

Knowledge on hygiene of rural women of Assam

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■ **ABSTRACT** : The study was carried out in the state of Assam (India) with 270 randomly selected rural women of 3 districts, viz., Tinsukia, Nagaon and Barpeta districts to find the existing knowledge level of respondents on hygiene. Majority of the respondents had medium level of knowledge on hygiene in all the districts, viz., Barpeta (67.78%), Nagaon (67.78%) and Tinsukia (61.11%). It is also found that Nagaon district had the highest percentage (21.11 %) of respondents with low level of knowledge on hygiene in comparison to the other two districts, i.e. Barpeta (17.78 %) and Tinsukia (17.78 %).

■ **KEY WORDS**: Knowledge, Hygiene, Rural women

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Hygienic refers to conditions and practices that help to maintain health and prevent the spread of diseases. It can be defined as the practice of certain habits to maintain a good health both at the personal level (personal hygiene – cleanliness, physical exercise, proper rest, sleep, bathing, avoiding smoking, drinking alcohols, drugs etc.) and at the community level (social hygiene – proper disposal of waste) (WHO, Jan, 2016). Hygienic practices play a vital role in the health status of human society. Health status of an individual reflects the quality of life. To maintain a proper health status, proper hygiene and good nutrition are necessary. India, though after independence, has progressed a lot, yet, spread of diseases, suffering from deficiency diseases, growth of harmful organisms due to improper disposal of sewage and refuse, lack of drainage system, habit of open-defecation by the people, lack of safe water, urinating and spitting in public places etc. are some of the common problems prevailing in the

society of the vulnerable areas like villages, slum areas etc. (Timung, 2011). Worldwide, 40 per cent of the population does not have ready access to clean, safe drinking water, and approximately 60 per cent does not have satisfactory facilities for the safe disposal of human waste. Infectious agents in drinking water and food cause diarrheal deaths of several million children annually (Samson, 2014). Access to improved water and sanitation facilities does not, on its own, necessarily lead to improved health. Evidences have shown that good hygiene practices are very important in the health status of people. Lack of proper hygiene has been the major cause of many killer diseases in most countries of the world, including India (Garrett and Woodworth, 1981). Many studies have shown that India is far away in the aspect of hygienic practices. To raise the health status of rural women, proper hygiene along with adequate nutrition has to be incorporated into practice in their daily living. It is necessary to make rural women aware

regarding proper hygiene such as provision of safe drinking water, proper defecation of human excreta, washing hands properly at critical situations, proper cleaning of body parts every day and proper maintenance of surroundings in rural areas etc. The hygiene information can be disseminated through education. Before disseminating information on hygiene, it was felt necessary to reveal the knowledge level on hygiene among the rural women. Therefore, the researcher has made an attempt to study the knowledge level on hygiene of rural women of Assam.

RESEARCH METHODS

The study was carried in the state of Assam. Three parts of Assam had been included, namely Upper Assam, Middle Assam and Lower Assam for the study. Three districts viz., Tinsukia, Nagaon and Barpeta were selected randomly from the three parts of Assam. From the three districts, three subdivisions namely: Tinsukia subdivision from Tinsukia district, Nagaon subdivision from Nagaon district and Sorbhog subdivision from Barpeta district were selected randomly. One development block from each selected subdivision, one gaon panchayat from each selected block and three villages from each selected gaon panchayat were selected randomly. Finally, nine villages were considered for carrying out the study. Selection of respondents was done by equal distribution method. Thirty respondents in the reproductive age group (15 yrs – 49 yrs) (according to WHO, reproductive age group is usually defined as 15-49 years or 12-49 years) were selected randomly from each village. Thus, there were two hundred seventy (270) numbers of respondents for assessing the existing knowledge of the respondents on nutrition. The data were collected personally by the investigator through personal interview method with the help of the prepared interview schedule.

The existing knowledge on hygiene was assessed by using a knowledge check developed by the researcher (Gohain and Sarmah, 2019). It consists of 30 statements on hygiene. As the scales had both positive and negative

statements, rural women’s responses were recorded on a two point continuum as correct and incorrect and scored as 1 and 0, respectively. Each positive statement, if responded ‘correct’ and each negative statement if responded ‘incorrect’ was given 1 (one) score, and each positive statement if responded ‘incorrect’ and each negative statement if responded ‘correct’ was given 0 score. Based on the scores obtained by the respondents, they were categorized into three categories: viz., Low (< mean - SD), Medium (between mean ± SD) and High (> mean + SD).

RESEARCH FINDINGS AND DISCUSSION

The results obtained from the present investigation as well as relevant discussion have been summarized under following heads :

Existing level of knowledge on hygiene (overall):

The distribution of respondents according to their existing level of knowledge on hygiene is presented in the Table 1.

Table 1 indicates that majority of the respondents (64.81 %) had medium level of knowledge on Hygiene. It might be due to the fact that because of respondent’s low educational qualification, lack of contact with extension personnel and lack of mass media exposure,

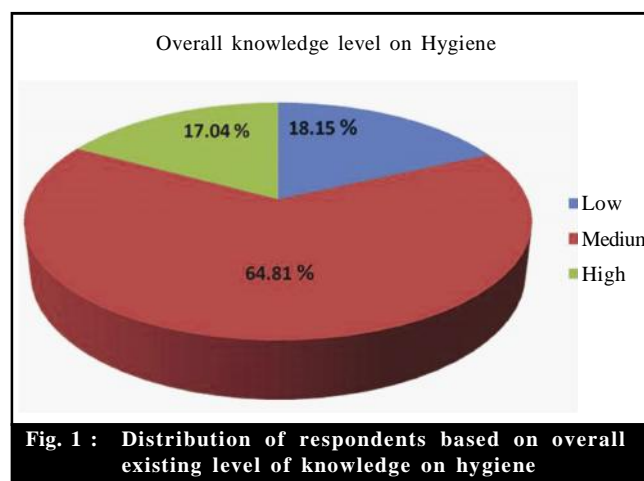


Fig. 1 : Distribution of respondents based on overall existing level of knowledge on hygiene

Table 1: Distribution of respondents based on overall existing level of knowledge on hygiene					(n=270)	
Category	Score range	Frequency	Percentage (%)	Mean	SD	
Low	< 5.21	49	18.15			
Medium	5.21 – 11.57	175	64.81	8.39	3.18	
High	> 11.57	46	17.04			

Table 2 : Distribution of respondents based on existing level of knowledge on hygiene (district wise)

Name of district	Category	Score range	Frequency	Percentage (%)	Mean	SD
Barpeta (N=90)	Low	< 5.56	16	17.78	8.45	2.89
	Medium	5.56 – 11.34	61	67.78		
	High	> 11.34	13	14.44		
Nagaon (N=90)	Low	< 5.11	19	21.11	7.61	2.50
	Medium	5.11 – 10.11	61	67.78		
	High	> 10.11	10	11.11		
Tinsukia (N=90)	Low	< 6.53	16	17.78	9.52	2.99
	Medium	6.53 – 12.24	55	61.11		
	High	> 12.24	19	21.11		

they might not be able to collect or gather information on hygiene and thus only 17.04 per cent of respondents had high level of knowledge on Hygiene.

Existing level of knowledge on hygiene (district wise):

The distribution of respondents based on existing level of knowledge on hygiene (district wise) is presented in the Table 2. The data presented in Table 2 shows that in the three assessed districts, majority of the respondents had medium level of knowledge on hygiene, namely Barpeta (67.78%), Nagaon (67.78%) and Tinsukia (61.11%).

From the Table 2 it is also observed that, Nagaon district had the highest percentage (21.11 %) of respondents with low level of knowledge on hygiene in comparison to the other two districts, *i.e.* Barpeta (17.78 %) and Tinsukia (17.78 %). This might be due to the fact that, none of the respondents in Nagaon district had regular contact with extension personnel. Contact with extension personnel helps one to collect and gather information on hygiene and allied subjects. The respondents of Nagaon district rarely contacted extension personnel and they rarely visited urban area. Low educational qualification might also be another reason for having highest number of respondents (21.11%) with low level of knowledge on hygiene.

The Table 2 also shows that among the three assessed districts, Tinsukia district had the highest percentage of respondents (21.11%) with high level of knowledge on hygiene. This might be due to the fact that the respondents of Tinsukia district were highly qualified than the respondents of other two districts. Therefore, their eagerness for new information was much more than the respondents belonging to the other two

districts and hence the percentage of respondents with high level of knowledge on hygiene was highest among the three districts.

Conclusion:

Good health is the key criterion which contributes to the well-being of human and economic growth. Adequate information regarding hygiene for women would help them to serve as productive members of the society. Women plays dual role in every family. The health condition of a family depends on the activities of a woman. She has to maintain hygiene while cooking food, cleaning surrounding and taking care of the members etc. The rural women should be made aware regarding different aspects of hygiene and its importance in their day to day life activities so as to maintain a hygienic atmosphere at the household level as well as at the community level. The government can play an important role in educating and creating increased awareness on nutrition and its needs among the rural women. Thus, if the knowledge level of rural women on hygiene is assessed, then varieties of educational programme can be undertaken for the rural women based on their knowledge level, which in turn will help them to improve their health status in general.

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