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Sanitary Habits among the Tribal Communities of Odisha: An Empirical Observation

Social Science

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ABSTRACT

Use of water, personal hygiene, sanitary habit and health status are interrelated and interdependent entities. The habit formation is the result of continuous process of imitation, repetition and learning a behavior to the extent that it is followed almost like a routine. Irrespective of societal development, the tribal women are the home managers who act as care takers of children and the aged at home also participate in production process. Children imitate the parents' and other adults' activities at home and outside which include behavioral components. Thus, sanitary habits of adults are being imitated by children. The paces of change in technology do not match with the change in habits easily as a result sanitary habits among the tribal communities remains relatively unchanged across the generations including personal hygiene and sanitation. The paper has been based on empirical observation. It offers a descriptive analysis on the personal hygiene and sanitary habits of the tribal communities of Odisha with special reference to the Parajas of highland undivided Koraput . The data derived from field observation are compared with reported data about a few other tribal communities of the nation with a view to identify the common trend across the tribal communities. It is observed that there has been a close relationship between the habitat and personal hygiene and sanitary habit of the communities. Further, it is interpreted that unless a continuous and constant motivational input commensuration with local culture to inculcate the benefits of better sanitation habits are given and strategically help them retain induced personal hygiene through traditional leaders as a demand driven approach, the objectives of sustainable development goals will be languished.

Introduction

Public health is the scientific approach to life and an art of preventing disease, prolonging life and promoting health and efficiency through organized community efforts for sanitation of environment. Poor sanitation and sanitary habits manifest in many kinds of diseases like scabies, malnourished somatic expressions among children having bulged stomach with projected veins and arteries, monkey face, helminthes, mild white sclera in eyes, swollen foot, split brownish hair, hair loss, whitish nail, cracked nipples, toad skin, diarrhea but also guinea worm, waterborne outbreaks of diseases such as typhoid, cholera, Jaundice and cryptosporidiosis and bloodlessness. People suffer a lot due to poor sanitation and hygiene. It is well known that safe water, improved sanitation and better hygiene as a prelude for economic and social development is well accepted throughout the world. Sanitation without water facilities is unthinkable .It is often stated that better sanitation and personal hygiene refuse the entry of more than 50% of diseases.

The sanitary habits of tribes inhabiting similar ecological set-ups do not differ much. The difference is attributed to shared cultural variations. Personal hygiene is not an independent phenomenon. It comes through group living that contribute to habit formation. Therefore personal hygiene and sanitary habits are inseparable parts of the way of life. Habit formation may be explained in two domains namely Physiological and Psychological. The physiological basis is related to our motor system and nervous system. According to this, when an act is repeated more number of times in a short span of time, a clear nervous connection is formed, leading to a path way. This makes smooth shifting of nerve energy from sensory to motor. The inhabitants across the generations have developed their adoptive strategies to fit into the ecological demands and lead their life with resources available. The act of using resources thus gets responded by motor system of mankind. Thus, one of the qualities of life of the people at the grassroots is expressed in terms of a few health indicators such as practice of open defecation, use of water, hand wash, cleanliness of the surrounding and frequency of ailments.

Community sanitation, cleanliness and sanitary habits are said to be culture specific and area specific as community is a culture sharing territorial group having a 'we' feeling. Thus, collective action among the tribal communities is an integral part of culture and therefore personal hygiene and sanitary habits are the intangible psychosomatic responses to cultural stimuli. For ages the members are being socialized for a particular pattern of life style that includes the sanitation and sanitary habits. Although most of the tribal societies are patriarchic, they tacitly attribute women for community sanitation and sanitary habit formation among children during socialization process. There are a few empirical studies recently made by social scientists on gender, sanitation and hygiene and health (Benerjee 1973, Bhat 1985, Rizvi, 1991, Danda 1997, Bhasin 2000, Sharma and Dwibedi 2007 and Panda and Mall 2012). While Bhasin wrote on the gender issues, others focused on empirical situation and explained the role of culture in relation to health, hygiene and sanitation. It is also stated by many public health experts that water collected from unprotected sources for consumption leads to adverse health outcome. While emphasizing on the tribal health and medicine, Nair has studied the sanitary habits of seven tribes of Kerala (2008) as inseparable part of health enquiry. For better understanding of health status scholars need to emphasize for holistic approach (Rao 2005).

In general tribal communities lag behind the non-tribal social groups on various economic frontiers and social parameters. However, they lead over others in notorious indicators of health in terms of child mortality, infant mortality and number of anaemic women. As per the recent Govt of India ministry report of 2016 on a comparative Human Development Indices(HDI)between all social groups and scheduled Tribes reveal that 68.5 of tribal women is anaemic. Due to bio-cultural reasons women retain poor health. Female disability was especially high in Asia as per the world development report (Devi 1990) and India even today retains the notorious health identity. Similarly the rate of child mortality and infant mortality figured 35.3 and 62.1 respectively. In a sense the rationale behind for such a grim scenario of the tribal health is attributed to the sanitation and sanitary habits which are culture specific and area specific. The concept of cleanliness varies across the cultural communities. A community is a culture sharing territorial group having a'we'feeling. Thus, collective action among the tribes for natural resources use still remains indivisible in their way of life. Forest ecology and people's culture are symbiotically related. For ages the members are being socialized for a particular pattern of life style that includes the sanitation and sanitary habits. Although most of the tribal societies are patriarchic, people attribute women as a custodian of sanitation, personal hygiene and sanitary habit formation of the children.

The intensity of poverty and quality of life can also be measured through parameters dealing with the quality of water consumption, access to adequate sanitation and occurrence of water related diseases. It is stated that health hazards are caused primarily due to open defecation (Dash 2016). In India, it is reported that 775 million

people do not have access t adequate sanitation, 76 million do not have access to safe water, over 140000 children die from diarrhea every year, 44 % of the population of the nation still defecate in the open and death per day exceeds 2300 caused due to water related diseases (http//wateraidindia.in 2016).

Fresh and safe drink water is limited and precious. It is declining fast in its quality and quantity due to man-made environment. However, a few global reports say that the situation for drinking water appears better than that for sanitation. Although around 13% of the world's population (884 million people) lives in households where water is collected from distant, unprotected sources, 54% (3.6 billion) receives piped water at home. However, many piped water systems in developing and middle income countries work for only a few hours per day and/or are unsafe. In larger Asian cities, for example, more than one in five water supplies fails to meet national water quality standards. Reliable safe water at home prevents not only diarrhea but many other dreaded bacterial infections like guinea worm and many waterborne outbreaks of diseases such as typhoid, cholera and cryptosporidiosis. Unclean and stable water is an effective breeding ground for the insects. The ditches, stock water in thrown away containers are the grounds of propagation for the mosquitoes.

India has world's 2.41% land areas and about 17% of population and 4% of its water resources. But gradually water is becoming a scarce resource in many of its states. According to UNDP's HRD, 2001 report, in the year 1999 nearly 120 millions of Indians do not have had safe drinking water. The reason is the pattern of rainfall is uneven and surface water bodies are not uniformly spread across the country. In the tribal areas drilling of bore-well or sinking dug-wells may not solve the problem for providing safe drinking water. Different studies revealed that the tribal usually drink water from the springs and not from wells or tube-wells (Rizvi: 1991). As the tribal villages are remotely placed in the hills and forests and dispersed too from one another, so the pipe water supply is not cost effective.. The surface water sources like rivers, streams, and lake need pre-treatment before supplying for drinking due to pollution caused by surface mining and other industries in tribal belt. . The other sources like rain and ground water has to be explored in tribal areas. To combat the probability the eco-friendly native tribal people have adopted flexible coping mechanisms which should not be undermined during development interventions.

Public health movement Initiatives for better sanitation in India

Influenced and inspired by Gandhian ideals, Padma Bhushan Dr. Bindeshwar Pathak founded Sulabh International Social Service Organization (SISSO) in 1970 and in missionary spirit launched a social reform-cum-environmental up-gradation movement against poor sanitation that led to environmental degradation and health hazards caused by the practice of open defecation and use of environmentally degrading bucket toilets. It was a movement for social justice to empower the depressed classes, untouchables and widows, improve community health, hygiene and their habitat and help them enjoy dignified life. The SISSO brought a fundamental change in the mindset of people favoring improved sanitation practices. His fight against historically created inhuman practice of scavenging is seminal and unparalleled in the sense that he not only researched social evil but provided its categorical solution through a low-cost toilet-technology and developed a self-sustaining sanitation system across the nation. In the process of providing alternative to scavenging and social up-gradation of scavengers his social reform movement had passed a message to all saying that "Nobody should go outside for defecation and every house in India should have a toilet". Thus, Pathak innovated eco-friendly two-pit, pour-flush compost toilet technology popularly known as Sulabh Shauchalaya for individual households as an alternative to the cost prohibitive sewerage or septic tank based systems of excreta disposal. This toilet technology has been recommended as a global best practice by UN bodies for about three billion people across the globe and the Economic and Social Council of United Nations granted General Consultative Status to Sulabh in recognition of its outstanding service.

In addition, his contributions of bio-energy and bio-fertilizer, liquid and solid waste management acclaimed honor. Recently to change the mind set of people and sanitary practices hither to remain unchanged many community led initiatives have been taken up besides the government development interventions. The subsidized toilets are being constructed in economically poor households with an intension of disallowing the people for their habit of defecation in open. In many places NGOs have acted as facilitators/ negotiators to help people and the State in achieving the sustainable development goals. However, these initiatives were targeted mainly to cater the need of the urbanites and benefits to be accrued by the tribals had never been there in his series of initiatives.

Habit of Open Defecation in Odisha:

Census of India revealed that by 1990 over 90% of households in Odisha had no access to sanitation (1991). By 2011 almost 78% households in Odisha did not have any access to a toilet (Census 2011). By and large the open defecation is still in practice even today. Despite advancement in education and raised awareness it is observed that around 50% people of Odisha retains poor habit of personal hygiene and sanitation. The use of water by them is traditional and erratic. The use of soak pit latrines in many advanced districts of Odisha is quite less. People of Odisha make use of river embankments, village roadsides, agricultural field, bushy area, barren land, construction site for the purpose of defecation and nala, ponds and river for ablution and cleaning. During morning and evening hours one can mark a group of male and female defecating in sitting gesture on both the side of the rural roads in certain districts with a tumbler in front. Some time one listening to the sound the defecators produces with palm hit on to the lower abdomen to defecate quicker and easier. Some both male and female brush a little tamakhu paste known as gudakhu as a prelude to defecation and spit uncouthly. However, places of defecation changes according to seasons and fortnights. Even in Bhubaneswar we often witness the male construction workers carrying a little water in used plastic bottles to the defecation sites and female workers go to bushy area to attend the nature's call without any water container with them. They never go alone to the defection site due to fear of being manhandled for sexual gratification. The women clean themselves while they take bath. Children are allowed to defecate and urinate in and around the house the fecal materials are thrown by the women outside the house and at times do not bother. They rationalize this uncared act to be cleaned by insects, and bovines like pigs and stray digs.

Though the practices of going outside do not give them privacy, still they prefer this due to hangover of cultural habits and poor socialization patter at home. A few stated that their economic compulsions made them defecate in the open area. The government organizations like ministry of water and sanitary, Department of Rural development and many Non-Government organizations have made attempts to popularize the sanitary latrine programs through multiple low cost designs, arrange many awareness campaigns, used media for social marketing etc yet the result is far from satisfaction. Many epidemiological and public health investigation reports revealed that open defecation leads to water pollution and provide opportunity for the spread of water borne diseases.

In rural villages in Odisha, irrespective of sex and caste affiliation, both men and women in substantial number, go for open defecation during morning and evening hours with or without foot- wear. While going for defection some change their clothes who take bath in village pond before entering into house. Change of clothes while for defecation is again ethnic specific. Not all ethnic groups follow the similar pattern. The upper caste people as a part of their tradition and adherence of the concept of pollution and purity invariably change their clothes while they move out for defecation followed by a body-

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wash, except head portion, almost like a bath twice a day. At the present rate and with the present strategy and interventions, making Odisha open- defecation-free by 2019 seems to be a big challenge. Making Odisha an open-defecation-free State by 2030, so as to coincide with the Sustainable Development Goals (SDG) set by the United Nations, seems to be more plausible. Even to achieve this it may not be an easy task for various reasons.

Eating habits

Male supremacy can be observed from eating habit at home even in tribal families. The sequence in which the members eat is based on gender identity; however, age relaxation is there for the children and the aged. The housewife takes food in the same plate used by her husband or son and eats late. The sisters eat together in the same plate which might have been used by the elderly male a moment ago. This has been rationalized in favor intimate relationship between the eaters, and care and share attitude of the kin that includes economic use of food etc. The way the children weaned / fed from others' plate is considered as an expression of love and affection.

Disposal of garbage and the dead:

Traditionally non-degradable items like glass and baked and broken clay pots, bangles were heaped nearer the white ant heaps outskirt of the village. The umbilical cord of the new born if often buried just at the entrance gate, cut-hairs, cut nails are either thrown at the backyard or buried into the soil. Impure hair or cuts are done on bank of the river or pond . The dung of the bovines is heaped in garbage heap at a little distance from house nearer to the kitchen garden. Some amount of cow or buffalo dung is being used to plaster the earthen floor and the earthen wall as rural people believed it to be sacred and purifier. At the early morning the village womenfolk sprinkle cow dung water in front of the house to purify the area. The dead of the adults are either buried or cremated at the definite ethnically decided site a little far away from the habitation. The blood of the scarified animal is smeared on the sacred spot and then washed in river /stream or drained outside home to a kitchen garden. The fresh cattle hides are cleaned by the scavenger and except skin the other portions of the carcass are thrown away from habitation . These provide food to the insects, birds and stay dogs. Similarly the dead carcasses are buried in soil or throw uncared in barren land at a distance from habitat. The bovine and pets are taken for wash in specific ponds meant for the cattle.

The household garbage is taken to the backyard either to be stored in a garbage pit or thrown onto a least managed heap which is later use as compost for agriculture ativities. The villagers spit wherever they feel suitable. Thus, the ugly feature of sputum and mucus spit on road is being eaten by crows observed. No spittoon is use either at home or outside. Very little change is observed since decades.. One observed the wastewater flows here and there, left to roads or left to backyard. This reveals that people have least awareness on the sanitation and personal hygiene. So also is the poor management of drinking water and wastewater. Disposal of the house sullage water in unplanned growth of thickly populated areas is a big problem.

Accessibility to Safe Drinking Water:

Odisha with special reference to the National Water Policy 1987 had prepared the State Water Policy in 1994. The Revised National Water Policy of 2002 was also seen in State Water Policy, and finally in 2007 the Dept of Water Resources of Government of Odisha came with a 'Comprehensive Odisha State Water Policy', after being consultations made by administrative departments. The water policy aims at laying down the principles of equitable and judicious use of water for survival of life, welfare of human beings and sustained as well as balanced growth of the State. However, such moves have least impact on tribal villages. Drinking water and Sanitation are the essentials of life and living. To provide safe drinking water to the people of State, it has been listed in the 11th Schedule of 73rd Constitutional Amendment Act and thus it is obligatory. Thus, the local self-governments hold responsibility to provide basic services. For the social security and social services, the Panchayati Raj Institution (PRI) assumes responsibility to provide safe drinking water facilities, maintain toilets and provide better sanitation to community members.

Traditionally use of water from dug-well/ pond //river /rivulets or perennial steam was the source of water for the rural and tribal people. The use of tube well/ dug well water for consumption is of recent origin .It is a product of technological transformation. Similarly, extraction of water from ground was done by the installation of India Mark-II hand pumps / Krusak Bandhu pump which are events of nearer history. In many villages of Odisha the water that is being used are of many kinds. Some are with highly saline, some with iron or fluorine contents, while some other sources are bacterial as well as industrial waste contaminated. The quantity and quality of water available for household vary across the seasons. Rain water harvest is not popular enough in Odisha.

In many places there have been sporadic agitations against the Government for scarcity of water and apathetic attitude towards this vital issue. To combat the perennial problem of safe drinking water many development and social welfare agencies including Government went in favor of deep tube-wells. Converting marine water drinkable is a distant dream till this day. For maintenance of tube well, village youths were given appropriate training. The trained villagers are expected to overcome the difficulties by repairing and maintaining of hand pumps. However, on the basis of complains for such water related health problem caused due to chemical deposits, like heavy fluorine contents and similar other oxidized particles, the tube wells were also banned and made defunct and alternate arrangements have been made.

Reported highlights on Sanitation in Odisha:

As per 2001 Census 1.172 million (14.90%) households in Odisha had access to toilet within their own household premises. After a decade this increased to a little less than double figuring around 23.5%) as reported in Census report 2011. The number has increased to reach at reached to 30% of population as per the recent data of NSSO 2015. This means between within last 15 years (from 2001 to 2015) households having access to a toilet have crossed twice in number. One will definitely feel disturbed when women men and children are seen defecating on both sides of the village road in Odisha. As one crosses the persons defecating on roadside, the passer-by tries to escape from ugly scene and irritating smell at the earliest and the persons sitting defecating stands for a while for privacy. Those who defecate behind the bushes possibly feel that the bushy will helps them to maintain privacy. The male members hardly retain a sense of guilt for this uncouth act. So also are the children and do not even stand. The stray dogs and the pigs are acting as scavengers in cleaning the fecal materials. The tribes of Odisha bury their dead away from their habitat like many other tribes do. Rarely do they cremate.

In fact, children open defecation is a big challenge for administration. It is a hilarious to notice that people in Odisha do not hesitate to spend money for Television set or cell-phone rather than toilet. In fact, Census India 2011 revealed that television and use of toilet percentage of households having access to television exceeds households having access to a toilet. These are indicative of the low priority given to sanitation at household level. It seems that majority people of Odisha keep toilet as their last priority and they are unaware of the connection between health and sanitation. This was the situation even some three decades back when a UNICEF study also revealed the lack of awareness among people on the sanitation-health link. A study made by the Ministry of Drinking Water and Sanitation through Centre for Media Studies (CMS) in 2010 reveals that one of the major causes of non-usage of sanitation facilities is poor quality of construction (41%) and incomplete toilets (22%) -that refers to lack of superstructure and problem of water availability. According to Public Health Association of India, stool of 80% of children is either left open or thrown into the nearby garbage. A decade back report of NFHS – III (2005-2006) revealed that only 7% of

children excreta are safely disposed off. It was observed that many rural women of low economic class who defecate in open do not wash their hands just after defecation and they do it when they take bath in village pond or river. The report of the developing agencies reveal that a little more than 50% of the population only wash their hands with soap after defecation.

It is stated that the benefits of Water, Sanitation and Hygiene (WASH) interventions are greater than the health benefits alone. It is also stated that with better sanitation and hygiene more than 50% health hazards will remain unseen. In other words a massive disease burden is associated with deficient hygiene, sanitation, and water supply and is largely preventable with proven, cost-effective interventions. Hygiene, sanitation, and water supply continue to have health implications in the developed world. The rate of death of infants and children is one of the important indicators of the quality of sanitation and sanitary habit of the community.

Environmental sanitation and personal hygiene among tribal communities:

In the context of water, sanitation and health (WASH) as an integral part of Sustainable Development Goals and also an inseparable entity of 'Swacha Bharat Mission' the role and responsibility of women in maintenance and management of cleanliness at home and outside is enormous. Cleanliness and hygienic life at the community level, by and large, depends on the way the members are being socialized towards use of water, adhere to the culture of sanitation and degree of awareness on health and hygiene. Water source is very important for the purpose of drinking, cooking, washing clothes, bathing, cleaning utensils and other uses. This encompasses dimensions like safe and cleanliness, continuity of flow and ease of accessibility.

The State tribal situation in the State

Odisha has housed 62 scheduled tribes who could be put under broad five socio-economic categories based on a few economic parameters namely: nomadic hunter and food gatherers, shifting cultivators, settled small peasants, artisans and unskilled migrant laborers. About 44% of its geographical area comes under tribal sub-plan area (TSP). Of the 30 district 12 districts, fully or partially comes under TSP area covered under 118 tribal Blocks spread over 51349 villages. From among the Scheduled tribal communities there are a few area specific households belonging to 13 ethnic groups who have been identified as Particularly Vulnerable Tribal Groups (PVTG). They are now under the surveillance of Govt. micro-projects for their holistic development to be treated with extra care by administration. They with their vulnerable demographic structure live in forest villages located away from modern amenities with their pre-agricultural technology. They are found in districts like Koraput, Rayagada, Nawaragpur, Malkangiri, Mayurbhanj, Sundargah, Kalahandi, Nuapada, Baud, Kandhamal, Keonjhar, Ganjam, and Gajapati They belong to ethnic groups namely; Birhor, Mankidia, Hill Khadia,Lanjia Soura, Chukutia Bhunjia,Lodha, Koya, Kolha ,Didayi, Saunti, Saura, Kondh, Santal, Gond, Kissan, Bhunya, Paraja and Juanga and many others who differ in their cultural pattern of Sanitation and Sanitary habits. Most of the tribal districts are forested and packed with mines. The surface mining operation has affected the water sources, denuded the forest, reduced the sources of food and nutrition of the tribal people and contributed pollution. There has been an unbroken history and many broken promises for the tribal communities. Their quality of life deteriorated mostly due to extraneous factors.

Observed Case of Paraja Tribe of Koraput :

About two lakh Parajas are distributed all over undivided Koraput area. Some are also found in Kalahandi district. Koraput has housed around 50 per cent tribal households. Koraput block has 13 Gram Panchayats .Field observation was made in two randomly selected villages out of seven villages of Litiguda Gram Panchayat. The village Mahadeiput and village Litiguda with a population of around 320 have been surveyed. Their traditional leaders are called as muduli and other magico-religious functionaries are the designated as jani, disari, gurumai, gunia, and bhatanaik . As per 2011census their literacy rate is 17.96 % with female literacy as low as 7.3 % (Ota and Mohanty 2010). Data collection was made for a period of one month spread over summer and rain season. In this Panchayat, there are different sources of drinking water available such as natural spring, tube-well and open wells. The area is a fortress of Maoists.

The cursory observation at the activities of Paraja people reveals that both men and women are contributing to the family income. Their immediate neighboring tribal community is the Kondhs. Both the tribal communities are animistic. Among the Paraja both men and women take native cigars and brewed liquor. They spit wherever it is convenient. The houses are small with one living room having poor ventilation and are also used for multipurpose. They domesticate chicken and pigs and rarely goats. At the entrance a small verandah exists in which a small earthen cave is created for chicken and covered by a sliding gate. The pigs are kept in a small kraal fenced by wooden poles. The observation revealed that due to lack of health facilities, many inhabitants are the victims of water borne diseases and other sanitation related illness. Informal interactions were made more among women than men to elicit information on their sanitary habits, accessibility to hygienic facilities and indigenous practices and health problems they face. The inhabitants of Litiguda Gram Panchayat were using different types of water sources for various purposes. It was observed village surveyed that an average of 5% households use tube-well water assuming it to be safe for consumption while around 90% tribal households use spring water for drinking The rationality behind the use of spring water is that it is natural and gift of god therefore pure and safe. Parajas are educationally backward and their socio-economic life is precarious. Their entire area is affected by extremists. Most of the Paraja adult men and women earn their living through small peasantry and wage labor in unorganized sector

Sanitation and Hygienic facilities in the Panchayat

No tribal households of Litiguda Grampanchaya has personal toilet. The sanitary condition here is very poor. The awareness among the community regarding sanitation and use of drinking water is poor and inadequate. It was that neither men nor women have shown any interest in personal or community toilet. The field is wide and safe for defecation they opined. A few tribal elite have their own private toilets even then many of them defecate in open. Cleaning after defecation is hardly observed. They clean while taking bath in spring. There are 30 numbers of tube-wells in the entire Panchayat and only 12 number tube-wells are functional however no tube-well is free from having mineral particles thus they have poor water quality. The tribal women fetch water from spring for cooking and drinking purpose. The sanitary condition in the villages provided by Govt. is bit encouraging, however, due to lack of awareness among the community members on sanitation and they do not use safe and healthy drinking water. Like other part of the States, the Paraja women and girl children are primarily responsible for collection, storage of water for household use and maintaining hygiene and sanitation.

Hand washing and personal hygiene:

In case of tribal communities, the practice of washing-hands with soap before eating is very negligible. Almost all never bother to wash hand before taking food. Only if the hands are visible having clay/ mud or dust, they go for a wash. In case, they work in field with water and mud or removing dung of the bovine from shed they wash and to dry up they at best rub their hand onto their cloth/sari as a part of cleaning hand. Parajas have no habit of washing hand before eating food. Seldom have they washed hands with clay after defecation in open. Younger tribal women respondents wash their hands with water before taking food. They never wash their nipple before feeding the baby. They give least importance to brush teeth and clean tongue. They usually skip over bath for few days. The duration increases during winter due to cold and scarcity of water during summer. The running nose of the children are cleaned by parents in

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their own cloth or rubbed against upper lips and thrown at any place. Use of foot bear is a rare commodity. Due to paucity of water in this locality they never wash their legs.

Huts and the premises are often accumulated with filth and debris. The surrounding of the habitat is shrouded with excreta of the bovines and stray dogs. The poultry cage in almost every house is located at one corner. They are allowed to nestle in ant part o the huts a night. The awareness about sanitation among the tribal is very poor. For the household activities the stream, river and natural spring water are being used most. Many tube-wells are having water bad quality. The incidence of mineral particles in this water has resulted in image formation on Govt. water supply. Even in many cases the tribal do not consume tube-well water. It is reported that in tribal villages of Kalahandi district people suffered from osteoporosis. . Due to fluorine content in water drawn from tube-well Govt. made these tube-wells defunct. They believe that an individual is in good health when he/ she is participating the day-to-day activities .

Discussion and Conclusion:

The environment of their habitat, nature of economic activities has a direct bearing on food intake among the tribal communities. A tribal person is socialized through their strong cultural heritage and accordingly defines their respective habitat and resources. The water resources, however, polluted it may be are considered as pure and hygienic. The sanitary habits and personal hygiene among the tribes who are at pre-agricultural technology hardly feel concerned to have a latrine in house. Hand-washing as a practice before and after food is a remote practice among almost all tribes. Open defecation during morning and evening hours is a dominant tenet with many tribal communities. After defecation, cleaning with leaf and washing in rivulets or stream water is a usual practice. The use of slipper or shoe is also extremely rare. The tribal literates use slipper when they go to urban centre. The brushing teeth are not a regular practice with man and women alike in tribal communities. Combing hair and keeping it free from lice is unusual. Tribal communities have cultural diversities. No two tribal communities replicate their culture sanitary habits and personal hygiene in totality. Even it varies at the sub-cultural level. Their ecology, the technology, social origination, demographic structure and the traditional cultural practices contribute a lot to socialize the members. The tribal people have poor personal hygiene. However, Unlike Dogaria Kondh, Paudi Bhunya and Paraja tribe a few tribal communities like Binjhal and Santal of Odisha keep their house and the surrounding relatively clean.

Nair writes that the migratory tribe whose livelihood is derived from hunting and gathering economy like Cholanaikans, Paniyars,Kanikars, Kuruchiyars, Mulla Kurumbas and Kurumbas are the open defecators (2008). However, the modern education and Govt. interventions brought a few changes in the mind set of the educated tribal families in the world of sanitation and personal hygiene. Among the tribes the subordination and gendered socialization process made the women over burdened for home management. The sanitary movement as a reform movement is yet to take a shape to yield cultural transformation in favor of WASH. Scientifically the water supply coverage is defined as the percentage of the population with access to safe (improved) water supplies that provide 20 liters/person/day within one kilometer of the household compound. Sanitation coverage is defined as the percentage of population with access to adequate (improved) sanitation facilities that hygienically separate human excreta from human contact.

The water borne diseases in the States also explain the need for the activation of Public Health Programs for well known reasons. Primary Health Care has to be developed as an integral part of socio-economic development and with full participation of the individual, family and community. The experience of many years in the water and sanitation sector proves that the education and communication elements have been completely neglected. The current situation in the water, sanitation and health sector required a more practicable working strategy to honor the commitment of the Welfare state towards it citizens and ensure the quality of life. Thus, patterns of use of water and sanitary habits are area specific and culture specific. As one examines on the sanitary habits and personal hygiene across the tribes of entire nation, it is felt that north Indian tribes are better off compared to the central Indian tribes. Among the south Indian tribes it was observed that Kattunayikans are least sensitive to personal hygiene. The tribes of Odisha fall in between the north and south Indian tribes as regards the sanitary habits and personal hygiene.

Irrespective of tribal and non-tribal, people in hinterland are ignorant about the methods as to how the water can be made safe for drinking purpose. So also is the food and liquor consumption. They live at the mercy of nature. A few decades back they were brewing liquor and consumed in group as a part of food and entertainment. The inroad of distilled liquor not only drained their income but came on the way of group solidarity and reduced the longevity. Poor sanitation and hygiene in rural Odisha reveal a grim picture. This has been evidenced by the rate of mortality, morbidity, and visible body morphology and growth stunt. Belief system disallows and indigenous practices the tribal and rural families to take proactive health strategies. The health menace accelerates due to faulty food habits and poor sanitation and hygiene, dependency on traditional healer and multifaceted poverty.

The use of toilet is physiologically related to our motor system and nervous system. Therefore repeated use of toilet ether by community led initiative or by other punitive means can create a clear connection between the nervous system and motor system for defecation. The inhabitants across the generations can develop their adoptive strategies to fit into the ecological demands and lead their life with resources available with the support of Governments. Welfare States are expected to ensures citizens to provide security, prevent destitution, stop all forms of exploitation, abolish squalid living condition, remove grosser forms of inequality, above all provide health security and other forms of social services that are parts of fundamental rights (Desai 1975). Since independence of India, the Government has been giving attention for safe drinking water and Sanitation in rural areas but a large section of the society is yet to receive these facilities. Therefore, the Govt. agenda of WASH must include all section of people with special attention to women and children since charity begins at home and mother is the first teacher that contributes and shapes the habit formation of the child. Article 21 of our constitution makes a commitment that nation is obliged to provide every citizen to live a life with dignity. This obviously mean that without access to safe drinking water, supply of adequate food and nutrition, access to better sanitation and health care facilities one can not enjoy a dignified life. Further, it has been realized that without a demand driven culture for improved sanitation, transformative personal hygiene and clean and healthy habitat, the Swacha Bharat Mission will be a daydream. Thus, motivational inputs at every stage of development are indispensable. However, to transform public health domain especially in areas of sanitation and personal hygiene, the political will of the Government is essential.

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