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Health and Hygiene Practices in the Rural Areas

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Abstract:
Personal hygiene and good habits are important aspects of community hygiene. Community health invariability depends on health and habits of people. But it is observed everywhere in rural areas that most of the people do not take care of their personal and house hygiene. Rural housing is far from satisfactory. Most of the houses in rural areas are Kachcha houses. There is no separate living space for all. We hardly find separate bathrooms, latrines and kitchens. There is no drainage system and we find open drains, which are blocked with mud and filth. It is worst when children for defecation every morning use community drains. This renders the rural environment smelling foul. Most of the people in rural areas hardly take note of the importance of hygiene and health.

Key words*: Hygiene, health, environment, rural areas*

1. Introduction

The health of the individual depends on the fulfillment of the basic needs of the body and mind and also the normal functioning of the body mechanisms. It is the balance between understanding of life and thought and action into practices. Thus, the health of an individual depends on three factors : (1) richness of the nature around (2) a cooperative effort to acquire, process, preserve and share the health needs (3) a mentality of trusteeship.

In ancient India, it is reported that men with imaginative and other psychological gifts became shamans of medicine men. Folk medicine was handed down from one generation to the other during the Neolithic culture. In short, the practice of medicine in early days remained the prerogative of priests. In the pre-historic period, animistic religion was evidence in India and diseases were attributed to supernatural causes or to the wrath of gods or spirits. They were also treated mostly by resorting to amulets, charms, magical rites, sacrifices and talisman (Mehta, 1992).

During the Vedic period (1500-800 BC), invocations were addressed to the gods for good health and for recovery from ill-health. However, during the Brahmanic or Upanishads period (800-600 B.C.), the medical beliefs were mainly of a magico-religious nature. Vaidyas (doctors) indulged in crude form of medical theory and used herbs, drugs and superstitious rituals and procedures. Buddhism brought values like healing qualities or kindness, mercy and love to the medical profession and Rahula, the son of Buddha, established hospitals for both humans and animals. Later, Ashoka is reported to have developed a great hospital system throughout the country and established two chairs at Taxila and Varanasi universities in medicine and surgery respectively. Post-Buddhist period (200-1000 A.D.) was virtually a blank period for medical development in India and obscurantism and quackery flourished as a reaction to Buddhism. During the Muslim period (1000-1500 A.D.), the Unani system was established. Unani hospitals were established in the time of Akbar and Jehangir. Unani schools ere opened in Lahore, Delhi, Agra, Lucknow and Hyderabad.

It was the Portuguese who introduced modern medicine in India during the 15th century and established a hospital in 1498 and a medical school in 1687 in Goa. Later, the French and the British introduced western medicine in the east coast and started hospitals. Medical colleges were established in 1835 at Madras, Bombay and Calcutta.

While hospitals were established at the state capitals and district headquarters, rural areas were largely served by quacks, hakims and vaids, astrologers, priests and magicians, sadhus, unregistered practitioners, barbers and practitioners of Ayurveda, Unani and naturopaths, besides people indulging in different forms of charms and sacrifices. In the 1920s licentiates of modern medicine were given subsidy to settle down in rural areas and manage the dispensaries established there. However, as doctors of modern medicine became scarce, these were mostly managed by Ayurvedic vaids or unregistered homeopathic practitioners (Rao, 1972).

The process of health planning in India began with the work initiated by the well known Bhore committee in 1946. The Bhore committee reviewed the state of health care in the mid 1940s and suggested valuable guidelines for its future development. In the following years, several other committees were set up by the central government to review the implementation of various aspects of

health policy in the country. The committee that deserve mention are : Mudaliar committee (1961), Chadah Committee (1963), Mukherjee committee (1965), Jungalwala committee (1967), Jain committee (1968), Kartar Singh committee (1973) and Shrivastava committee (1975). Besides these committees, autonomous institutions like the ICSSR and the ICMR conducted some studies on health policy. The important recommendations by these various committees can be thematically grouped under the following : (a) to improving the existing structure of health and care delivery system, (b) to improving the supporting services for a proper and quick delivery of medical facilities, and (c) to improving the quality of the delivery system thereby improving the health standard of the masses.

2. Objectives

- The study aims at understanding the personal hygiene of the rural agriculturists.
- The study proposes to understand health and hygiene practices in rural areas.

3. Methodology

This study was conducted in Manvi taluk of Raichur district, which consists of 170 villages. Out of 170 villages the researcher selected 9 villages which are having gram panchayats and primary health centres. From these 9 villages the researcher selected 360 respondents as sample for the study.

4. Limitations of the study

From each gram panchayat the researcher selected only one village for the study, each village covering only 40 respondents out of large population. It covers only one taluka of Raichur district.

5. Personal hygiene

To maintain and sustain good health status, personal hygiene is very essential. Habit of eating, type of food, cleanliness with regard to their food, use of toilets, regular bathing, place for domestic animals, etc., determine the personal hygiene of the people. In this context, an attempt has been made to examine the level of hygiene among the respondents.

6. Cleanliness of mouth and teeth

Cleanliness of mouth and teeth are essential to overall health of an individual. However, people often are reluctant for the cleanliness of mouth. It is needed important for dental health. One can keep healthy mouth and teeth by using a brush and tongue scrapper and good toothpaste. Therefore, we asked the respondents to state the way the respondents clean their teeth.

Sl. No.	Clean teeth with	Nos.	%
1.	Salt	67	18.62
2.	Tooth powder	65	18.05
3.	Tooth paste	54	15.00
4.	Neem- stock	78	21.66
5.	Charcoal	80	22.22
6.	Nothing	16	4.45
	Total	360	100.0

Table 1: Respondents' habit of cleaning their teeth

It is evident from the Table 1 that, except about 30 per cent, rest of them use very traditional means like charcoal, salt, neem stick. It is also shocking to note that, about 5 per cent of them do not use anything to clean their teeth. A little above one-fifth (22.22%) of them use charcoal. Due to the absence of oral cleanliness, large numbers of respondents were suffering from dental diseases.

7. Habit of Spitting

Spitting is a common habit in India. It is further aggravated due to tobacco chewing, chewing beetles, beetle nuts, gutka packets. It was observed that people spit not only on the roads but also in their rooms, places of work. Spitting is dangerous as it is responsible for spreading communicable diseases. Most of the respondents, men and women of the present study area, chew tobacco and intoxicate beverages. They keep in their mouth, pieces/powder of tobacco for a long time. As a result, some of the respondents complained about mouth ulcers, mouth cancers, etc.

Sl. No.	Whether chew tobacco	Respondents		
		Female	Male	Total
1.	Yes	178 (89.00)	145 (90.62)	323 (89.72)
2.	No	22 (11.00)	15 (9.37)	37 (10.27)
	Total	200 (100.0)	160 (100.0)	360 (100.0)

Table 2: The habit of chewing of tobacco among the respondents

8. Habit of smoking

Smoking is socially acquired and culturally recognized behavior in rural India. But, smoking is injurious to health. It aggravates respiratory diseases and impairs oral hygiene and disturbs digestion. The children of the families of smokers suffer badly. In this context, when we asked about their smoking habits, 43.33 per cent of respondents reiterated that they smoke.

Sl. No.	Habit of smoking	Respondents		
		Female	Male	Total
1.	Yes	8 (4.00)	148 (92.50)	156 (43.33)
2.	No	192 (96.00)	12 (7.50)	204 (56.66)
	Total	200 (100.0)	160 (100.0)	360 (100.0)

Table 3: Habit of smoking among the respondents

9. Intoxication

The habits of intoxication directly affect the life style of the people and also the eating habits. In rural areas, people often resort to illegal liquors causing further damage to their personal health. In the present study, about half of the respondents resort to intoxication.

Sl. No.	Habit of intoxication	Respondents		
		Female	Male	Total
1.	Yes	54 (27.00)	128 (80.00)	182 (50.55)
2.	No	146 (73.00)	32 (20.00)	178 (49.44)
	Total	200 (100.0)	160 (100.0)	360 (100.0)

Table 4: Habit of intoxication among the respondents

The proportion of men drinkers is more than women. However, women also have not lag behind. About 30 per cent of them have the habit of drinking alcohol.

For the foregoing analysis, we can say that the life style of the people in rural areas in general is largely unorganized. There are widespread problems of smoking, drinking and irregularities of eating. The maintenance of personal cleanliness is at lowest level. The biggest factor in poor personal health is poverty. Health workers in rural areas are also responsible for poor health status. Naturally, poor are more exposed to various communicable diseases. People do not think much of their time to maintain good health. Therefore, until the socio-economic and education status of these people improved, the overall status of personal hygiene cannot be improved.

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