CHAPTER VIII

SUMMARY AND CONCLUSIONS
Good health plays a substantial role in economic growth. Health is not only the absence of illnesses; it is also the ability of people to develop to their potential during their entire lives. In that sense, health is an asset individuals possess, which has intrinsic value, that is, being healthy is a very important source of well-being as well as instrumental value. In instrumental terms, health impacts economic growth in a number of ways. For example, it reduces production losses due to worker illness, it increases the productivity of adult as a result of better nutrition, and it lowers absenteeism rates and improves learning among school children. Finally, it renders the financial resources productive, which otherwise is destined for the treatment of ill health. In sum, health positively affects economic growth directly through increasing labor productivity and reducing the economic burden of illnesses.

Goa classically fits the bill for such a society that has achieved certain economic developmental targets. It is one of the best performing states in India in the matter of health and medical care. The remarkable achievements in health sector have been mainly due to the socio-economic development, wider provision of safe water, sanitation facilities and expansion of health infrastructure coupled with implementation of various programs on health and family welfare. (Salelkar, A. V., 2001). But despite this impressive range of health services, the State appears to be losing the ground on health front. Malnutrition, communicable diseases and non-communicable diseases are still present. Non-infectious diseases such as heart disease, diabetes, renal failures and mental illness are becoming more common. Tackling these woes in the State's health care system is not an easy task and social and economic changes are rapidly bringing in a new set of problems. Addressing these health problems requires far more than mere infrastructure and rudimentary support (Patel, V, 2001). As Inkeles, A. and Smith, D.H. (1974) rightly remark that 'nation building
and institution building are only empty exercises unless the attitudes and capacities of
the people keep pace with other forms of development'. The situation thus demands
suitable intervention strategy in order to create scientific knowledge and positive
attitude towards various health issues amongst the general public that will help them
to understand and tackle their health related problems in a better way.

But in order to do so, adequate tools are required to measure the actual
knowledge and attitude of the people. Health Modesty Scale is one such tool that
can be used to identify the areas of misconceptions and ignorance. Once the areas of
misconception and ignorance are identified, suitable Health educational intervention
can be developed. The health educational intervention can be designed taking into
consideration the demographic characteristics and present knowledge, attitude and
health practices of the target population in order to make a strong impact on that
population. Besides it is also important to identify the misconceptions and areas of
ignorance prevalent amongst the target population.

A suitable health educational intervention will not make illnesses disappear or
make everyone healthy forever. But it will help people cultivate scientific knowledge
with regard to various health issues, differentiate between healthy and unhealthy
practices, and develop right attitude, which in turn will ensure and enhance the overall
development of their own self and that of their family members.

The present research was conducted to measure the extent of health modernity
in other Goans and fisher folks samples and to study gender, SES, education, religion,
age group, domicile, and marital status as correlates of health modernity. The research
also focused on the areas of ignorance and misconceptions existing in the samples.
The sample of the study comprised of the men and women belonging to the
reproductive age group, that is, 15-45 years in Goa. The total sample size was 800
with equal number of men and women. Stratified convenient method was used in the research. Sample was selected on the basis of the fisher folks (group of people involved in fishing activities like catching and selling of fish) and other Goans (400 in each group) and further on the basis of the SES. With an objective to access the extent of health modernity of the sample on different dimensions, mean scores were obtained. T test was used for assessing the significance difference in the sample sub groups. Analysis of variance (ANOVA) was used to assess the influence of independent variable on dependent variable and two way ANOVA was used to study the interactional effect of independent variables.

The following important observations were made based on the statistical analysis of the data:

1. Percentages of ‘modern’ scorers for the two sample groups were obtained in order to get an idea about the scientific knowledge possessed by the two sample groups, namely, other Goans and fisher folks sub groups. The percentage of ‘modern’ scorers for other Goans was found to be higher, almost double, than the percentage of ‘modern’ scorers for fisher folks. Thus indicating that though both the groups have low percentage of ‘modern’ scorers, the scientific knowledge about health possessed by other Goans sample sub group is better than the fisher folks sub group.

Further assessment was carried out by calculating mean scores and t values. Significant difference was found between the two sub groups, with other Goans sub group having significantly higher health modernity compared to fisher folks sub group. Dimension-wise AIDS had highest mean scores for both the sub groups. The lowest mean score was on the dimension child care for other Goans.
sub group and on the mental health and child care dimension for fisher folks sub group.

Significant interaction was found to exist between the types of sample: other Goans and fisher folks and domicile: urban and rural. The results indicated that the other Goans sub group in urban dwellings had better health modernity due to appropriate exposure to the various modernizing agents than other Goans in rural dwellings. Similar findings can be observed with regard to the fisher folks sub group, where the health modernity of urban dwellers is better than the rural dwellers.

2. Item-wise percentage of ‘modern’ scorers indicated that the fisher folks sub group has less scientific knowledge about health related issues as compared to the other Goans sub group, as the other Goans sub group had a total number of 41 misconceptions when compared to fisher folks sub group that had 57. The dimension of AIDS had least misconception in both the sub groups compared to other dimensions. Whereas maximum misconceptions were observed in mental health dimension. Fisher folks sub group had misconceptions on all the ten items of mental health dimension, where as the other Goans sub group had misconceptions on seven items. With regard to AIDS dimension, other Goans sub group displayed scientific knowledge on all the ten items. The fisher folks sub group however possessed misconception with regard to two items.

3. The comparison of health modernity scores gender-wise indicated that females sample sub group had higher health modernity compared to males sample sub group. Further comparison between the males and females of other Goans sub group indicated that the females of other Goans possessed greater scientific knowledge about health related issues compared to males, other Goans. However
no significant difference existed between the females and males of fisher folks sub group. Also the health modernity of males and females of other Goans sub group had higher health modernity than males and females of fisher folks sub group, thus suggesting that males and females from other Goans sub group are better exposed to the modernizing agents of health modernity than the males and females of fisher folks sub group.

Two way ANOVA was used to investigate the interaction between gender and marital status. The results indicated that the health modernity of married males is higher than the unmarried males, thus indicating that marital status had an influence on the health modernity of the males sample sub group. But contrasting results can be seen with regard to the females, as unmarried females have higher health modernity compared to married females, a possible reason being that the percentage of highly educated married females was lower than highly educated unmarried females. Education is a key modernizing agents and may lead to higher health modernity scores.

4. High SES had significantly higher health modernity compared to low SES. High and low SES of other Goans sub group had significantly higher health modernity compared to high and low SES of fisher folks sub group.

Analysis with the help of two way ANOVA showed that a significant interaction existed between SES and domicile with regard to their effect on health modernity scores. Urban dwellers with high SES had higher health modernity compared to the rural dwellers with high SES and urban dwellers with low SES had higher health modernity compared to the rural dwellers with low SES.

5. The high educational level sample sub group possessed significantly higher health modernity when compared to the medium and low educational levels. However
the three sample sub groups displayed low mean scores on health modernity and its dimensions thus indicating that health specific educational intervention was required. Comparisons between other Goans sub group and fisher folks sub groups on the basis of high, medium and low educational levels indicated that other Goans sub group with high, medium and low educational levels, had significantly higher health modernity when compared to the fisher folks sub group with high, medium and low educational levels.

Two way ANOVA was used to investigate the interaction between education and SES indicated that no significant interaction existed between the variables. Thus indicating that whether, low or high SES, high educational level contributes to a greater extent to high health modernity level.

6. Significant influence of religion was found on health modernity. Christian religious group possessed greater scientific knowledge compared to Hindus and Muslims sample sub groups. Hindus and Christians of other Goans sub group had higher health modernity than the Hindus and Christians of fisher folks sub group. However, no significant difference existed in Muslims of other Goans sub group and Muslims of fisher folks sub group.

7. Results obtained with the help of ANOVA indicated that significant difference existed in health modernity of various age groups. 25-30 age group had highest mean score and the 35-40 age group had the lowest mean score. When the other Goans and fisher folks sub groups were compared, significant difference was found in the age groups of 20-25, 35-40 and 40-45.

8. Urban dwellers had significantly higher health modernity compared to rural dwellers. Urban and rural, other Goans sub group had significantly higher health modernity when compared to urban and rural, fisher folks sub group.
9. Significant influence of marital status was found on health modernity. Married sub
groups had higher health modernity compared to unmarried and any other
constituting of separated, widow/er and divorce:. The married and unmarried,
other Goans sub group had higher health modernity compared to the married and
unmarried, fisher folks sub group.

Based on the item-wise percentage of modern scorers of other Goans and
fisher folks sub groups, an educational intervention was designed. The intervention
constituted of various methods like lectures by experts in the field of health and
medical field, group discussions, role plays, demonstrations, screening of health
related films and documentaries and use of posters and flip-charts to help the
participants overcome the lack of scientific knowledge and improper attitude towards
health related issues. Further specific suggestions were also made to deal effectively
with the areas of ignorance and misconceptions dimension-wise.

The following main conclusions were drawn from the results obtained:

1. There is significant difference in health modernity of other Goans and
fisher folks sub groups, with other Goans sub group having significantly higher
health modernity as compared to the fisher folks sub group.

2. Significant interaction was found to exist between the types of sample sub
groups: other Goans and fisher folks and domicile: urban and rural.

3. Significant difference existed in the health modernity score with regard to
gender: the health modernity score is significantly higher for females than
males of other Goans sub group, where as no significant difference was found
in males and females of fisher folks sub group.

4. The males and females of other Goans sub group have significantly higher
health modernity than the fisher folks sub group.
5. Significant interaction was found to exist between gender and marital status with regard to health modernity.

6. Significant interaction was found between SES and domicile with regard to their effect on health modernity.

7. There is a significant influence of SES on health modernity. High SES had significantly higher health modernity than low SES.

8. High and low SES of other Goans sub group had higher health modernity compared to high and low SES of fisher folks sub group.

9. There is significant difference in health modernity of the sub groups with high, medium and low educational levels. The extent of health modernity is significantly higher in highly educated than moderately educated and low educated.

10. Comparisons between other Goans sub group and fisher folks sub groups on the basis of high, medium and low educational levels indicated other Goans sub group with high, medium and low educational level had significantly higher health modernity when compared to the fisher folks sub group with high, medium and low educational levels.

11. No significant interaction was found to exist between SES and education with regard to health modernity.

12. There is significant difference in health modernity of the three religious groups. Christian sub group has higher health modernity compared to Hindu and Muslim sub groups.

13. Hindus and Christians of other Goans sub group had higher health modernity than Hindus and Christians of fisher folks sub group. However, no significant difference existed in Muslims of other Goans sub group and Muslims of fisher
There is a significant influence of age on health modernity. The age group of 25-30 has the highest mean health modernity score, followed by 20-25 and 40-45 age group. The age groups of 15-20, 30-35, 35-40 have lower mean score as compared to the other age groups.

When the other Goans and fisher folks sub groups were compared, significant difference was found in the age groups of 20-25, 35-40 and 40-45.

Domicile had a significant influence on the health modernity. Urban dwellers had significantly higher health modernity as compared to rural dwellers.

Urban and rural, other Goans sub group had significantly higher health modernity when compared to urban and rural, fisher folks sub group.

There is a significant influence of marital status on health modernity. Married sub group has higher health modernity score.

The married and unmarried, other Goans sub group had significantly higher health modernity compared to the married and unmarried, fisher folks sub group.

There are dark areas and misconceptions in each sample sub groups. The fisher folks sub group has less scientific knowledge about health related issues as compared to the other Goans sub group. Mental health dimension showed maximum misconception and AIDS dimension showed the lowest.
SUGGESTIONS FOR FURTHER RESEARCH

1. Present research was conducted on a sample belonging to 15-45 age group, that is, reproductive age group. Further research should be conducted to assess the health modernity of the individuals falling in the age groups 10-15 and 45 and above. Health related problems can strike at any age. Individuals falling in age groups 10-15 are at risk of developing health related problems as they are more prone to developing misconceptions. A suitable intervention at this age can play a crucial role in determining their health related behaviour and overall development. The health modernity assessment of individuals in age groups 45 and above is equally important as they can have great influence on the development of beliefs and values of subsequent generations.

2. In Goa, Non Governmental Organizations (NGOs) play a significant role in creating health related intervention. A health modernity assessment of the social workers, counselors, project coordinators, field workers in these NGOs can be conducted so as to ensure that they possess scientific knowledge and positive attitude towards health related issues. In case of presence of any misconceptions and dark areas, suitable intervention can be developed.

3. Studies can also be conducted to assess the health modernity of tribal communities in Goa. Misconception and areas of ignorance can be identified and suitable intervention can be accordingly designed.

4. Health modernity assessment can be conducted of migrant population in Goa. Comparison can also be made between the health modernity of migrants and Goan population. Further the health modernity of migrants with high and low SES can also be compared.
5. Investigation into differential impact of different strategies of intervention, like lecture method, group discussions, demonstrations and so on, on different sample sub groups with regard to different variables like age and education can also be conducted. The strategies of intervention need to be studied depending on their effectiveness.

6. A study can also be conducted to explore the influence of personality type on health modernity.

7. An intervention strategy based on ‘train the trainer’ programme can be developed and investigation can be conducted to assess the effectiveness of this programme as a strategy for health educational intervention. Under ‘train the trainer’ programme, certain members of a particular community or sample sub group are chosen and trained with regard to health related information and these trained members further train the other members of the community or sample sub group. Before-after design can be used to evaluate the effectiveness.