

# CULTURAL PHENOMENA AND RURALITES HEALTH BEHAVIOUR

**Dr. N. SUKUMARAN**

Assistant Professor, Department of Sociology, Annamalai University

---

**Abstract :** Culture influences health and healing practices. People, whether rural or urban, have their own beliefs and practices about causes and management of various diseases. Not all customs and beliefs are bad. Health has always been a major concern for community development. “It is a basic requirement, not only for the fulfillment of human aspirations, but also for the enjoyment of all mankind of a better quality of life. It is also indispensable for a balanced development of the individual within the family and as part of the community and the nation. The present aims to understand how myths, belief and traditional practices influence the people in their health seeking behaviour. The researcher intended to carry out a study in rural Pondicherry to examine the health care seeking practices of rural population.

**Key Words:** Health Care Practices, Health Seeking Behaviour, Mal Nutrition, Health Beliefs

---

## **Introduction**

Health attributions are partly shaped by culture. In turn, cultured health attributions affect beliefs about disease, treatment, and health practices. Likewise, culture influences health and healing practices. People, whether rural or urban, have their own beliefs and practices about causes and management of various diseases. Not all customs and beliefs are bad. Some are based on experience and have positive values, while others may be useless or harmful.

Most sociological studies of lay health beliefs agree that public conceptions of health and illness vary according to the immediate material and social circumstances in which people find themselves. Tipping and Segal et al. (1995) *note that* health seeking behaviour generally *rely* on the factors that enable or prevent people from making healthy choices in either their life style behaviours or their use of medical care and treatment service. They pointed out that the underlying assumption is that behaviour is best understood in terms of an individual's perception of their social environment.

It is also clear that in the rural areas that traditional beliefs and practices have its own influence on people to have specific response to illness and disease. In general in India, such superstitions, beliefs and practices are still prevalent in rural areas. For example, though people know that fever with small eruptions on skin is pox and treatment to the pox is necessary, many (including those live in urban areas) still believe that this is due to the anger of one female deity namely 'Mariamman'. Such beliefs based on traditional myths influence people to have specific response in seeking medical/health care services. This affects the very approach of their help seeking behaviour.

**Statement of the Problem:** The present study aims to understand how myths, beliefs and traditional practices influence the people in their health seeking behavior. The researcher intended to carry out a study in rural Pondicherry to examine the health care seeking practices of rural population with the following objectives:

1. To study the health status of rural respondents on the basis of self rated assessment,
2. To examine the respondents place of health care seeking practices,
3. To analyse the practices of the respondents relating to personal hygiene and domestic sanitation,
4. To find out the health care practices of the respondents in the study area, and
5. To study the knowledge of the respondents on health and medical beliefs in the study area.

**Selection of the Study Area:** There are 92 Villages in the Puducherry region of the Puducherry Union Territory. All the villages were grouped in six clusters (commune) officially by the revenue department and from each cluster one Village has been selected using lottery method for the study. The clusters comprise 14 to 17 Villages. From these clusters researcher has selected six Villages - one Village from each cluster - namely Korkadu, Mangalam, T.N. Palayam, Parikkal pattu, Kodaathur and Manapet for this study.

**Selection of the Respondents:** The total households of the selected Villages are 3174; Since it is very difficult for the researcher to study all the households due to time factor, the researcher has decided to select 10 per cent of the households from each village for the present study as sample. The researcher has collected data from 300 respondents from all the villages. By adopting simple random sampling procedure the households were selected after listing all the households of each Village. Every 50<sup>th</sup> household was included for this study.

**Tool for Data Collection:** The researcher has collected the relevant household data from the respondents by using a well-structured interview schedule. The researcher visited each household and collected the data personally by establishing a good rapport with them. The respondents extended full co-operation and in the opinion of the researcher their responses are fair and good. Their health status is also measured as high, medium and low level using 20 health factors - feeling of tension, pain on neck, staying asleep, experience of depression, presence of negative feelings, backache, constipation, cold and flu, stiffness, fatigue, lack of flexibility in spine, incidence of allergies in skin, dizziness, light headedness, negative feelings, incidence of accidents, presence of negative feelings, interest in maintaining healthy lifestyle, emotional well being, nutritional status and body mass index.

**Significance of the Study:** This study intends to highlight how rural people choose to respond to their health issues. The study results will help in understanding to relation between culture, health, medicine and society. The results of the study will be useful for health care deliverers and health policy makers.

**Findings – Socio-economic Status:** Of the total 300 rural household-respondents 27.00 per cent of them belong to the age group 20 - 30 years and 25.33 per cent of them come under the age group of 30 - 40 years. Further, 17.33 per cent belong to the age group 40 - 50 years, 15.33 per cent of the respondents belong to the age group 50-60 years and the rest 15.01 per cent of them belong age group of above 60. It is found from the present study that the head of the household-respondents included in the study were an average of 43.2 years old. As far as the caste-group of the respondents is concerned of the total 15.33 per cent of them belong to the Forward Caste, 17.33 per cent of them come under the Backward Caste group, 35.33 per cent of them belong to the Most Backward Caste and the rest 32.01 per cent of them are Scheduled Caste?.

While considering the educational status of the respondents selected for the study of the total one-thirds (34.00%) of them have primary level of education whereas another one-fourths (25.33%) in the total possess secondary level of education and 17.33 per cent of them reached up to higher secondary level. 14.00 per cent of the households have under graduate level of education all they were from Korkadu region, and the rest 9.33 per cent of them have postgraduate level of education. The analysis of the occupation of the respondents indicates that out of the total 300 rural households one-fifths (20%) of them were daily wagers, 18.33 per cent of them belong to the marginal farm group, 16.67 per cent of them belong to the small farm group. 14.00 per cent of them belong to the medium farm group, 16.00 per cent of them belong to the large farm group and the rest 15 per cent of them belong to the business group.

Out of the total 300 about two-fifths (38.33%) of them earn upto Rs. 2000 per month, 28.67 per cent of them earn in the range of Rs. 2000 - 4000 per month and 13.67 per cent of them earn in the range of Rs. 4000 - 6000. Further, in the industrial region, 10.67 per cent of the households belong to the income group of Rs. 6000 - 8000 and the rest 8.66 per cent of them belong to the income group Rs. 8000-10,000. Out of the total 300 rural households 32.67 per cent of them belong to the small family size group, 45.00 per cent of them belong to the medium family size group and the rest 22.33 per cent of them come under the large family size group.

**Health Status of the Ruralites :** The findings of health status of the respondents reveal the following facts. The possession of moderate level health status is commonly evident among the selected respondents in the study area. However, a significant percentage of respondents possess low health status. Possessions of high health status are also evident from the respondents of the study area. In general respondents of Mangalam Village and Korkadu Village have relatively high level health status, indicating their physical, mental and social well being due to their good socio economic condition. The low health status is quite common among the respondents of Manapet Village and Kodaathur Village, due to their low socio economic status. It is observed that majority of the forward caste respondents and backward caste respondents have high level health status. Majority of the most backward caste respondents have moderate level health status and majority of the scheduled caste respondents have low level health status.

**Table 1 Village wise Respondents' Health Status**

Villages	High Level Mean Score 3.5-4.5	Moderate Level Mean Score 2.5-3.5	Low Level Mean Score below 2.5	Total
Mangalam	30 (60.00)	12 (24.00)	8 (16.00)	50
Korkadu	32 (64.00)	9 (18.00)	9 (18.00)	50
T.N. Palayam	11 (22.00)	33 (66.00)	6 (12.00)	50
Parikkal pattu	8 (16.00)	22 (44.00)	20 (40.00)	50
Kodaathur	9 (18.00)	19 (38.00)	22 (44.00)	50
Manapet	8 (16.00)	7 (14.00)	35 (70.00)	50
Total	98 (32.67)	102 (34.00)	100 (33.33)	300

Chi-square tabulated value is 18.3 significant at 0.05 level

The result of occupation wise analysis reveals that business group respondents and large farm group respondents possess high health status. This is due to their better educational status and income status. In general, wage labour group respondents and marginal group respondents have low health status because of their low level education and low level income.

The result of age wise analysis reveals that respondents in the age group 20-30 years and 30-40 years have high health status. The educational attainment enables them to undertake better health care practices. Usually educated rural people have more household income and this status enables them to take required nutrition and medicine towards their health care practices. In general, old age respondents have low health status due to their poor awareness about health care practices. Usually they belong to the poor rural households so they are not able to take adequate nutrition and health care practices.

**Village Health Seeking Behaviour :** Health seeking behaviour depends on socio economic condition, cultural background within the context of available health resources, national health policy and planning. The findings of respondents' place of health care seeking indicate the following facts. Majority of the respondents take health care in government hospital and primary health centres followed by taking health care in private hospital and from traditional religious healers. A significant percentage of the respondents take health care in government hospitals and also in the ayurvedic and siddha hospital. It is observed that majority of the high caste respondents take health care in private hospitals. It could be observed from the data that majority of the low caste respondents take health care in free government health services.

Table 2 Health Care Seeking Place by the Respondents' Occupation

Occupation	Government Hospital	Government Hospital and Primary Health Centre	Private Hospital	Ayurvedic and Siddha Hospital	Traditional Religious Healers and Government Hospital	Total
Wage labour	10 (16.67)	23 (38.33)	8 (13.33)	7 (11.67)	12 (20.00)	60
Marginal farmer	10 (18.18)	14 (25.45)	8 (14.55)	7 (12.73)	16 (29.09)	55
Small farmer	9 (18.00)	18 (36.00)	5 (10.00)	6 (12.00)	12 (24.00)	50
Medium farmer	8 (19.05)	10 (23.81)	12 (28.57)	5 (11.90)	7 (16.67)	42
Large farmer	13 (27.08)	5 (10.42)	15 (31.25)	9 (18.75)	6 (12.50)	48
Business	5 (11.11)	6 (13.33)	22 (48.89)	7 (15.56)	5 (11.11)	45
<b>Total</b>	<b>55 (18.33)</b>	<b>76 (25.33)</b>	<b>70 (23.33)</b>	<b>41 (13.67)</b>	<b>58 (19.33)</b>	<b>300</b>

Chi-square tabulated value is 46.64 significant at 0.05 level

The results of occupation wise analysis reveals that majority of the business group respondents take health care in private hospitals. Contrastingly majority of the low occupational group respondents take health care in government institutions. The result of age wise analysis reveals that majority of the respondents of below 40 years age take health care in private hospitals. Interestingly majority of the respondents above 40 years age take health care in government institutions.

**Hygienic and Sanitation Practices:** The findings of respondents hygienic practices indicate the following facts. The respondents have very high hygienic practices of regular use of toilet soap, washing hands before eating, consuming fresh food, proper washing of cloths, consuming fresh vegetables, proper protection of food from flies and insects, endorsing their household members to follow healthy practices and boiling water before drinking. It is observed that the forward caste respondents are very effectively following all the hygienic practices, followed by the backward caste, most backward caste and the scheduled caste respondents.

Table 3 Village- wise Respondents' Domestic Sanitation Practices

Village	Mangalam		Kortadu		T.N. Palayam		Parikkal pattu		Kodaathur		Manapet		Total	
	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No	Yes	No
Cleaning Latrines and Using Sanitary Latrines	38 (76.00)	12 (24.00)	39 (78.00)	11 (22.00)	32 (64.00)	18 (36.00)	33 (66.00)	17 (34.00)	28 (56.00)	22 (44.00)	31 (62.00)	19 (38.00)	201 (67.00)	99 (33.00)
Safe Disposal of Infant Excreta	39 (78.00)	11 (22.00)	37 (74.00)	17 (34.00)	36 (72.00)	14 (28.00)	29 (58.00)	21 (42.00)	24 (48.00)	26 (52.00)	23 (46.00)	27 (54.00)	188 (62.67)	112 (38.67)
Proper Washing and Protection of Utensils	38 (76.00)	12 (24.00)	28 (56.00)	22 (44.00)	25 (50.00)	25 (50.00)	26 (52.00)	24 (48.00)	27 (54.00)	23 (46.00)	29 (58.00)	21 (42.00)	173 (57.67)	127 (42.33)
Proper Cleaning of House Floor and Wall	40 (80.00)	10 (20.00)	35 (70.00)	15 (30.00)	26 (52.00)	24 (48.00)	29 (58.00)	21 (42.00)	23 (46.00)	27 (54.00)	22 (44.00)	28 (56.00)	175 (58.33)	125 (41.67)
Proper Washing Rooms and Home Environment	27 (54.00)	23 (46.00)	37 (74.00)	13 (26.00)	33 (66.00)	17 (34.00)	26 (52.00)	24 (48.00)	24 (48.00)	26 (52.00)	22 (44.00)	28 (56.00)	169 (56.33)	131 (43.67)
Proper Removal of Dust and Debris from the Household	28 (56.00)	22 (44.00)	25 (50.00)	25 (50.00)	26 (52.00)	24 (48.00)	23 (46.00)	27 (54.00)	21 (42.00)	29 (58.00)	18 (36.00)	32 (64.00)	141 (47.00)	159 (53.00)
Proper Discharge of Waste Water	41 (82.00)	9 (18.00)	29 (58.00)	21 (42.00)	27 (54.00)	23 (46.00)	26 (52.00)	24 (48.00)	23 (46.00)	27 (54.00)	22 (44.00)	28 (56.00)	168 (56.00)	132 (44.00)
Preventing Accumulation of Sewage Water	30 (60.00)	20 (40.00)	29 (58.00)	21 (42.00)	21 (42.00)	29 (58.00)	19 (38.00)	31 (62.00)	17 (34.00)	33 (66.00)	16 (32.00)	34 (68.00)	132 (44.00)	168 (56.00)
Grand Total	50		50		50		50		50		50		300	

The findings of respondents' domestic sanitation practices indicate the following facts. Majority of the respondents follow the best domestic sanitation practices like cleaning of latrines, using sanitary latrines, and safe disposal of infant excreta. Proper cleaning of house floor and wall, proper washing and cleaning of utensils, proper maintaining of home environment, safe discharge of waste water, removal of dust and debris, and preventing accumulation of sewage water are the other practices not followed effectively by the respondents. The respondents of T.N. Palayam Village have high level of overall domestic sanitation practices, followed by the respondents of Korkadu Village. However from the data it is evident that the respondents

Parikkal pattu Village, Kodaathur Village, and Manapet Village have low level sanitation practices. It is observed that the forward caste respondents follow all the domestic sanitation practices, followed by the backward caste respondents, most backward caste respondents, and scheduled caste respondents.

**Prevalence of Common Diseases :** The findings regarding prevalence of common diseases among the rural households indicate the following facts: The rural households have common health problems relating to fever, malnutrition, dysentery, malaria, itching and diabetes. Some of the rural households have health problems like body swelling, colic pain, jaundices, hysteria, syphilis and gonorrhoea, leprosy, typhoid, scabies, measles and high blood pressure. It could be noted that Manapet households mainly have common diseases of fever, colic pain, malnutrition, dysentery, and diabetes. The households of Parikkal pattu Village mainly have common diseases of fever, colic pain, malnutrition, dysentery, and diabetes. The households of Parikkal pattu Village have common diseases of fever, malnutrition, dysentery, diabetes, and high blood pressure. It is observed that forward caste households possess many of the common diseases.

**Table 4 Common Diseases Prevalent in the villages selected for the study**

Common diseases	Villages						Total
	Mangalam	Korkadu	T.N. Palayam	Parikkal pattu	Kodaathur	Manapet	
Fever	10 (20.00)	11 (22.00)	13 (26.00)	21 (42.00)	25 (50.00)	28 (56.00)	108 (36.00)
Swelling of the body	10 (20.00)	11 (22.00)	9 (18.00)	10 (20.00)	5 (10.00)	6 (12.00)	52 (17.33)
Colic pain	7 (14.00)	8 (16.00)	11 (22.00)	10 (20.00)	15 (30.00)	16 (32.00)	67 (22.33)
Malnutrition	15 (30.00)	14 (28.00)	11 (22.00)	23 (46.00)	25 (50.00)	27 (54.00)	115 (38.33)
Dysentery	12 (24.00)	15 (30.00)	21 (42.00)	29 (58.00)	31 (62.00)	35 (70.00)	143 (47.67)
Jaundice	7 (14.00)	6 (12.00)	5 (10.00)	5 (10.00)	8 (16.00)	9 (18.00)	40 (13.33)
Piles	7 (14.00)	5 (10.00)	8 (16.00)	6 (12.00)	5 (10.00)	7 (14.00)	38 (12.67)
Diabetes	5 (10.00)	8 (16.00)	9 (18.00)	11 (22.00)	15 (30.00)	17 (34.00)	65 (21.67)
Hysteria	5 (10.00)	6 (12.00)	7 (14.00)	6 (12.00)	8 (16.00)	9 (18.00)	41 (13.67)
Syphilis and gonorrhoea	3 (6.00)	2 (4.00)	3 (6.00)	2 (4.00)	4 (8.00)	5 (10.00)	19 (6.33)
Leprosy	2 (4.00)	3 (6.00)	3 (6.00)	2 (4.00)	2 (4.00)	1 (2.00)	13 (4.33)
Itching	3 (6.00)	2 (4.00)	3 (6.00)	4 (8.00)	3 (6.00)	2 (4.00)	17 (5.67)
Malaria	5 (10.00)	6 (12.00)	5 (10.00)	7 (14.00)	8 (16.00)	5 (10.00)	36 (12.00)
Typhoid	7 (14.00)	5 (10.00)	3 (6.00)	2 (4.00)	4 (8.00)	6 (12.00)	27 (9.00)
Scabies	5 (10.00)	6 (12.00)	7 (14.00)	5 (10.00)	6 (12.00)	5 (10.00)	34 (11.33)
Measles	7 (14.00)	8 (16.00)	5 (10.00)	6 (12.00)	5 (10.00)	7 (14.00)	38 (12.67)
High blood pressure	9 (18.00)	8 (16.00)	10 (20.00)	11 (22.00)	9 (18.00)	6 (12.00)	53 (17.67)
Total	50 (100.00)	50 (100.00)	50 (100.00)	50 (100.00)	50 (100.00)	50 (100.00)	300 (100.00)

The result of occupation wise analysis reveals that the respondents business households, large farm households and medium farm households have common diseases of high blood pressure, dysentery, and fever.

**Health Care Practices of Rural Population :** The findings of respondents' physical health care practices reveal the following facts. Majority of the respondents have high level physical health care practices relating to devotion of time and efforts health care, motivation towards physical wellbeing. preventing future health problems, satisfaction with status of physical work, and attention need for maintaining physical health. A significant percentage of the respondents have moderate level physical health care practices relating to coping with own physical health, ability to take care of health problem, competent to have good physical health, dealing and handling health status, perception on changes in physical health, realization of unhealthy status, avoiding illness through proper care , own ability determines good physical health, accidental happening controls physical health, keeping proper physical health status, skills and ability towards ensuring good physical

health, and body control towards health improvement. However, the respondents who have low level physical health care practices are pre-occupied with other issues, rather than on their health and well being.

**Table 5 Respondents' Caste Group and of Physical Health Care means**

Physical Health Care means	Caste - Group				Mean
	Forward caste	Backward caste	Most backward caste	Scheduled caste	
Ability to take care of health problem	4.11	3.77	3.52	3.36	3.37
Motivation towards physical wellbeing	3.96	3.68	3.41	2.96	3.74
Devotion of time and efforts health care	3.41	3.11	2.96	2.42	3.91
Dealing and handling health status	3.78	3.58	3.10	2.76	3.32
Preventing future health problems	4.01	3.77	3.14	2.52	3.67
Avoiding illness through proper care	3.98	3.44	3.26	2.96	3.19
Own ability determines good physical health	3.52	3.77	2.96	2.77	3.18
Competent to have good physical health	3.86	3.51	3.03	2.58	3.36
Accidental happening controls physical health	2.85	3.90	3.49	2.42	3.17
Skills and ability towards ensuring good physical health	3.87	3.66	3.52	2.43	3.11
Keeping proper physical health status	2.85	2.42	3.01	3.26	3.16
Realization of unhealthy status	3.77	2.86	3.36	2.46	3.20
Perception on changes in physical health	3.98	3.72	2.52	2.31	3.27
Self motivation to be physically healthy	2.77	3.01	3.15	2.46	2.68
Body control towards health improvement	3.78	3.59	2.86	2.77	3.05
Coping with own physical health	2.78	3.36	2.99	3.10	3.40
Satisfaction with status of physical work	2.96	3.42	3.77	3.81	3.55
Attention need for maintaining physical health	3.98	3.77	3.52	2.42	3.51
Pre occupied with our physical health issue	3.92	3.81	2.87	3.01	2.89
Sense of pride in maintaining physical health	3.77	2.99	3.86	2.40	2.87
Average	3.60	3.46	3.22	2.76	3.28

The result of caste wise analysis reveals that forward caste respondents have highest overall health care practices followed by the backward caste respondents, most backward caste respondents and scheduled caste respondents. The result of occupation wise analysis reveals that business group respondents have highest overall personal health care practices followed by the large farm group respondents, medium farm group respondents, small farm group respondents, marginal farm group respondents and wage labor group respondents.

**Medical Beliefs of Ruralites :** The findings of the respondents' medical belief indicate the following facts. The respondents with high level medical belief felt that physicians should ask about how an illness is impacting patients' life, and explain how natural remedies are safer than medicine. Also, they expressed that physicians should ask patients about their opinion with regard to their illness. More importantly they pointed out that physician can learn from patients about their beliefs and practices relating to illness, medication and prevention.

Table 6 Village Wise Respondents' Medical Beliefs

Belief	Villages						Mean
	Mangalam	Korkadu	T.N. Palayam	Parikkal pattu	Kodaathur	Manapet	
Health Depends on Modern medicine	3.65	3.72	3.88	2.89	2.72	2.49	3.15
Most medicines are addictive	3.72	3.66	3.90	2.79	3.01	3.12	3.33
Natural remedies are safer than medicine	3.90	3.92	4.10	3.36	3.65	3.81	3.76
Medicines do more harm than good	2.72	2.52	2.11	2.05	3.36	3.45	2.49
Doctors place too much trust on medicine	3.90	3.88	3.76	2.90	3.36	3.01	3.52
Physicians should ask patients for their opinion about their illness	4.01	3.90	3.88	3.52	3.44	3.40	3.70
It is important to know patients' point of view for the purpose of diagnosis	3.88	3.77	3.90	2.86	2.55	2.36	2.96
Understanding patients' opinions about their illness helps Physician reach the correct diagnosis	2.79	3.85	3.91	3.36	2.80	3.42	3.30
Understanding patients' opinions about their illness helps Physician provide better care	3.70	3.66	3.85	2.77	2.11	2.56	2.65
Physician should ask their patients about the causes of their problems	3.36	3.72	3.89	2.87	2.78	2.57	3.45
Physician can learn from their patients perspectives in their illness	3.56	4.01	4.11	3.85	3.49	2.77	3.65
Physicians should ask their patients about the occurrence of illness	3.77	3.88	3.96	2.79	2.60	2.46	3.20
Physicians should ask about how an illness is impacting patients' life	4.01	3.99	4.11	3.77	3.52	3.36	3.82
Physicians should make empathetic statement about their patents' illness	3.75	3.59	3.92	2.77	2.56	2.15	2.81
Physicians should ask patients for their feelings	2.89	3.56	4.02	3.52	2.58	3.16	3.25
Physicians need not ask about personal life issues of patients	3.89	3.92	3.99	3.16	2.79	2.52	3.38
Changing habit towards diet control	2.80	3.50	3.86	2.79	2.56	2.16	2.52
Taking medication interferes with normal daily activities	3.16	3.80	2.88	3.42	3.56	3.79	3.42
Medication prevents diseases	4.01	3.77	4.10	3.88	3.52	2.49	3.60
Average	3.55	3.72	3.80	3.12	2.99	2.89	3.25

The respondents with moderate level medical belief points out that physician should ask their patients about the causes of their problems, how taking medication interferes with normal daily activities. Also they expressed that physicians need not ask about personal life issues of patients. They further pointed out understanding patients' opinions about their illness help physician to provide better health care services. The respondents with low level medical belief expressed that the doctors should tell the importance of knowing patients' point of view for the purpose of diagnosis. Also they expressed that physicians should make empathetic statement about their patients' illness, understanding patients' opinions about their illness so as to provide better care to the patients.

**Health Beliefs of Villages :** The findings of respondents' health belief indicate the following facts. The respondents have high level health belief relating to influence of occutinism, breach of taboos, non fulfillment of obligations towards mashes, intrusion of spirit, displeasure of super natural elements, spirit sent by witchcraft and low quality food. The respondents have moderate level health belief relating to drinking polluted water, changes in weather, inadequate immunization, anathema and lack of hygiene behaviour. The respondents have low level health belief relating to displeasure of family deity, eating uncooked food,

deficiency in food intake, excess manual power, super natural wrath, eating old food, anger of goddess, and fate / karma.

The result of caste wise analysis reveals that scheduled caste respondents have high level of overall traditional health belief followed by most backward caste respondents, backward caste respondents, and forward caste respondents.

**Table 7 Respondents' Health Beliefs by their Occupation**

Belief	Wage labour	Marginal farmer	Small farmer	Medium farmer	Large farmer	Business	Mean
Displeasure of super natural elements	3.95	3.36	3.10	2.90	2.86	2.77	3.40
Breach of taboos	3.95	3.79	3.52	3.06	3.10	2.93	3.80
Non fulfillment of obligations towards mashes	3.90	3.77	3.52	3.42	3.35	3.36	3.77
Influence of occutinism	4.01	3.69	3.52	3.16	3.10	3.01	3.85
Lack of hygiene behaviour	2.95	3.52	3.77	3.87	4.10	3.99	3.05
Low quality food	2.52	2.85	3.35	3.71	3.98	3.80	3.30
Intrusion of spirit	3.90	3.80	3.56	2.32	2.20	2.16	3.47
Spirit sent through witchcraft	3.80	3.52	3.48	3.36	2.88	2.77	3.38
Displeasure of family deity	3.88	3.51	3.06	2.69	2.53	2.56	2.96
Super natural wrath	3.81	3.77	3.51	2.52	2.43	2.76	2.76
Deficiency in food take	2.45	2.77	2.85	3.80	3.99	4.05	2.85
Excess manual power	3.85	3.52	3.33	2.52	2.77	3.06	2.80
Anathema	3.85	3.42	3.06	2.70	2.77	2.65	3.11
Anger goddess	3.87	3.52	3.16	2.72	2.65	2.45	2.60
Changes in weather	2.86	2.90	3.36	3.98	4.10	3.87	3.20
Drinking polluted water	2.58	3.36	3.72	3.98	4.09	4.01	3.25
Eating old food	2.59	2.77	2.96	3.97	4.10	4.02	2.65
Eating uncooked food	2.65	2.77	2.95	3.66	3.87	3.70	2.90
Inadequate immunization	2.76	3.36	3.58	3.95	4.06	3.98	3.16
Fate karma	3.92	3.44	3.35	2.52	2.17	2.32	2.52
Average	3.75	3.56	3.34	3.18	3.11	2.96	3.13

The result of occupation wise analysis reveals that wage labour respondents have high level of traditional health belief followed by marginal farmer respondents, small farmer respondents, medium farmer respondents, large farmer respondents, and business group respondents. The result of age wise analysis reveals that respondents in the age group 50-60 years have high level of overall traditional health belief followed by the respondents in the age group 40-50 years, respondents in the age group 30-40 years, and respondents in the age group 20-30 years.

## Conclusion

From the results of the study it is concluded that age, caste, education, occupation and income factors influence the health behaviour of the rural households of Puducherry Union Territory. The respondents who are below 40 years of age have high level of health status. The educational attainment enables them to undertake better health care practices. These age group respondents take adequate nutritional food and necessary health care practices. They visit private hospitals for treatment. However, respondents with over 40 years of age have low health status, due to lack of awareness about the health care practices. They could not have nutritious food and hygienic health care practices.



They are not commonly affected by seasonal diseases due to their awareness about the health and hygienic practices and strict adherence healthy practices. Almost all the aged respondents have to depend on the free health care services extended by the government. They are also not following all the hygienic and domestic sanitation practices. The higher age group respondents suffer due to the common seasonal diseases like fever, swelling of the body malnutrition, dysentery, diabetes and high blood pressure. The business group respondents take treatment in private hospital and follow the best hygienic and domestic sanitation practices than other occupational group respondents of rural Puducherry.

Majority of the forward caste and backward caste respondents practice all the hygienic and good domestic sanitation practices. The data reveal that they are not suffering from many of the common diseases. The scheduled caste respondents have strong health beliefs such as occutinism, breach of taboos, evil spirit, displeasure of super natural elements, spirit, witchcraft, super natural wrath, anger of gods and fate / karma, etc.

In conclusion the researcher points out that the factors like age, caste, education, occupation and income play a significant role in influencing health behaviour of the rural households in Puducherry Union Territory. Also the study is modest enough to highlight that traditional beliefs, myths, religious dogmas have no role to play in influencing the health behaviour of the rural people of their healthy life. The study results highlight that only age, caste, education, occupation and income have significant role in influencing the health behaviour of the rural people of Puducherry Union Territory.

#### References

1. Park, K. "Textbook of Preventive and Social Medicine". 17<sup>th</sup> ed. Jabalpur India; M/s Banarsidas Bhanot Publishers: (2002) pp. 459-488.
2. Tipping G. and Segall. M.M. et al., (1995) "Health care seeking behaviour in developing countries" An annotated bibliography and literature review. Development Bibliography 12. Institute of Development Studies, Sussex University; 21 Brighton.
3. Aurelien Franckel, Frederic Arcens and Richard Lalou, (2008). "Village Context and Health-seeking Behavior in the Fatick Region of Senegal", Population (English Edition), Vol. 63(3).
4. Brit S. Schneider and Udo Schneider. (2009). "Determinants and Consequences of Health Behavior: New Evidence from German Micro Data", No 253, SOEP Papers on Multidisciplinary Panel Data Research from DIW Berlin, The German Socio-Economic Panel (SOEP).
5. Janz, N. K., & Becker, M.H., (1984). "The Health Belief Model: A Decade Later", Health Education Quarterly, Vol. 11(1).
6. Patil, A.V. Somasundaram, K.V. and Goyal, R.C. (2002). "Current Health Scenario in Rural India", Australian Journal of Rural Health, Vol. 10.
7. Srinivasan K. and Sharan Raka, (2005) "Religiosity and Health" MPRA Paper from University Library of Munich, Germany.
8. Stuart Capstick, Pauline Norris, Faafetai Sopoaga and Wale Tobata, (2009) "Relationships Between Health and Culture in Polynesia - A Review", Social Science & Medicine, Vol. 68(7).