Health Practice among the Villagers with special reference to Mandaiyur Village, Pudukottai District-Tamil Nadu

Dr.P.Mariyappan
Dr.V.Shanmugam

Assistant professor, Department of Sociology, Bharathidasn University,

Thiruchirappalli-620024.

Guest Faculty in Sociology, Government Law College, Namakal-637001.

ABSTRACT

Health is an important aspect of human life .It is very difficult to survive in this modern world without good health. International conference declaration which has confirmed the ideology that health is the fundamental right of every individual and society, thus the goal of all countries at the global level. The conference declared the slogan "Health for All by 2020. Scientific progress has brought to the health scene new medical technology, new drugs, innovative methods in diagnostic procedures, computerisation to facilitate quick diagnosis and scientific research. In various developing countries tries to attain health for all but it will attain very difficult, especially in India, because of population exploitation main cause. After independence, separate national level and state level councils were created, for allopath, homeopathy and the Indian System of Medicine (ISM). The national level councils have control and supervise medical education; Community health is defined in a broader way of community organised efforts for maintaining, Protecting and improve the health. In a modern society, allopathic system of medicine dominates the scene and quick treatment of modern medicine creates credibility of the same among the masses**.** Cure of disease effective treatment began in the twentieth century. The term "Community Health" has replaced the term "Public Health" The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promote aspects of health care. In modern India rural areas are implemented various programmes for Health and educational development. Hence this paper deals the implements these programmes after that how is villager life, what are they follow and practice in his/her day to life.

Keywords; Public Health, allopath, homeopathy, medicine, implement.

INTRODUCTION

The practice of medical care is as old as the first recordings in human history, conceiving the human body and disease in a holistic manner. Early medical traditions include those of ancient Egypt and Babylon. The Greeks went even further, introducing the concepts of medical diagnosis, prognosis, and advanced medical ethics. In India the process was begun in 1912 when Bombay Medical Act was passed. This was followed in 1914, by the Madras Medical Registration Act, Bengal Medical Act and so forth. In 1933, the Indian Medical Council Act brought higher education in medicine under the purview of a national level medical council. Whereas the state councils maintain registers of doctors and have powers to discipline doctors whose conduct was found to be unethical.

Community health is defined in a broader way of community organised efforts for maintaining, Protecting and improve the health. During pre industrial period, due to increases in population, large urban centres came into existence. Food and water had to be supplied to a larger population. Hence larger amount of waste products had to be removed. The rapid urban development resulted in increased infestation by rats, a situation that favours the epidemic of plague. As people interacted frequently, the chances of disease spreading through human contact increased urban areas became denser and heavily populated and the slums expanded due to industrialization. Increased industrial wastes, increased air and water pollution and harsh working conditions took their toll on the health of people for instance significantly increases in respiratory disease such as tuberculosis, pneumonia and bronchitis during this period.

Out reaching of medical benefits and facilities to the interior most corner and outer parts in a nation or a state or a district or a village is medical practice. It can be done by both government and private sector.

By government sector: Through govt primary health centre the basic and primary medical needs of the people are carried out free of cost.

By private sector, Doctors selecting outer and corner most interior villages for this medical practice in both senses to earn money and to serve village people.

When a country gets fulfilled in health plans all their fields will be glowing. But in India it is still a question mark because of the government policy. The government doctors should not be allowed to-do private practice. The government doctors should be given family quarters and they should to stay within government hospitals premises for 24 hours. Then only the private roaring practitioners should not be given government jobs then only the interior most parts of the country will be fulfilled with all benefits.

There are few more important issues confronting medicine at the present time than the organisation of medical practice. The fact that patterns of practice very different in countries with a common language and similar social and political institutions suggests that medical practice has now here reached a satisfactory or stable

Cure of disease effective treatment began in the twentieth century. Some useful drugs were introduced much earlier but the circumstances and the manner of use and the limited grasp of their mode of action suggest that they must have been relatively ineffective. Before the discovery of anaesthesias, operations were mainly for cataracts, amputations, incisions for abscesses, Dichotomy, and repining of the skull, and even after the introduction of anaesthetics, results were poor until aseptic technologies become widely used.

In India medical practices were also associated with cultural and religious orientations. The Hindus traditionally believed in Ayurveda, Muslims had faith in USANi and rural and tribal had their indigenous methods of treatment. During the British rule a significant change in" the development of medical profession on the lines of modern professional characteristics was witnessed in India. There are evidences which reveal the fact that the ancient allopathic medicine was also related to religious Organizations and that medicine functioned as intermediary to the spiritual world.

Allopathic system of medicine was opted as an official system of medicine. Although earlier allopathic doctors who came to India along with Christian Missionaries, after the expansion of this profession the Government supported several doctors came from the west and suggested a new model for medical professional training in this country.

Medical education began with the establishment of medical colleges in Bombay (1845), in Madras (1852), Lahore (1860), and Lucknow (1911). The Calcutta school was converted into a college of medicine in 1935, along with the establishment of medical colleges engaged in teaching of allopathic medicine, dispensaries and other medical institutions were established in urban and rural areas.

A medical practitioner enjoys a respectable position in the community or society. As a healer in the folk-medicine or as a Practitioner in the indigenous system of medicine in different cultures or as a professionally skilled doctor, he always enjoyed a prestigious position in the community

In a modern society, allopathic system of medicine dominates the scene and quick treatment of modern medicine creates credibility of the same among the masses. The professionals in this field are largely drawn from elite class of society comprising people of higher class and castes, urban bred, and with attitudes and value orientations different from that of large segment of population, Thus, the recruitment and the socialization process of medical professionals has affected their role structure and they tend to acquire an effectively-neutral and universalistic behaviour pattern towards their clients and their

relations. Further, this pattern of “structure” and "process”™ has resulted in their concentration in the urban centres. This problem is significantly visible in the Indian context in view of a Target population inhabiting rural areas. Because of lack of facilities in the rural areas, urban orientation elite consciousness, living style, and different value orientations than the villages, the medical professionals would continue to work in the urban areas.

Thus their service in the rural areas neglected. In order to get health and medical care, people from the villages have to look towards medical professionals in urban grease: They are forced to go to hospitals mostly situated on urban centres for specialised services of the medical practitioners. In view of this, hospitals provide a 900d setting to study doctor-patient relationship in the context of recruitment socialisation process of the doctors and that of expectations and satisfaction levels of the patients from the doctors with whom they develop clientele for a short or a long period depending upon the nature of disease and severity of illness.

The PHCs were envisaged to provide an integrated curative and preventive health care to the rural population with emphasis on preventive and promote aspects of health care. The PHCs are established and maintained by the State governments under the Minimum Needs Programme.

STATEMENT OF THE PROBLEMS

The study of evolution of humankind takes into consideration, the inter relationship of an individual to his environment since pre historic times too; historians have documented the existence of public health activity. For instance there existed an organized community effort to prevent diseases, prolong life and promote health, ever since community living started.

Changes in cultural adaptation occurred as, a consequence of increased population density and the ecological imbalance that result when human beings disturb their environment to accommodate community life. Human interference on environment, in turn, showed a marked influence on community health. As the wandering people became sedentary, small encampments and villagers were formed. The concentration of people in small areas brought different kinds of problems. Those collected during gathering days and this reduction in nutrients might have led to deficiency diseases. Primary health care cannot be achieved without the involvement of the local community. There must be a continuing effort to secure meaningful involvement of the community in the planning, implementation and maintenance of health service, besides maximum reliance on local resources such as man power, money and materials. Health service must be shared equally by all the people irrespective of their ability to pay and all must have access to health services and bring the service as near to peoples home as possible. Special attention should be given to the needy, vulnerable, oppressed and suppressed groups. This has been termed as social justice.

Methodology

The researcher has examined the existing literature cautious in the study areas of research and assed the ground realities existing in the study area to develop a methodology, particularly sampling design for the present study.

OBJECTIVES

1. *To study of the socio-economic conditions of the rural respondents.*
2. *To understand the educational background of rural people.*
3. *To assess the health practice among the rural people.* .

Area Profile

According to Census 2011 information the location code or village postal pin code of Mandaiyur village is 622515. Mandaiyur village is located in Kulathur Tehsil of Pudukkottai

district in Tamil Nadu, India. It is situated 14km away from sub-district headquarter Keeranur and 43km away from district headquarter Pudukkottai. As per 2009 stats, Mandaiyur village is also a gram panchayat. This panchayat comprises seven hamlets.. The majority of people belong to backward communities. few packets of schedule caste also there.

The total geographical area of village is 2014.27 hectares. Mandaiyur has a total population of 5,680 peoples. There are about 1190 houses in Mandaiyur village. Among this household the researcher collect data from 112, through simple random sampling method adopted. As per 2019 stats, Mandaiyur villages come under Viralimalai assembly & Karur parliamentary constituency. Keeranur is nearest town to Mandaiyur.

The present study adopted Descriptive Research design of a particular individual or of a group or situation. It enables to analyse the respondents' views regarding the issues like the of work, health conditions, hygiene practices, medical practices and life style.

The researcher collecting data from this village 1190 houses from125 household. Ten percent universe among this area, the researcher adopted simple random sampling in this study. The researcher adopted a structure interview schedule to elite the real, relevant and comprehensive information from the respondents. The structural interview schedule includes the questions related to the socio economic characteristics, hygiene practice, medical practice, educational level. To establish a rapport , the researcher spent & good time with the respondents in each household ,further, the researcher has verified and validated the data during the course of the field visit .The field work was conducted during the month of march 2021.

Further, secondary data mean collected through books, block development offices, statistical office, newspapers, state and districts censes in order to understand the ground realities.

Table: 1

Distribution of the Respondents by Their Caste and Educational Status

S.No	**Caste**	**No. of the Respondents**	**Educational qualification**
1.	Forward Caste	12 (9.6%)	8 Graduates 4Higher secondary
2.	Backward Caste	73 (58.4%)	16 Graduates 32Highersecondary 22Below 10th std 03 Illiterates
3.	Most Backward Caste	10 (8%)	05 Graduates 03Highersecondary 01Below 10th std 01 Illiterates
4.	Scheduled Caste	30 (24%)	12 Graduates 10Highersecondary 05Below 10th std 03 Illiterates
	Total	**125**	**125**

Above the table-1 shows that the researcher collecting data 125 respondents from 9.6 percent of the respondents are Forward castes among the66, 7 percent are Graduates remaining are completed higher secondary educations.58.4 percent of the respondents are backward castes among the 22percent of the respondents are graduates44 percent of the respondents are completed higher secondary educations. 30 percent of the respondents are completed SSLC, remaining are illiterates. 8 percent of the respondents are most backward castes among the 50 percent of the respondents are graduates 30percent of the respondents are completed higher secondary educations. 10percent of the respondents are completed SSLC, remaining 10 percent are illiterates. 24 percent of the respondents are scheduled castes among the 40 percent of the respondents are graduates 33percent of the respondents are completed higher secondary educations. 17 percent of the respondents are completed SSLC, remaining 10percent are illiterates in the study area.

Table: 2

Distribution of the Respondents by Their Occupation and Toilets Facilities

S.No	Occupation	No. of the Respondents	Toilet Facilities
1	Farmer	45(36%)	43(95. 5%)
2	Wage Labour	25(20%)	19 (76%)
3	Govt employee	15(12%)	15(100%)
4	Private	40(32%)	40(100%)
	Total	**125**	**117**

Table 2 deals, 125 respondents among 36 percent of the respondents are involve in farming activities and they have95.5 percent household having toilet facilities, very household haven't toilet facilities.32 percent of the respondents are working in private companies, those almost having toilet facilities, 20 percent respondents are working in wage labourer, 76 percent they have toilet facilities in the study areas, 12 percent of the respondents are working in the government sectors, they have ten percent toilet facilities.

Table-3

Distribution of the Respondents by Their Drinking Water Source

S.No	Resource of Drinking Water	No. of The Respondents	Percentage
1.	Mineral Water	10	8.00
2.	Tap Water	25	20.00
3.	Hand Pump	5	4.00
4.	Pond	25	20.00
5.	Well	60	48.00
	Total	**125**	**100.00**

The table-3 mentioned above that 125 respondents among the 48 percent of the respondents are get drinking water from well, 20 percent of the respondents are use pond water, 20 percent of the respondents are use tap water, 8 percent of the respondents are use purifier water and 4 percent of the respondent are use hand pump water. Majority (48%) of the respondents are getting drinking water at well in the study area.

Table: 4

Distribution of the Respondent by Their Often Facing Health Problems

S.No	Normally Seen Disease in village	No of The Respondents	Percentage
1.	Respiratory Disease	10	8.00
2.	Fever	80	64.00
3.	Headache	10	8.00
4.	Allergies	5	4.00
5.	Major Diseases	15	12.00
6.	General	5	4.00
	Total	**125**	**100.00**

The table-4 mentioned above that 125 respondents among the 64 percent of the respondents are suffering from fever.12 percent of the respondents are suffering from major diseases like TB, Cancer etc.8 per cent of the respondents are affected the respiratory disease.8 per cent of the respondents are affected by headache.4 per cent of the respondents are affected some other diseases. Majority (64%) of the respondents are suffering from fever in the study area.

Table: 5

Distribution of the respondents by Their Treatment Practices

S.No	Treatment Practices	No. of the Respondents	Percentage
1.	Dispensaries	15	12.00
2.	Primary H.C	83	66.04
3.	Government Hospital	20	16.00
4.	Home remedies	5	4.00
5.	Priest	2	1.06
	Total	**125**	**100.00**

The table-5 mentioned above that 125 respondents among the 64 4percent of the respondents are taking treating from primary health centre.16 percent of the respondents are taking treatment at government hospital.12 per cent of the respondents are getting medicine from dispensaries.4 per cent of the respondents are taking treatment from home remedies.1.6per cent of the respondents are going to meet the priest. Majority (66.4%) of the respondents are getting treatment from primary centre in the study area.

Table: 6

Distribution of the Respondents by Their Tooth Brushing Use Material

S.No	Brushing use materials	No. of the Respondents	Percentage
1.	Brick powder	5	4.00
2.	Tooth paste	110	88.00
3.	Herbal Stick	5	4.00
4.	Ash	0	0.00
5.	Tooth powder	5	4.00
Total		**125**	**100.00**

The table-6 mentioned above that 125 respondents among the 88 percent of the respondents are using tooth paste for brushing. 4 percent of the respondents are used tooth powder for brushing. 4 percent of the respondents are used herbal stick for brushing. 4 percent of the respondents are used brick powder for brushing. Majority (88%) of the respondents are using tooth paste in the study area.

Table: 7

Distribution of the Respondent by Their Getting Types of Treatment

S.No	Getting from treatment	No. of the Respondents	Percentage
1.	Siddha	12	9.06
2.	Unani	0	0.00
3.	Mid-wives	15	12.00
4.	Allopathi	98	78.04
Total		**125**	**100.00**

The table-7 mentioned above that 125 respondents among 78.4 percent of the respondents are getting treatment from allopathic medicine from primary health centre, nearest government hospital and private clinic.12 percent of the respondents are getting medicine from village mid-wives.9.6 percent of the respondents are getting medicine from siddha doctor. Educational mostly can see in the study area, so majority (78.4%) of the respondents are getting allopathic medicine from various places in the study area. This village people haven't aware of Unani medicine. Nearly 80 percent of the respondents are known about AYUSH but not practice this medicine in the study areas.

FINDINGS & CONCLUSIONS

The result of the data collected from the respondents on mandaiyur village people's medical practises revealed certain major findings. It deals with problems of the hygiene practices and availability medicines. The major findings are as follows;

The Researcher collected data wise majority (75%) of the respondents are Males, age groups are31-40, 88percent people are Hindus, Majority of the people are living in backward castes. Majority (36%) of the respondents are graduates, majority (64%) of the respondents are married, most (68%) of the respondents are living at nuclear family, highly amounts (36%) of the respondents are working as farmer, majority (96%) percent of the respondents are using electrification facilities in home, large number (48%) of the

respondents are getting drinking water from well, majority (96%) of the respondents are having toilet facility, Most(56%) of the respondents have own land, Majority (96%) of the respondents have vehicles. Majority (60%) of the respondents had their own cattle. Most (64%) of the respondents live in their own house Majority (36%) of the respondents have one child, Majority (48%) of the respondents are giving education to their children at government schools and private schools also, majority (36%) of the respondents children are not getting higher study, majority (80%) of the respondents family one or two members are going for work**,** Majority (72%) of the respondents are suffering during rainy season, majority (64%) of the respondents are suffering from fever, Majority (66.4%) of the respondents are getting treatment from primary health centre, Majority (44%) of the respondents are getting treatment from siddha, Majority (92%) of the respondents are taking proper food, Majority (84%) of the respondents are taking bath once a day

Majority (88%) of the respondents are using tooth paste, most (92%) of the respondents are brushing teeth once a day, Majority (88%) of the respondents are using toilets, Majority (64%) of the respondents are making herbal smoke, from protecting mosquito bite, Huge amount(96%) of the respondents are not affected by any hereditary disease , Majority (96%) of the respondents are not saving any amount for medicine Majority (78.4%) of the respondents are getting allopathic medicine Majority (56%) of the respondents are not affected by any chronic diseases Majority (96%) of the respondents are getting stabled medicine, Majority (96%) of the respondents were didn't get any side-effects by their following medical practice, Majority (79.2%) of the respondents are getting medicine from medical shop.

From the findings the researcher concluded that the education creates more aware among the villagers, for instance the most of the young girls are using napkin when the menstruation period and all are used constructed toilet, mostly seen absence of school dropouts in the village. Same time people could not get safe drinking water, nearly half and villagers use unprotected drinking water, those are getting water from well and pond. Nearly all the house holders rearing cattle but they have not separate shed and garbage. If anyone get severe ill, they go to hospital, if they get normal ill do not get any prescription from doctor, to get self medicine from petty shop and dispensaries. Most of them practised diet in food. People are mostly using soap when they bathing, brushing time using tooth paste. Primary health centre mostly creates awareness among the villagers about hygiene practises. Majority of the male respondent have drinking alcohol habits and smoking habits among the village people.

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