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 30th 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 bowled over emotions of fear, anger, love of 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 phonotypical 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).

### 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 (Cockerham, 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).

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 (Cockerham, 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 know 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 in 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 presenting 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 contact 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, psycho–social 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). Fault up 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’ 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 it’s 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 countries 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 ramifications 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” (Tailor, 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 Artic 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 tuberculosis. 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 19th 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 one’s liver is obliviously 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.
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