A Sociological Study of Women's Health Modernity in Meerut City

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ABSTRACT

Health Modernity is the scientific knowledge, attitude and practices towards health and its various dimensions. Several studies have described health modernity within the context of various groups of people. However, health modernity among population sub-groups is still scanty. Here, an attempt is made to find out the health modernity among urban women. This cross-sectional study is carried out in Meerut City of Uttar Pradesh state. A total sample of 100 urban women, age between 21-50 years, is selected through purposive sampling method. The data are collected using pre-designed and structured interview schedule and analyzed using simple statistics techniques. The findings of the present study reveal that on different dimensions of health modernity, less than one-fourth of the respondents have high health modernity on physical health dimension, one-third on reproductive health dimension, three-fourth on nutrition & diet dimension, a little less than half of the respondents on family planning dimension, and a little more than one-third on child care dimension. Thus, the current study has found that there is a need to enable such training programs and campaign which can help in improving health modernity of urban women.

Introduction

Women constitute a significant part of our society. In many ways, women's health differs from men's health. Women's health is a matter of concern and it is of great importance both for their own sake and for the sake of future generations (Hariharan, 2016). Generally, health is understood as 'the absence of any disease or infirmity'. Health is one of the key elements in human as well as in social development. In the field of health care world leading organization, World Health Organization (WHO) gave a holistic and inclusive approach towards health. It defines health as a "state of complete physical, mental and social well-being and not merely the absence of any disease and infirmity" (Nagla, 2018).

As health is a multi-dimensional concept, the concept of modernity is also multi-dimensional in nature. It consists of a set of psycho-social qualities which are empirically conducive to individual growth, development, adjustment, progress, and well-being. In other words, modernity is quality of being modern which is pre-requisite for all social and individual

development (Singh, 1984).Because modernity is a multi-dimensional concept, so here, the main focus is on the health notion of modernity i.e. health modernity and it is considered as the extended form of modernity. A.K. Singh introduced the concept of 'health modernity' in his health modernity education project. He defined 'health modernity' as "scientifically correct knowledge, attitudes, and behaviour towards health matters. These different health matters include physical health, mental health, reproductive health, diet and nutrition, family planning, child care, personal hygiene, environmental sanitation and such other issues. These are essential and pre-requisites for healthy living and, also for human and social development" (Singh 1984). Sound health is prerequisite for having equal opportunity to participate in the benefits of the society. Whereas health modernity is the scientific knowledge, attitudes, and behaviour towards health matters. Therefore, it is necessary to measure health modernity of the people. In the present study, the main focus is on measuring the extent of health modernity among women residing in urban area.

Conceptual Framework

The conceptual framework (table-1) shows the different dimensions of measuring health modernity (scientific knowledge of & attitudes to health matters) with different indicators, which can be positively and negatively related.

In the present study, health modernity is measured through a scale which is known as health modernity scale. This scale consists of five dimensions and each dimension is represented by five items. Among total of twenty-five items, each item is represented by five alternatives i.e. strongly agree, agree, neutral, disagree, strongly disagree. For each positive question, score is from 5-1 i.e. strongly agree to strongly disagree; and for each negative question, score is from 1-5 i.e. strongly agree to strongly disagree. Responses are coded as 'low health modernity' (1, 2, & 3), and 'high health modernity' (4 & 5). On each dimension, one who scores 20 and above has high health modernity and one who scores below 20 has low health modernity.

Table-1 Dimensions of Health Modernity with different indicators

Physical Health dimension Indicator (Score range)	Reproductive Health dimension Indicator (Score range)	Nutrition & Diet dimension Indicator (Score range)	Family Planning dimension Indicator (score range)	Child Care dimension Indicator (score range)
Treatment of ill health (5-1)	Source of sexual diseases (5-1)	About Pregnant woman & her diet (5-1)	Determination of child sex (5-1)	Infant & its food pattern (5-1)
About Physical exercise (5-1)	About indiscriminate sex (5-1)	Knowledge of over-eating & under-eating (5-1)	Children as blessings from God (1-5)	About diseases of children (1-5)
Body composition & health status (1-5)	Prevention of sexually transmitted diseases (1-5)	About life-problems & food (1-5)	Need of son to keep continuity of the family (1-5)	Cure of diseases among children (1-5)
Knowledge of Emergency situation (1-5)	Protection from sexually transmitted diseases (1-5)	About eating habits (1-5)	Need of son for life's last rituals (1-5)	Prevention of diseases among children (5-1)
Diseases & planets relationship (1-5)	Consumption of oral tablets (5-1)	Smoking & health (1-5)	Recurrence of birth of girl child (1-5)	Diseases in 40s/50s & childhood health status (5-1)

An overview of selected studies

Several researchers have been carried out studies about health modernity from different point of views in different regions as carried out by A.K. Singh, 1984; J.S. Budihalmath, 1992;

K.R. Suraj, 1992; T. Gangadharan, 2004; and so on. A brief discussion of the available studies is as follows:

A.K. Singh (1984) surveyed the extent of health modernity in South Bihar among four main ethnic-religious groups. J.S. Budihalmath (1992) showed the influence of socio-economic status on the health modernity of hindu and muslim women in Dharwad district of Karnataka. K.R. Suraj (1992) measured the extent of health modernity in the sample sub-groups of Anganwadi workers, target and non-target groups in four talukas of Dharwad district of Karnataka. R.N. Kenchappanavar (1997) studied improvement in the knowledge and information level, attitudes and behaviours of the women due to health modernity and educational intervention project (HMEIP) in four villages of Dharwad taluka of Dharwad district of Karnataka.A. Sharma and M. Dhilon (1997) have studied health modernity among rural women in Kangra district of Himachal Pradesh. T. Gangadharan (2004) analyzed the influence of age, sex, educational status, marital status, and family size on health modernity awareness among the people of Lakshadweep. S.B. Shetgovekar (2007) aimed to study the extent of health modernity among different sample sub-groups in Goa state. A.S. Dey and A. Shrivastava (2011) assessed health modernity attitudinal and health modernity behavioural scale in the form of an interview schedule in a pilot survey in Sagar district of Madhya Pradesh.

Moreover, the extent of health modernity has not been adequately studied within the present study area; hence this study is conducted. Thus, the rationale of the current study is primarily to explain the extent of health modernity among urban women. This study aims to find out socio-economic profile of urban women in terms of age, marital status, category, religion, education-level, and so on. It also aims to measure health modernity of urban women in terms of physical health, reproductive health, nutrition & diet and so on.

Methodology

It is a cross-sectional study which is carried out in Meerut city of Uttar Pradesh. Using the purposive sampling method, total of five areas are selected from the city and this selection is on the basis that all of these areas are more or less highly developed. Name of these areas are Shastri Nagar, Jagriti Vihar, Ganga Nagar, Gagan Vihar, and Modipuram. From each area, 20 women are selected purposively as respondents. In this way, a total of 100 urban women are selected and surveyed with the help of pre-designed and structured interview schedule from selected five areas. Interview schedule is used as the method of data collection. Before collecting the data, each respondent is clearly informed about the research matter and verbal consent is taken from each respondent regarding it. The collected data are processed, tabulated, and classified. Analysis of collected data is done using simple statistics techniques.

Results

In the present study, total 100 participants are included. It is carried out in Meerut city. This study is aimed to find out socio-economic profile of urban women and to measure the health modernity of them. The results of this study are discussed below:

1. Socio-economic Profile of the respondents

This study aims to find out socio-economic characteristics of the respondents. In the present study (Table-2), socio-economic profile of the respondents covers parameters such as age, marital status, category, religion, education-level, involvement in income earning activities, class, and family type.

Table-2: Distribution of respondents according to their socio-economic profile

S.No.	Socio-economic Profile	No. of respondents (%)
1.	**Age**	
	21-30	67.0
	31-40	16.0
	41-50	17.0
2.	**Marital Status**	
	Unmarried	55.0
	Married	45.0
3.	**Category**	
	General	50.0
	OBC	34.0
	SC	16.0
4.	**Religion**	
	Hindu	92.0
	Muslim	3.0
	Christian	3.0
	Others	2.0
5.	**Education Level**	
	Uneducated	3.0
	Moderately Educated (Primary & Secondary)	20.0
	Highly Educated (UG/PG & above)	77.0
6.	**Involvement in income earning activities**	
	Yes	25.0
	No	75.0
7.	**Class**	
	Lower (≤ Rs. 10,000)	15.0
	Middle (Rs. 10,001 -30,000)	36.0
	Higher (≥ Rs. 30,000)	49.0
8.	**Type of Family**	
	Nuclear	64.0
	Joint	36.0

The results from table 2 show that majority (67%) of the respondents belong to age group 21-30years followed by 41-50 years (17%) and 16% of the respondents to 31-40 years. Majority (55%) of the respondents are unmarried followed by married (45%) respondents. Half (50%) of the respondents belong to general category followed by OBC (34%) and SC (16%).Majority

(92%) of the respondents are Hindu. While 3 percent of the respondents are Muslim and other 3percent are Christian and remaining 2 percent of the respondents follow other religion. Majority (77%) of the respondents are highly educated, followed by moderately (20%) educated and uneducated (3%). Majority (75%) of the respondents are not involved in any income earning activity whereas only one-fourth (25%) of the respondents are involved in income earning activities. Most (49%) of the respondents are from higher class followed by middle (36%) class and lower (15%) class. Majority (64%) of the respondents live in nuclear type of family while 36% of the respondents live in joint family.

Thus, from the above described findings, it is clear that majority of the respondents belong to 21-30 years age-group, are unmarried, in general category, and are Hindu. They are highly educated but not involved in income earning activities. They belong to higher class and live in nuclear family.

2. Health Modernity level of urban women

Generally, health modernity is considered as an 'extension of the concept of modernity'. In the present study, health modernity of urban women is measured through a scale which is known as Health Modernity Scale (HMS). It includes five dimensions i.e. physical health, reproductive health, nutrition & diet, family planning, and child care. Among five dimensions, each dimension is represented by five items. Among total of twenty-five items, each item is represented by five alternatives i.e. strongly agree, agree, neutral, disagree, strongly disagree. Responses are coded as 'low health modernity' (1, 2, & 3) and 'high health modernity' (4 & 5) on each item. On each dimension, one who scores 20 and above has high health modernity and one who scores below 20 has low health modernity. Table-3 represents the health modernity of urban women.

Table-3: Distribution of respondents according to their Health Modernity

S.No.	Health Modernity Dimension	Health Modernity Extent	
		High (Score = 20 and above) (%)	Low (Score = Below 20) (%)
1.	**Physical Health** • Treatment of ill health (5-1) • About physical exercise (5-1) • Body composition & health status (1-5) • Attitude to emergency situation (1-5) • Diseases & planets relationship (1-5)	22	78
2.	**Reproductive Health** • Source of sexual diseases (5-1) • About indiscriminate sex (5-1) • Prevention of sexually transmitted diseases (1-5) • Protection from sexually transmitted diseases (1-5) • Consumption of oral tablets (5-1)	33	67
3.	**Nutrition & Diet** • About pregnant woman & her diet (5-1) • About over-eating & under-eating (5-1) • About life-problems & food (1-5) • About eating habits (1-5) • Smoking & health (1-5)	76	24

4.	**Family Planning** • Determination of child sex (5-1) • Children as blessings from god (1-5) • Need of son to keep continuity of family (1-5) • Need of son for life's last rituals (1-5) • Recurrence of birth of girl child (1-5)	48	52
5.	**Child Care** • Infant & its food pattern (5-1) • About diseases of children (1-5) • Cure of diseases among children (1-5) • Prevention of diseases among children (5-1) • Diseases in 40s/50s age & childhood health status (5-1)	38	62

From table-3, it is showed that in physical health dimension, majority (78%) score below 20, thus, have low health modernity and only 22% of the respondents score 20 and above, thus, have high health modernity. In reproductive health dimension, majority (67%) of the respondents score below 20, thus, have low and 33% of the respondents score 20 and above it, thus, have high health modernity. Majorities (76%) of the respondents scores 20 and above, thus, have high health modernity and only 24% of the respondents score below 20 and has low health modernity in nutrition & diet dimension. More than half (52%) of the respondents score below 20, thus, have low and 48% of the respondents score 20 and more than it, thus, have high health modernity in family planning dimension. Majority (62%) of the respondents scores below 20, thus, have low health modernity and only 38% of the respondents score 20 and above it, thus, have high health modernity in child care dimension.

Field observations have found that number of women with high health modernity is low on four dimensions except nutrition & diet dimension; this is because many women have low scientific knowledge, attitudes, and behaviour and have many myths or misconceptions about health matters. These misunderstandings, misinterpretations, and myths related to health issues lead to low health modernity among urban women.

Discussion

The present study is conducted in Meerut city of Uttar Pradesh state among 100 women aged between 21 and 50 years. It aims to find out socio-economic profile of urban women and to measure health modernity among them. The results of this study show that majority (67%) of the respondents belonged to 21-30 years age-group. The findings of the current study reflect several myths or misconceptions among women regarding health modernity and its various dimensions. In a study conducted by A. Sharma and M. Dhilon (1997) in Himachal Pradesh, it was observed that there was a considerable degree of fatalism about health matters among women. Similarly, the current study has found that many women have misconceptions regarding health matters.

In another study conducted by K.R. Suraj (1992) in Karnataka, it was revealed that caste, religion, income and education had not influenced health modernity of the participants. In this study, majority (77%) women are highly educated but very less number of the respondents has high health modernity. In contrast to the findings of the present study, a study conducted by R.N. Kenchappanavar (1997), the findings showed that higher level of education and socio-economic status resulted into higher health modernity of the subjects.

R.N. Kenchappanavar (1997) conducted a study and the results showed that the percentages of modern scorers in the sample were below 50% on all the dimensions and on total health modernity. Similarly the present study has found that the percentages of high health modernity women are below 50% on four dimensions except on nutrition & diet dimensions.

Conclusion

The present study is aimed to measure health modernity of urban women. Field observations have found that number of women with high health modernity is low. The reason for this is that many women have misunderstandings, and misconceptions regarding health related matters. These misunderstandings, misinterpretations, and myths related to health matters cause low health modernity among them. It emphasizes the need to create awareness about health and correct and scientific knowledge of its various aspects. Although in this study, majority of the respondents are highly educated yet maximum of them has low health modernity. Therefore, it is concluded that women should be provided with the right health education so that they can improve their health modernity which will result in the improvement of their health status. It also suggests that health education should include in the study curriculum on both school and college level. Government, self-help groups, ASHA workers, Anganwadi workers, NGOs and politicians can play vital role in creating and developing scientific disposition towards health and diseases.

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