size family for expectant mothers. In the case of many deliveries by a woman complication associated with pregnancy may be more expected. Hence large families may also be more conscious about arranging prenatal care for pregnant women.

**Table 8.9.7**

Family Size and Practice of Arranging Medical Care to Expectant Mother in the Family

Family Size (No. of members)	Very Particular to Arrange Medical care	Not Very Particular to Arrange Medical Care	Total
Up to 5	190	36	226



(Smaller)	(84.07%)	(15.93%)	(100%)
5-8	213	91	304
(Medium)	(70.07%)	(29.93%)	(100%)
8 & above	54	16	70
(Larger)	(77.14%)	(22.86%)	(100%)
Total	457	143	600
	(76.17%)	(23.83%)	(100%)

Chi Square value = 14.05, df = 2, Table Value = 9.210,  $P \leq 0.01$

The association is significant.

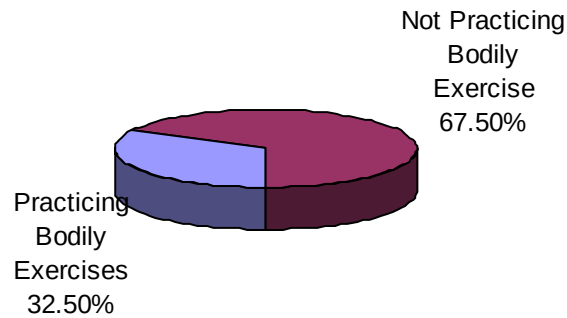
The demographic characteristic-sex is not associated with the practice of arranging medical care to expectant mother

### **8.10. Bodily Exercise**

It is the general principle that when a structure is deprived of its expected function for a long time, it becomes worn out and ultimately face decay. In the case of human body all its parts have certain expected movements for which energy is absorbed and thus keep them in healthy conditions.

Earlier, rural family was sustaining on hard work of its members. This hard work gave good exercise for the body, mind and spirit of the ruralites. Rural Kerala has undergone drastic changes especially in the wake of the acceptance of small family norm and the spread of education. The necessity and the willingness of people for hard work are no larger seen here. Naturally, people become prey for diseases, which are appendages of urban lifestyles.

**Diagram 8.10 Bodily Exercise**



In this study an enquiry was conducted to reveal the importance given to bodily exercises. This would naturally decide their health and disease conditions. The respondents were asked whether they are in the habit of doing bodily exercises daily. The responses indicate that only 32.50% are in the habit of practicing bodily exercises and the rest (67.50%) are not. In the sample 54.50% are manual workers. If we avoid the group since they have sufficient bodily exercise through their work, still then there are some 23% of the respondents who lack proper exercise to keep their body lively. So it is to be concluded that the rural Keralites are not so serious to practice bodily exercise and keep them healthy (Table 8.10.1).

#### **8.10.1. Sex Difference and Habit of Practicing Bodily Exercise**

The first analysis under this section was to see the relation between sex and habit of practicing bodily exercise, if any existing. The results of the

analysis show that male respondents practice exercise daily to a greater proportion (34.26% of the total male respondents) than their female counter parts do (23.16%). The reason for the lower proportion of females is quite clear, namely, multiplicity of the roles they have to play and shortage of time to attend to their personal matters. This is a common problem faced by our rural folk. This lack of proper exercise, however, may be compensated by their over work in the household.

**Table.8.9.1**  
**Sex Difference and Habit of Practicing Bodily Exercise**

Sex	Practicing Bodily Exercises	Not Practicing Bodily Exercise	Total
Male	173 (34.26%)	332 (65.74%)	505 (100%)
Female	22 (23.16%)	73 (76.84%)	95 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi Square value = 4.49 df = 1, Table Value = 3.841,  $P \leq 0.01$

The association is significant.

### **8.10.2. Age Status and Habit of Practicing Bodily Exercise**

For reasons best known to every one, it was assumed that the younger people are more interested in doing exercises. The data was analyzed as shown in table 8.10.2 to establish the validity of the assumption. It is seen that as age increases the habit of doing exercises decrease, thus validating the assumption.

45% of the younger age group, 33.63% of the middle age group, and 17.65% the older group are in the habit of practicing bodily exercises.

**Table 8.10.2**  
**Age Status and Habit of Practicing of Bodily Exercise**

Age (in years)	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
Up to 30 (Lower)	27 (45.00%)	33 (55.00%)	60 (100%)
30 – 60 (Medium)	153 (33.63%)	302 (66.37%)	455 (100%)
60 and above (Higher)	15 (17.65%)	70 (82.35%)	85 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi square value =13.08, df = 2, Table value =9.210,  $P \leq 0.01$

The association is significant.

### **8.10.3. Religious Affiliation and Habit of Practicing Bodily Exercise**

The study attempted to find out whether the practice is religion specific. Analysis carried out with the data revealed that 43.64% of the Hindu

(Forward) and 39.25% of the Muslims practice bodily exercise systematically. The figures in respect of Christians and Hindu (backward) are respectively 21.43% and 9.59%. This shows that the forward Hindus are most conscious about the role of exercise in keeping their body healthy and free from diseases. Muslims come very closer to this category. There is a wide gap between Christians and the first mentioned two religious groups. The backward Hindus are far behind the other communities in the matter.

**Table 8.10.3**  
**Religious Affiliation and Habit of Practicing Exercise**

Religious Affiliation	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
Hindu (Forward)	127 (43.64%)	164 (56.36%)	291 (100%)
Hindu (Backward)	14 (9.59%)	132 (90.41%)	146 (100%)
Christian	12 (21.43%)	44 (78.57%)	56 (100%)
Muslim	42 (39.25%)	65 (60.75%)	107 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi Square Value =56.76, df = 3, table value = 11.345,  $P \leq 0.01$

The association is significant.

The disparities may be explained on the basis of relationship between religion and occupation. In rural areas the backward Hindus are either marginal farmers or agricultural labourers and they may be doing hard work in farmland or paddy field. So they need not practice any sort of exercise and

probably they may not be getting spare time to engage themselves in physical exercises. The case of Christians too may be having a direct bearing on their craze for work on land. They are big and marginal farmers in Kerala at present. The forward Hindus are generally leisure group who get more time for engaging themselves in art, gymnastics, etc.

#### 8.10.4. Educational Status and Habit of Practicing Exercise:

Education based analysis of the practice revealed that 42.12% of the primary educated (the group is the topper) and 22.64% of illiterates practice physical exercises. The fraction among the secondary educated respondents is very small consisting of only 16.67%.

**Table 8.10.4**

Educational Status and Habit of Practicing Exercise

Educational Status	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
No Formal Schooling	60 (22.64%)	205 (77.36%)	265 (100%)
Primary	131 (42.12%)	180 (57.88%)	311 (100%)
Secondary	4 (16.67%)	20 (83.33%)	24 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi Square Value = 27.61, df = 2, Table Value = 9.210,  $P \leq 0.01$

The association is significant.

The analyses show that the primary educated ruralites are more interested in doing physical exercise. The higher educated group's strength is lesser than that of the group who have no even formal education (Illiterate). So an interpretation requires further probe connecting the variables (education) to other intervening variables.

#### 8.10.5. Income and Habit of Practicing Bodily Exercise

The study enquired into the nature of relation ship between income status and practicing bodily exercise.

**Table 8.10.5**  
**Income and Habit of Practicing Bodily Exercise**

Monthly Income (Rs)	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
Up to 1000 (Low)	14 (12.61%)	97 (87.39%)	111 (100%)
1000-2000 (Middle)	72 (27.91%)	186 (72.09%)	258 (100%)
2000 & above (High)	109 (47.19%)	122 (52.81%)	231 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi Square Value = 45.20, df = 2, Table Value = 9.210,  $P \leq 0.01$

The association is significant.

The analysis shows that there is a definite pattern in the relationship between the variables, namely, the higher the income the greater the practice is. 12.61% of the lower income category, 27.91% of the middle-income group and 47.19% of the higher income group are regularly practicing physical exercises. It

is to be inferred that the higher income groups are more engaged in non-manual jobs that impart bodily exertion. So they have to bank upon physical exercises.

### 8.10.6. Occupational Status and Habit of Practicing Bodily Exercise

**Table 8.10.6.**

Occupational Status and Habit of Practicing Bodily Exercise

Occupation	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
Manual Labour	99 (30.28%)	228 (69.72%)	327 (100%)
Skilled	48 (36.36%)	84 (63.64%)	132 (100%)
Salary	10 (19.23%)	42 (80.77%)	52 (100%)
Business	38 (42.70%)	51 (57.30%)	89 (100%)
Total	195 (32.50%)	405 (67.50%)	600 (100%)

Chi square Value = 10.03, df = 3, Table Value = 7.815,  $P \leq 0.05$

The association is significant.

As cited in many fore gone analyses, occupation decides the physical exertion under going by people. When physical strain in the occupation is higher people feel lesser necessity for bodily exercise done systematically. Therefore, in this study an analysis was carried out under the assumption that there is association between occupation and the practice. The analysis (Table 8.10.6) indicates that the assumption is true. The business people do exercises very systematically more (42.70%). Then come skilled Employees (36.36%). Below them come manual labourers (30.28%) and finally the salaried group (19.23%). In



many analyses the behaviour of the businesspersons were mentioned and explained. Here one significant result is that of salaried group. Though they are not facing much physical exertions during their jobs, they are not interested in practicing bodily exercises. Their behaviour may be explained only after further probing.

### **8.10.7. Socio Economic Status and Habit of Practicing Bodily Exercise**

Finally it was established that socio economic status of the rural people and their habit of practicing physical exercises are associated. Results of empirical analysis were that the middle Socio-Economic Status group and the high Socio-Economic Status group have similar habit in this regard. 37.96% of the middle Socio-Economic Status group pay attention to keep their body fit through physical exercises. However it can be seen that the middle Socio-Economic Status group has a slight edge over the high Socio-Economic Status group in the matter. Only 18.63% of the low Socio-Economic Status group pay heed to this matter. Low Socio-Economic Status group may be facing time constraints to do physical exercises systematically. More over their work itself may be demanding more physical exertion that negates the necessity for further physical exercises by them.

**Table 8.10.7**

Socio Economic Status and Habit of Practicing Bodily Exercise

Socio Economic Status (in score)	Practicing Bodily Exercise	Not Practicing Bodily Exercise	Total
Below 22	30	131	161

	(18.63%)	(81.37%)	(100%)
22-29	156	255	411
	(37.96%)	(62.04%)	(100%)
Above 29	9	19	28
	(32.14%)	(67.86%)	(100%)
Total	195	405	600
	(32.50%)	(67.50%)	(100%)

Chi Square Value = 19.69, df = 2, Table Value = 9.210,  $P \leq 0.01$ .  
The association is significant.

## Summary

In this chapter the practices relating to health and disease of the rural people are analysed in ten sections.

The indices of health care practices were preference for system of medicine and treatment, habit of keeping surroundings hygienic, method of waste disposal, giving ventilation for dwelling units, using foot ware, pattern of treating disease, changing clothing daily, keeping dental hygiene, arranging medical care to expectant mother and practicing bodily exercise.

The analyses indicate that Kerala rural community has fairly good health and hygiene maintenance practices.

Regarding the relationship between socio-cultural background and health care practices it is seen that religious affiliation, educational status and income status are strong background factors that influences the practices.



## **CHAPTER - IX**

### **CASE STUDY - 1**

The present case is one of an acute diabetic patient who has been suffering from the disease for the past 10 years. His right leg is very badly affected by the disease. Pussu wound is there on his leg and this creates a lot of pain and inconveniences to him. More over he is suffering from hypertension and coronary ailment. Occasionally he becomes unable to move around and hence bed ridden.

The researcher has attempted to establish association between the diseased condition and the socio-economic and cultural backgrounds of the patient and substantiate his central proposition that they are associated.

Accordingly, environmental and social background of the patient was probed. The physical environment in which he lives is not very healthy the dwelling unit is a two-bed room structure. A kitchen and a small work area are appended to it. Eight members of the family share the house. Naturally, we could understand the congestion that the members experience. The house is ill ventilated and the family is not in the habit of opening the windows. Polluted air is repeatedly inhaled and the situation is conducive for the spread and aggravation of respiratory diseases.

Source of drinking water is an unprotected well. Washing, bathing and cleaning of utensils are carried out by the side of the well. The water is contaminated and the chances for water borne diseases are very high. The leach pit is very nearer to the well. The latrine is squatting type and not fitted with fleshing type closet. On the whole, it is unhygienic.

The small piece of land is smeared with waste materials and wastewater. Occasionally the materials are broomed and burned. So intermittently the atmosphere around becomes clogged with smoke and fumes. Inside the house also the air is smoky due to burning of firewood for cooking purposes and lack of proper ventilation. The head of the household is a chain smoker and the members of the family are forced to experience passive smoking. Unpleasant smell of cigar, clog around, creating nausea for occasional visitors.

The economic status of the family is fragile. On an average the family secure Rs.5000 per month and it is to cater to the needs of 8 members. The earning members are the two sons of the diseased person. They are employed in private firms. The income per capita is an indicator of their poor nutritional standard.

The social status indicators reveal a grim condition. The family belongs to backward Hindu community, which had been, as we know, victims of social stigma and backwardness. The diseased person is 58 and his wife is 50,

both illiterate. None of the family has got education beyond primary level. The educational backwardness of the family gives boost for blind believes. Regarding the cause of diseases they believe that past sins are responsible for them. Therefore, medicine and treatment have very little role in keeping people healthy – they believe. They have faith in *manthravatha* (black magic). So they prefer *manthravatha* for curing disease.

They have certain unfounded faith regarding food habit too. Rice is unavoidable, wheat and other cereals are insufficient. By and large, they take non vegetarian food items. Leafy vegetables are given very little importance in their diet. The family is also under the clutches of much folk beliefs relating to health and food habit. Male members are to take food first; the left over food are to be consumed by female members. Pregnant woman shall not be given fatty and nutritious food for they shall complicate the delivery. Pregnant woman is not allowed to take rest she has to do hard work, then only the delivery will be normal.

Analysing the socio cultural background of the family and the disease of the head of the household on the basis of scientific principles, it can be strongly believed that they are related. As known to modern medicine diabetic has a genetic cause for its occurrence. However, lack of awareness about the disease and its management are aggravating factors of it. Here it is seen that the personal and environmental hygiene of the patient are seen very low. Further, he is a chain smoker, which is a supporting factor for the occurrence of many ailments like

hypertension, heart and lungs problem. Blockade of proper blood circulation and decay of body cells (diabetes patients problem) are also attributable to the smoking habit.

Their strong faith in *mantravatham* is a supporting factor for the continuance and aggravation of the body decay. This is because of physical cleanliness is must for preventing the body from decaying. As we know *mantravatham* performances themselves are capable of making the surroundings and the performers and the client's body unclean. They will give little importance to the hygiene aspects because the spirit that is propitiated through *mantravatham* will take care of disease whatever be the casual factor.

Their over dependence on rice and non-vegetarian food materials and negligence to take green and leafy vegetables are certainly promoting the disease. Another background factor that helps augment the disease is the unsatisfactory medical facilities and know-how available in their neighbourhood. Since the person is having very poor economic background, he is depending on the local PHC for knowledge on sanitation and medical assistance. The ill-equipped PHC is incapable of disseminating awareness about managing disease like diabetics, which though seems to be simple to common people, is a very complicated one. The PHC is not capable of giving proper medical attention for the reason that medical and health care expert are in acute shortage.

On the whole, it is to be seen that the personal and social factors are playing important roles in the causation and continuance of the diseases of the person.

## **CASE STUDY – 2**

In this analysis the case of a person suffering from Tuberculosis (TB) is discussed. The person is 50 years old. He is a member of the Scheduled Caste. His family consists of his 45 year old wife, two daughters and two sons. The eldest child (son) is 23 years and the youngest (also son) is 12 years old a seventh standard student. The two daughters are aged 20 and 18 years.



The husband and wife have primary education. The person was a coolie but during the last 5 years his ailment interfered with his occupation and now he is keeping himself idle and confined to the domestic environment. His wife is suffering from severe asthma and she also has no gainful occupation. She attends to the domestic duties whenever she is free from the severe problem. The earning members of the family are the eldest son and first daughter. The former is a tailor and the later a domestic servant. The total monthly earning of the family is around Rs.3500/- per month and it is to be shared by the six members.

In terms of income the family is living in poverty. The family owns a piece of land (5 cents) and a small tiled house. The unit consists of two small bedrooms, a kitchen and a work area. The house is poorly ventilated and whatever provisions for it are seldom open. So the air inside is totally polluted. The pollution is increased due to the burning for the firewood for cooking purpose. Another polluting agent is the smoking of the person under consideration. He smokes beedi, causing passive of other members of the family. Since six members share the unit that itself is creates poor quality living environment in the unit.

The source of the drinking water is an unprotected well. It is close to the leach pit and waste ditches. The ditches are breeding places of mosquitoes and harmful flies.

The male members of the family use a pit type latrine with out water seal. The female members go pretty away in the company of female members of the other families for open defecation. The people of the locality think that female members do not require latrine since they are leisure group. Naturally, this practice is conducive for environmental pollution.

The social habits and beliefs are significant to be mentioned here. Even if the member of the family is infected with disease like TB and leprosy, it is kept confidential as far as possible because it has social stigma. So treatment is also delayed which necessitates prolonged future treatment. Hence the treatment cost is increased. The family also upholds the concept of *Kaippuniyam* (unexplained expertise of the medical practitioner) and prefers Ayurveda.

The awareness level of the family about the disease is very low. They do not know how the disease is spread out and can be controlled.

Now let us look into the possible relationship between the diseases and the social and the personal factors that influence them. According to medical insights both TB and asthma have connections with contaminated air space. TB is an infection disease spread out through bacteria present in the air. Asthma, though not an infectious disease, polluted air can aggravate its symptoms. In the case of the present persons (husband and wife) the environmental factors creating the disease are strongly present. Polluted air is adversely affecting both the patients.

We see that there is congestion in the house, poor ventilation, smoke created and presence of germs due to open defecation in the air. Water is almost certainly contaminated.

Poor nutrition due to poor economic status is a harsh reality for the family and it is definitely casual for TB and Asthma. Early detection and treatment are also blocked due to blind belief and social stigma related to the disease. More over economic status of the family prevents the patient from seeking better treatments. They only approach the local PHC for treatment where basic health delivery facilities even are scarce. The folk belief of the family regarding *Kaippuniyam* and auspicious day observance of starting with treatment are adverse factors for the control of the diseases.

As in the case study, the personal and social factors are found to be intimately related to the awareness about the diseases and management of them. Here we are once again reminded the observation of a Prudue University Health Communication expert that “improving a persons health in India, or in any country, need to start with an understanding of culture”.

### **CASE STUDY - 3**

The present case reveals how style of life and cultural factor become causal for diseases. This is a case of the wife of the head of the household of a Muslim family. She is suffering from hypertension that was identified some three years ago when she fainted and fell down. She is now an acute sufferer of the disease.

The head of the household is a shopkeeper, 58 years old. He resides in his own house with his 50 year old wife, four sons and an unmarried daughter. His sons are married and all except the last one have children. The last son is expecting a baby soon. In the family altogether there are fourteen members residing under the same roof.

The family is residing in a semi-permanent house having three bed room, a kitchen and work area. The congestion in the house is quite clear, roughly five members have to share a small room. By habit they are averse to open the ventilators and windows of the house. They use firewood and smoke remains stagnant in the rooms. Inside the house there is full of sound produced by the children and grand children. The orchestration is augmented by the sound produced by the mothers and grandmother. The congestion and sound inside the house aggravate the health problem of the woman (spouse of the head of the household).

Though the family is not very affluent, the style of life of women in the family is somewhat leisure prone. None of the female members go for work outside. Household tasks of a small house are attended by six adult female members. This gives no scope for physical exercise for them the members use pardha and do not usually expose themselves to outside world.

The household has fairly good income earned by the male members. However, mental tension may be much experienced by the female members, due to the lower status ascribed by male members on whom they much depend upon. The spouse of the head of the household is the patient here. Her mental agony may be many fold due to the reason that she has coordinate the joint family which consists of many sons and daughter-in-laws and her own daughter.

The food habit of the family is conducive for the occurrence of disease like B.P and hypertension. They quiet often take non-vegetarian food materials. Their menu very rarely consists of vegetable items.

The analysis very well reveals the relationship between the socio-cultural background of the patient and her ailment.

A second component of this case study focused on another reality. That is over all religious ethics and low educational standard of couples may create unhealthy environmental sanitation, which can create severe health hazards.

Here as has been pointed out the head of the household is only primary educated. So too the educational background of his spouse – a third standard women. The family has satisfactory income. Rs.4000/-is the income reported by the head of the household from his own shop. Other three sons have their own individual income, which are pooled together. However, when the environmental sanitation, food habit, childbirth pattern and personal hygiene are analysed we understand that the income by them is not capable of generating good living condition. Instead, socio-cultural factors are very much a determinant of the matter.

The family is residing in very congested and badly maintained house. Suffocating atmosphere is created inside the dwelling unit by bad

ventilation and smoke from the hearth. The women are practicing purdha. They are not permitted to freely mingle with the outside world.

Their food consists mainly of non-vegetarian stuffs, which shall create fatty bodies and complaints of cholesterol. As we have seen, the spouse of the head of the household is a hypertension patient.

When we analyse the strength of the family and the childbirth history of the women, it is seen that she had given birth to the first child at the age of 18. By 31 years of age she gave birth to 5 children. The facts indicate the mental and physical strain faced by the woman.

Naturally, when strength of the family is higher other infra structural and sanitation facilities are to be enhanced so that a peaceful and healthy life can be ensured. But these matters have been given scant attention.

Drinking water is taken from an unprotected well and hence the danger of water born diseases exists. The family is using water seal latrine. The female members are very particular in this regard. However, it can be inferred that, since there are many members using one latrine, the hygiene condition is very low.

Waste disposal is carried out in a very careless manner. Solid waste is either burned or dumped here and there. Liquid waste is collected in ditches, which become breeding places of varieties of harmful flies and insects.

This discussion concurs with the observation of a Purdue University expert that, “today’s healthcare technology that is used to communicate and to treat people is amazing, but there are many cultural barriers that prevent some rural groups accessing this benefits”. It can be stated with great confidence that the religious ethics and educational standards of the leading members of the households are mainly determining the demographic profile and environmental sanitation (healthy living) of rural families.



## **CASE STUDY - 4**

The present case demonstrates how life styles coupled with cultural lag affect health and hygiene of rural people. The case of head of the household under analysis is a female, 52 year of old and member of forward community (Nair). Economic prosperity is at it's zenith. Husband and her two sons are employed in gulf. The daughters-in-law are residing with the woman and there are no other members in the family. The educational status of the members is not very high. Her sons are completed technical education. The head is only illiterate. The daughters-in-law are completed pre-degree.

However, economic prosperity is high, as gulf money has been pouring in for the last 10 years. They built a very good house with European type toilets, water supply system etc. LPG and firewood are using for cooking purposes. The lower educational status is reflected in the up keeping of the toilets, washbasins, kitchen sinks, bathroom towels and such other facilities. The windows and ventilators are rarely opened. They have excuse for not opening them - the absence of male caretakers.

The cultural lag lies in the fact that there are modern arrangements and gadgets in the household, but the inmates are not used to them and are maintained in a very bad shape. Though not very acute, the members are every

now and then are affected by air born and water born diseases like malaria, cholera, dysentery, typhoid etc.

Coming to the life style disease, all the female members are suffering from obesity, which is considered as the consequences of over eating (particularly fatty food), lack of bodily exercise. The obsess person becomes fatty and unduly gain weight.

In the family the problem of obesity is very seriously faced by the mother-in-law. Since they have very good income none of them is needed to attend to even house hold task. The mother-in-law is particularly “taken care of“ by the two daughters-in-law. The mother-in-law is not getting opportunity even for washing a spoon in her kitchen; she consumes very high calorie food, watches TV and sleeps at intervals. What else is needed for getting fatty? Her daughters-in-law are also getting obsess. Obesity has been linked to several diseases like heart diseases, cancer, and diabetes. Many risk factors are associated with these diseases, such as high cholesterol and blood pressure.

This is a common problem faced by rural households in Kerala. People are migrating to the west and middle-east. There they do very hard, good work and remit good amount to the NRI accounts. Back in their homes the family members enjoy all sort of material comforts. In India obesity is typically characterized as the consequence of irrational eating. The prevalence of over

weight and obesity are seen related to the level of education particularly among women.

## **CASE STUDY - 5**

Here is another case of a small family consisting of 62-year-old mother; her 45-year-old divorced daughter and her two children aged 15 and 12 years respectively. The elder grandchild is a son and the other, a daughter.

The daughter was divorced by her husband's ill-treatment, ten years ago. The divorce is a case of ultimate end point of a story of confusion created by traditional belief of the mother, ideological difference between the spouses and all the more the, behavioural problems of the two parties. The details are not very relevant in our discussion and are avoided. Any way one thing is to be noted down very painfully; that is the status of the divorcee ascribes her social stigma and she is not welcome in public and social situations. Being a divorcee she is looked upon as a deficient woman. The stigma transcends to her children and mother too.

The family is living in a small dwelling unit consisting of a two-room tenement. The physical environment is quiet shabby-water clogged and mosquito breeding. The bathing and washing are carried out near well that is not properly fenced and protected. The wastewater stagnates around the house making it marshy.

The income of the family is around two hundred rupees earned through their work as domestic servants. Both of them have to work hard to earn

the amount and buy some food items, both prepared and raw. The returns are hardly sufficient to feed their younger ones. The children are studying in 10<sup>th</sup> and 7<sup>th</sup> standards and they are to be given uniforms and study materials from this meagre income.

The study is to be focussed on their health care practices since they are closely related their traditional beliefs in the power of gods and goddesses. Incidentally it may be pointed out that they are members of Hindu backward community. The mother is suffering from asthma, acidity and swelling on the leg (limbhoedema disease). Any one who has visited her dwelling place can understand that the problems are caused due to the unhealthy condition, particularly air pollution and presence of vectors. The family is highly under mental stress. The hyper acidity experienced by the mother and daughter is directly related to the stress and lack of proper food. The swelling on the mother's leg is due to bad environmental condition and may be due to filariasis.

Being these are the conditions, the mother and daughter do not know the real reason for their health problem, instead, they believe that they (diseases) are the incarnation of the wrath of gods and goddess. So they spend on visiting temples and shrines and great offering to propitiate the deities.

Their rationality is eclipsed by blind faith in black magic and crude religious practices. Their educational backwardness (the mother is illiterate and

the daughter is only third standard) may be the major reasons for their blind faiths and practices related to them.

They very much like the revelations by Sooth Sayers and *manthravadies*. For the curing of their diseases they also consult with such persons. In addition, they call back on religious faiths and practices. Occasional relief got to their health problems that are the nature of certain diseases, is interpreted by their problem solvers as the blessings of the super natural forces that create the turbulence. This reinforces the faith of the victims in the godly persons' interpretations. They accept remedies suggested by them like certain threads, powder that are claimed to have magical curative powers.

Whenever they use medicines they resort to traditional medicines like Ayurvedic and Unani preparations. Modern medicines are not much welcome by the mother and daughter.

Here we see the health problems that are created by the poor socio-economic backgrounds of a small family who are under the clutches of blind faiths related to diseases and curing methods. These cases are representatives of a section of rural Keralites who strongly believe that supernatural forces can become healers of their diseases and act accordingly. Good education and over all development of the incumbents only can help tide over the situation.

## **Conclusion**

The case studies strongly support the central hypothesis of this research, that personal and socio-cultural backgrounds are determinants of the concept of health and practices related to it.

## CHAPTER - X

### SUMMARY OF RESULTS AND CONCLUSION

The study is an attempt to analyze the influence of culture on the concept of health, beliefs relating to it, awareness about and adoption of health-care practices of rural people of Malabar region of the State of Kerala.

The specific objectives of the study are :

1. To analyse how rural people look upon the state of health and disease and the variations on their perceptions on account of their social and cultural backgrounds.
2. To enquire into the belief system relating to the determinants of health and disease and how it varies according to the socio-cultural background of rural people.
3. To analyse rural communities' perceptions on and approaches to different systems of medicines and treatments and the influence of their socio-cultural backgrounds on them.
4. To enquire into the personal hygiene and environmental sanitation of rural people and influence of their socio-cultural backgrounds on the matters.
5. To analyse the practices of health care and controlling diseases of rural people and how they vary with their socio-cultural backgrounds.

Under the major objectives the following hypotheses were formulated for testing.



1. The sanitation scenario of the study area is not conducive for good public health and it varies with geographical location.
2. The population of the area is, by and large, ignorant about the social and psychic dimensions of health and their ignorance is related to the socio-cultural characteristics, namely, age, sex, education, religious affiliation, occupation and income status.
3. Rural people under study have strong faith in the causation of diseases by supernatural forces and the faith is related to their socio-cultural background.
4. The rural people define health, by and large, on the basis of physical well being and this outlook varies according to their socio-cultural background.
5. Rural people of the area have strong faith in traditional systems of medicines and treatments and the faith is related to their socio-cultural characteristics.
6. The people are, on the whole, ignorant about the significance of personal hygiene and environmental sanitation in the maintenance of health and preventing diseases and their ignorance is related to the socio-cultural backgrounds.
7. The people are, by and large, ignorant about proper waste disposal and their ignorance is related to their socio-cultural characteristics.
8. The people, generally, are unaware of the necessity of the special care required for expectant mothers and the lack of awareness depends on their socio-cultural background.

The data required for the empirical part of the study were collected from six hundred out patients of the PHC areas of Malabar region. One PHC each from six districts (Palakkad, Kozhikode, Wyanad, Kannur, Kasargode and Malappuram), which constitute the region, was first selected using random selection procedure. From the selected PHCs 100 outpatients each were selected randomly following client-flow sampling method. They were interviewed for primary data.

Interview schedule was the major tool used for collection of data. Secondary data were collected from appropriate sources. Using SPSS package the data were analysed and conclusions arrived at.

A summary of the results and conclusion arrived at from the analyses is given below :

### **10.1. The Sanitation Scenario**

The first segment of the study investigated into the health and sanitation condition the study area, the relevance of which in the study need not be articulated. Enquiry on the type of housing revealed that only 15.17% of the respondents have permanent, and properly built houses and the rest are residing in temporary dwelling units. This will definitely have impact on the health and hygiene of the people.

District wise analysis of the availability of good housing facilities indicates that Wayanad is more blessed with them, though not satisfactory. 31% of the respondents have permanent dwelling units. Kannur is very backward in this matter.

The study further reveals that 54% of the respondents are keen in keeping their domestic environment clean and this habit is more among Palakkad population. The higher proportion of Hindu population of the area may be responsible for this achievement.

Source of drinking water also was analysed in the study, which is a strong indicator of health and sanitation of a locality. The analysis indicates that public well is more depended upon for drinking water (35.17% of the respondents come under this category). 22.83% have own pipe system, 21.67% depend own well and 15.67% on public tap.

Palakkad district has more own well users while Kozhikode is first in common well users. Malappuram have more own pipe system users while Kannur more depends on public tap.

It is to be highlighted on the basis of the study that majority of the wells are not sanitary type. They have no proper protection from contamination.

When taking the question of contamination, the analyses considered the proximity between well and leach pit of the toilet. It is seen that majority of the wells are not sufficiently away from the pits. That is, there is the possibility of contamination of the well from the leach pit.

The enquiry, which attempted to reveal the sanitation scenario of the study area, analysed the type of latrine used. The analysis reveals that 60.17% have latrines without proper flushing system. The rest are having the facility (39.83%). In this matter Kozhikode is very backward, only 8% of the respondents from this area use flush type closets. Palakkad and Kasargode are far ahead of Kozhikode in this matter.

Another index of sanitation condition was the behaviour of solid waste disposal of the population. It was seen that only 12.50% of the respondents handle waste in a meaningful and harmless manner. They use it for making manure. 54.67% dump the waste in some corner of their courtyard and 32.00 % burn it. Both these methods are harmful for maintaining good health and sanitation. In this profile Kozhikode and Palakkad are in a better standing by using waste for manure production.

Finally, expense of the households on care medical was analysed. The analysis indicates that 43.83% of the sample spent Rs.50 per month and 21.83% more than Rs.50 but below 100. 13.67% spent more than Rs.100 per

month for this purpose. The enquiry also indicates that the people heavily depend on the services of governmental organisations to satisfy their health care needs. This might be a strong reason for the comparatively lesser spending on medical care. The sick health care organisations run by the government are the major support for the rural people of the region.

Analyses of this section indicate that the sanitation condition of the region is not anything healthy. This will definitely tell upon the health condition of the people. Further, there are variations in the sanitation status of different districts, which are indicative of the difference in the general culture of the localities. By thus, this section reveals that sanitation is influenced by the general culture of the people.

## **10.2. Beliefs Related to Health and Disease**

One of the core themes dealt with in the research was the belief of the rural people relating to health and disease and how they are influenced by the socio-cultural characteristics of the people.

Various indices were chosen and analyses were carried to satisfy the objective above stated. The analyses are briefly discussed in this section.

The study; enquired into the belief of the people regarding the cause of mental illness. When the data was analysed it was revealed that the people have

very irrational belief about the cause of the disorder. 77.50% of the respondents believe that evil spirits cause mental illness.

When sub analyses were carried out it was revealed that the primary educated, higher income group and skilled labourers are the easy prey for the blind belief. The people believe that certain types of diseases have stigma attached to them and hence their occurrence shall not be revealed to others. This study also revealed the existence of the belief among the respondents. 77.83% have such belief and the rest do not uphold such belief. The belief is stronger among Hindus, primary educated section, higher income group,, middle socio-economic status group and small family category.

The people of the region have wrong motion about sexually transmitted diseases. Only 24.17% believe that the diseases are spread through unprotected sex. The rest cited many other reasons, which are far away from rational thinking. Breach of taboo and past sins are seen as reasons for STDs. 12.67% look upon the disease as a hereditary problem.

Breach of taboo is highlighted by Hindu (Forward) and Christians as reason for STDs spread. Among the educational categories the illiterate and primary educated subscribe more to the belief. The low income group's belief regarding the reason for STDs transfer is closer to the reality than that of the other

groups. Similarly the belief of the salaried, low SES, large family size groups come closer to the true reasons in the matter.

Auspicious day for starting with medical treatment is much emphasised by the rural people – the study indicates. 84.17% of the respondents believe that it is a good practice and they follow it. The rest (15.83%) have no such belief and do not observe the practice.

Secondary analyses reveal that the belief is greater among high-income categories. Medium SES group also has firm belief in the observance of auspicious day for starting with medical treatment.

Analysis on *Kaippunuyam* (unexplainable talent of medical practitioner to cure diseases) indicates that the belief is strong rooted in the population. Regarding the influence of background variables, Hindus (Backward) and Christians are strong believers of this notion. Another result is that the belief becomes diluted as income status increases. However the belief is very strong among the high SES group.

Belief regarding the diet of pregnant lady was analysed. Overwhelming majority believe that no particular care is needed for expectant mothers. The general belief is that nutritious food may complicate pregnancy and childbirth of women. The belief is strong among female members. In this matter

age is a deciding agency. The elder the age the stronger the belief that pregnant woman need not require special attention in diet.

### **10.3. Awareness About Health and Disease**

To analyse the awareness of the rural people about health and disease various indices were taken and studied.

The first analysis was relating to the perception on health. 45.67% consider health as total well being. 37.67% define it as capacity to do work and the rest (17.67%) look upon it as the state where there is no disease. This shows that a larger portion of the population, but not majority, ignores the mental and social dimensions of health.

The total welfare concept of health is emphasised by around 45% of all the religious groups except Muslims. In the case of Muslims the figure is 39%. Further, the concept is more accepted by primary educated, middle income, medium SES, skilled worker and small family size groups.

The concept of disease, on analysis, reveals that the rural people conceive disease in terms of bodily pain, which is some what away from the definition of WHO (inability to carryout vital functions).



Regarding the influence of the background variables the correct understanding of disease is more among middle age and illiterate groups. The low-income group also reveals correct understanding to a greater extent.

Awareness about water born disease, was analysed as another index. Overwhelming majority is aware about the mediating role of polluted water in creating diseases. The awareness is greater among Christians and Hindus (Forward), educated, salaried and business groups. As income and SES increase the awareness also go up.

Enquiries about the awareness of vector born diseases revealed that 61.83% of the respondents are aware about the matter. The awareness is influenced by such background variables as sex, religion, education, income and SES.

Awareness about the importance of using foot ware was assessed in the study. 65.83% of the respondents are well aware of the matter. But ignorance of 34.17% is a significant draw back as far as Kerala State is concerned. Kerala is a state, which is at the forefront in health awareness. Age structure, Educational status and Income status are determinants of the awareness.

Very high portion of the respondents (80.35%) are aware about the health hazard of washing cloths near unprotected well. Among the Hindus the

awareness is greater (88.19%). Christians come next and others are almost in the same footing. Income and SES are also associated with the awareness. The greater the income the higher the awareness. In the case of SES the awareness levels of middle and high groups are almost the same. The low SES group is far below the other groups in this regard.

The role played by mental hygiene in keeping individual healthy is known to only 40.33% of the respondents. It is seen that income and socio-economic statuses influence the awareness. The greater the statuses the better the awareness – the study indicates.

#### **10.4. Practices Relating Health and Disease.**

The relationships between the socio-cultural background and health practices of the community was analysed as another segment of the study.

Which type of medicine and system of treatment the rural people prefer and how the preference varies with their socio-cultural background were the first theme considered. The results show that Ayurvedic systems have a slight edge over Allopathic and Homeopathic systems. Homeopathy is the least preferred system. Among the religious groups considered the Hindu (Forward) prefers Ayurveda more; then comes Muslim Community. Backward Hindus and Christians have more attraction to Homeopathic System. As educational status increases the preference for Ayurvedic system increases. Another important result

is that the illiterates are more interested in Homeopathic system. The higher income groups are more interested in Ayurvedic and the low-income group turns to Homeopathic system.

Another analysis was relating to the care taken in keeping the surroundings clean and tidy. It is revealed that 54% of the respondents give utmost care to keep the surroundings clean and hygienic and the remaining portion is not that much careful. Two background variables are associated with the practice, namely, socio-economic background and marital status. The general trend in the case of socio-economic status is that the higher the SES the greater the care taken to keep the surrounding hygienic. When we come to the behaviour of the marital status groups it is seen that the widow/widower gives more care to environmental hygiene and the divorced occupies the lowest position.

Proper ventilation is given in the households of 63.67% of the respondents and the rest of them are unmindful of this important practice. The latter category is in the habit of keeping the ventilation closed for different reasons. Hindu forward and Christians are more careful to keep proper air-circulation inside their dwelling units. In the case of income categories, the pattern observed was, the higher the income the more the attention given to keeping the ventilation properly. Almost the same pattern is seen in the case of SES groups too.

The practice of using foot ware is popular among 82.67% of the respondents. However, 17.33% are not very particular to resort to the practice. The behaviour of all the sociological groups, except SES group is the same. In the case of SES groups, the pattern seen is that the higher the SES the greater the practice of using foot ware.

Whom the rural people approach first, when they are faced with a disease?, is a theme analysed in the study. The result was rather amazing – priests are first consulted with by 77.67% of the people. Only 18.33% consult a medical practitioner first under such an eventuality. The lesser educated are more inclined to go for this practice. Manual labourers & skilled workers, the lower SES groups and low & high family sized households prefer a priest first to be consulted with.

71.17% are very particular to wear clean dress and they are in the habit of changing their dress daily. 28.83% wear their dress few days together before cleaning them. So according to this index the people are following good health care practices. The practice is followed to a greater extent by the Hindu (Forward) community. The educated is following this practice more than the illiterate does. Coming to the influence of income status it is revealed that the higher the income the greater the practice.

The care given for keeping dental hygiene is deplorably low. Only 4% of the respondents clean their teeth twice a - day. Subsidiary analyses show

that the better-educated, high income and SES groups give care for keeping dental hygiene to a greater level.

Medical care given to expectant mothers is found to be appreciable. 76.17% of the households are very particular to arrange medical care to expectant mothers. Another important result is that all the background variables except sex difference are associated with this practice.

Inductively stating this study indicates that bodily exercise is a neglected health care practice of the rural people of Malabar area. The study shows that only 32.50% of the respondents practice bodily exercise daily. The practice is associated with all the independent variables considered in the study; except family structure.

### **10.5. Case Studies**

As a part of this study five cases of variously diseased respondents were analysed in-depth in qualitative terms. The analyses sustain the validity of the core hypothesis of this study, namely, the personal and social backgrounds of rural people of Malabar region, are associated with their concept of health and beliefs & practices relating to health care.

### **10.6. In Brief**

The sanitation scenario of the study area is not very satisfactory. It varies considerably with the geographical area. The variations due geographical

area are indicative of the influence of the socio-cultural background of the people, as the material world by itself is incapable of producing social phenomena.

The rural community, which has been studied, is upholding many irrational beliefs relating to health, disease and health care practices.

The rural community has good awareness about health, disease and health care.

The community follows health care practices satisfactorily. However, in certain matter like dental hygiene it is not up to the standard.

The study further reveals that socio-cultural backgrounds of the population are strongly associated with the concept of health and disease, beliefs relating to and awareness about health and health care. The health care practices are also strongly associated with the socio-cultural characteristics.

It is seen that four background variables, namely, religious affiliation, educational status, income and socio-economic status are very strongly associated with the dependent variables

Thus the results of the study support the hypotheses formulated.



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## Appendix-2

### Influence of Culture on Health & Disease of Rural People

#### 1 Personal data

1. Name & Address of the respondent with district
2. Sex - 1. Male 2. Female
3. Age - \_\_\_\_\_ Years
4. Religious affiliation -
  1. Hindu ( Non SC/ST)
  2. Hindu( SC/ST)
  3. Christian ( Forward)
  4. Muslim
  5. Others .....
5. Educational status -
  1. Illiterate
  2. Primary
  3. Secondary
  4. College
  5. Others
6. Marital status -
  1. Single
  2. Married
  3. Separated
  4. Divorced
  5. Widow
  6. Widower
7. Monthly income of the family (in Rs ) \_\_\_\_\_
8. Present occupation \_\_\_\_\_:
  
9. Family composition:  
(please give tick mark against those members who are residing with the respondent)



24. If you use well water, do you purify the well? 1. Yes 2. No
25. Distance of the well from leach pit 1. 50ft away 2. Close 3. Near
26. What type of fuel do you use for cooking?  
1. Gas 2. Electricity 3. Kerosene 4. Firewood
27. Toilet facility  
1. Attached to the bed room 2. Attached to the house  
3. Detach from the house 4. Open air
28. Type of latrine used 1. Sanitary 2. Insanitary
29. Do you think latrine is not need in rural area? 1. Yes 2. No
30. What type of waste disposal method you prefer?  
1. Manure pit 2. Burning 3. Dumping  
4. Throw it on the road side 5. Others
31. What do you mean by Health  
1. Free from disease 2. Mental and physical well being  
3. Able to do day- today activities 4. Others
32. What you mean by disease?  
1. Body pain 2. Discomfort 3. Disability 4. Accident Others
33. What type of treatment you prefer?  
1. Ayurvedic 2. Alopathic 3. Homeopathic
34. How much money spend for medical care \_\_\_\_\_
35. When you are ill what will you do first?  
1. Consult doctor 2. Consult the priest 3. Others
36. What is the reason for preferring the treatment:  
1. Less harmful 2. Tasty 3. Convenient  
4. Permanent effect 5. Others
37. What is your opinion about the cause of mental illness?  
1. Wrath of God \ Goddess 2. Ghost intrusion 3. Others
38. If some body becomes ill do you tell the fact to others? 1. Yes 2. No
39. If some body in your family got contagious disease like leprosy, do you tell the fact to others  
1. Yes 2. No

40. What is your opinion about cause of disease?  
 1. Heredity                      2. Past sin                      3. Worth of God or Goddess  
 4. Breach of taboo    5. Evil eye                      6. Spirit or ghost intrusion
41. Do you think S T D is caused by  
 1. Breach of taboo    2. Illicit sexual                      3 Heredity    4. Past sin
42. Do you observe specific day for beginning treatment    1.Yes    2.No
43. Do you believe that certain medical parishioners have non-rational talent for treating (kaipunnyam)                      1. Yes                      2. No
44. Do your environment is related health & Disease                      1. Yes    2. No
45. Do you keep around your house neat and clean:                      1. Yes    2. No
46. Do you open the ventilation at daytime?                      1. Yes    2. No
47. Do you know that over crowding is one of infection    1. Yes    2. No
48. Do you know that certain disease s are spread through contaminated water                      1. Yes    2. No
- If yes, how will you make water safe to drink  
 1. Boiling    2. Use filter                      3. Chlorinate                      4. others
49. Do you know that certain diseases are related to air pollution  
 1. Yes                      2. No
50. Do you wash cloths near to the well?                      1. Yes    2. No
51. Do you wash utensils near the well?                      1. Yes    2. No
52. Do you know these habits are harmful to health?                      1. Yes    2. No
53. Do you know fly breeding places are harmful to health 1. Yes    2. No
54. Can you identify which of the diseases caused by flies 1. Yes    2. No
55. Do you know mosquitoes are harmful to health                      1. Yes    2. No
- If yes how will you protect from mosquitoes  
 1. Use net    2. Use fan    3 Use fumigants                      4. Others
56. Do you use chapels for walking outside home?                      1. Yes    2. No



57. Do you know walking without chapels cause disease? 1. Yes 2. No
58. Do you know personal hygiene is necessary for good health?  
1. Yes 2. No
59. Do you wash your hand before and after food? 1. Yes 2. No
60. Do you change your dress daily? 1. Yes 2. No
61. Do you cut your nail occasionally? 1. Yes 2. No
62. How often clean your teeth one day? : 1. Once , 2. Twice
63. What type of food you prefer? 1. Vegetarian  
2. None vegetarian  
3. All type
64. Do you know that daily one has to take various items food stuffs?  
1. Yes 2. No
65. What are the usual foodstuffs that you daily take? 1. Yes 2. No
66. What type of food you prefer for pregnant ladies? 1. Yes 2. No
67. Do your family has any belief related to the food habit of pregnant ladies  
If yes, mention the reason 1. Yes 2. No
68. Do you think fatty food harmful to pregnant lady?  
If yes, give the reason 1. Yes 2. No
69. Do you antenatal checkup for pregnant ladies? 1. Yes 2. No
70. .Do you give special care to pregnant ladies? 1. Yes 2. No
71. Do you have any special ceremony regarding the birth of male child?  
1. Yes 2. No
72. Do you believe colostrums is not given to the new born?  
1. Yes 2. No
73. Do you encourage breast-feeding? 1. Yes 2. No
74. Do you categories food into hot and cold? 1. Yes 2. No  
If yes mentioned the name of hot and cold stuffs

1. Hot \_\_\_\_\_

2. Cold \_\_\_\_\_

75. Do you believe any combination of food considered harmful? 1. Yes 2. No
76. Do you practice any exercise? 1. Yes 2. No
77. Do you know exercises are needed to good health? 1. Yes 2. No
78. Do you know walking is a good exercise? 1. Yes 2. No
79. Do you have any religious beliefs regarding seeking medical care  
1. Yes 2. No
80. Do you believe traditional system of medicine? 1. Yes 2. No
81. Do you believe yoga or meditation is good for health? 1. Yes 2. No
82. Do you think mental health is important for good health? 1. Yes 2. No
83. Do you feel low income is the reason for ill health? 1. Yes 2. No
84. Do you feel lack of education is the reason for ill health? 1. Yes 2. No