CHAPTER - III

REVIEW OF LITERATURE
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In the present era knowingly or unknowingly, quite often people use the term modernity. It has varied connotations. Some refer it to the latest miracles, some to the westernized styles and manners, some in relation to the time and so on, above all modernity is antonym of tradition. Therefore it is much used and abused word. It is used in a positive and negative sense. There is a fascination and admiration on one hand and on the other it is also derision and ridicule. It refers to glorious human achievements and it also includes perverse and debase values and behaviour. There is a great deal of ambivalence about modernity and, the tug-of war between tradition and modernity continues.

In this respect social scientists differ from the common people. They consider modernity as the psychological syndrome consisting of certain attitudes, values and personality traits which are conducive to social and economic development. Economic development for the progress of any country cannot be denied at all, and researchers have treated modernity as a pre-requisite for the economic development. Max Weber (1958) a German Sociologist in his seminal essay entitled 'The protestant ethic and the spirit of capitalism' argues that higher economic development in the protestant countries is only because of the attitudes the people had towards the "protestant ethics" i.e., where the people commit themselves to hard work and simple living and which results into saving. Such people believed that work was worship and laziness as sickness. Authors like Myddal (1968).
Loomis and Loomis (1969) are of the opinion that non-modern attitudes and institutions are the main barriers to economic development.

Again Max Weber (1958b) in his book 'The Religion of India, has argued that, Hinduism lacks the essence of 'Protestant Ethics'. According to him the religious value system, combined with the rigid caste system was the main reason for the economic backwardness in this country. He asserted that Hinduism did not provide psychological motivation for economic development. Scientists differed in their opinion towards Weber's argument in reference to the Indian economic backwardness. Several Indian as well as Foreign scholars such as Elder (1959), Gupta (1975), Inkeles and Smith (1974) McClelland and Winter (1969) Rudolph and Rudolph (1967), Singer (1972) and Singh (1967, 1975) strongly opposed Weber's statement that Hindu religion and culture was barrier for the economic development.

Many Scientists have concentrated on the economic development as the major concern for the total progress. Kusum Nair (1964) is of the opinion that low standard of living in the rural communities is mainly because of lack of desire and aspiration in the people. More or less ;even Ronald Segal (1966) is of the same opinion but with different words. According to some people ;Indian poverty is not because of the incapabilities of the people, but because of the indifferent attitudes and fatalistic belief in Karma. Even D.Narain (1957) describes Hindu Character as Passive, dependent, and other worldly. Taylor (1948) also calls Hindus as low aspirants and passivists. McClelland (1961) based on his empirical study explains Indian economic
backwardness in terms of lack of need for achievement, Singh (1975) has attributed it to religious beliefs.

However, the major influencing factor of modernity are education, industrialization, mass media exposure, urban rural domicile and so on, and these have a high correlation with the individual modernity.

Empirical studies conducted both in developed and underdeveloped countries are of the opinion that education is the most powerful means to incalculable modern attitudes, values and behaviour in the people (Inkeles and Holsinger, 1973). Scientists have tried to relate education and socio-economic status (SES) with modernity and health modernity.

The Harvard study conducted by Inkeles and Smith (1974) reveals 'Education as the most powerful factor in making men modern'. Studies on adult population proved significant association between education and modernity (Lerner 1958; Kohl 1968; Waisanen and Kamat, 1972). In the studies the Investigator has observed that education is considered as an independent variable or as a component of SES. Indian scholars like Rayhuvanshi (1984). Sharma (1979), Pandey (1977) and Halyal (1984) confirm that education has significant influence on individual modernity. Suzman (1973) gives more important to schooling. To him schooling is the basic sort of psychic dispositions.
Majority of studies have tried to correlate the influence of socio-economic status on modernity and health modernity. In such studies SES is a combination of occupation and income along with education. In Indian studies individual's caste is added to it. Scientist like Holisinger (1973), Kahl (1968), Klineberg (1973), Inkeles and Smith (1974); Cunningham (1973), Halyal and Mallappa ;(1983) found SES had significant correlation with individual modernity. Studies conducted by Rayhuvanshi (1984), Sen (1962), Halyal (1984) confirm that attitudinal modernity increases along with the social classes.

Other factors like mass-media urban dwelling, factory experience along have great influence and there is a positive correlation between modernity and these factors. However, scientists are of the opinion that quality of influence is more important. Schneibery (1971), Mulay and Ray (1973) and Lerner (1958) are of the opinion that urban residence and urban contacts have strong linkage with modernity.

A series of research projects have been conducted by A.K.Singh and his associates in Ranch district of Bihar State making use of variables like Education, SES, marital status, urban/rural domicile, age and sex in relation to health modernity. Singh (1983a) studied the health modernity a large sample of 1040 cases from Chotanagapur and Santal pargana of Ranchi district. Thje results obtained clearly indicate that SES was a highly influencing factor i.e., health modernity varied according to the high, middle and low SES levels. He also reported that dark areas prevailed even in the
high SES group. Very low percentage of the sample had current knowledge and scientific attitudes towards health and diseases.

Jayaswal (1985) conducted an empirical study specifically on 640 women of South Bihar. The author examined the influence of religion, ethnic influence, SES, age and domicile with health modernity. The obtained results indicate the very low extent of health modernity of the sample. It was found that only 25% of them were 'modern' scorers and SES was a highly influencing factor in all the religious and ethnic groups including Hindu, Muslim, Tribal Hindu and Tribal Christians. In urban and rural sample, in all the religious groups, the percentage of 'modern' scorers was more in high SES than the other two SES groups.

Another empirical study was conducted by Singh (1987a) in Kanke and Num Kum blocks of Ranchi district. The male and female samples were from the reproductive age group (15 - 45 years). Health modernity of these sample was measured by using health modernity Questionnaire. The obtained results indicate that the percentage of 'modern' scorers varied from 0-5 in the seven dimensions. Not a single male sample had health modernity in child care dimension and less than 1 per cent of the male and female had health modernity in physical health, nutrition and diet, and child care. Although women scored higher than men in breast-feeding dimension, 95% of women had unscientific information and attitudes in relation to breast-feeding.

The author strongly pleads that health education is very necessary for those who are dominated by misconceptions and ignorance in relation to health and diseases.
Singh (1987b) and his associates have reported in detail about the three dimensions viz., family planning, child care, and breast feeding, based on 1440 sample in the ICMR project, a research conducted earlier. The obtained results indicate the areas of ignorance in all the three dimensions. Out of 30 items from the three dimensions on 15 items more than 50% of the samples had unscientific, and incorrect information and attitudes. They had strong preference for son; did not know who determined the sex of the child, believed that vasectomy makes men impotent and so on. Hardly 7% had correct knowledge and information about immunization schedule, only 8% knew about the birth weight, believed that pregnant women did not need immunization, and the first breast milk was harmful hence child should not be fed during mother's illness. The study reported that the younger age group (15-24) had 'modern' attitudes than the older age groups. The study also reveals that all this was due to illiteracy, particularly among the women folk.

Singh (1988) and others conducted another study to identify the importance of individual participation in the group discussion. They used audio-visual intervention materials on two matched groups (experimental and control groups) in terms of age, (equal cases from each age group), Sex (equal cases of males and females), ethnicity (all tribals), literacy (all illiterates) and place of residence (all rural). The investigators found that learning and retention was higher in the experimental group to whom the discussion was introduced before intervention.
Ahsan (1987) also conducted a study on 320 men and women in Chotanagapur and Santala region of South Bihar. They also found that SES had the highest impact on health modernity of the sample, and the rural-urban residence, sex, age did not have much impact on the health modernity of the sample.

Khan and Rao (1989) also reported that SES had its own impact in several health factors in their study on family welfare programme in Bihar. They concentrated on the immunization coverage in terms of BCG and DPT. They compared between those who were below the poverty line and above poverty line. They found that the coverage was higher in the above poverty line than the below poverty line.

Kanitkar and Sinha (1989) took up a large study in five states of India. They were interested in examining the influence of SES on ante-natal health care services. Their study proved that mothers with higher literacy and economic status utilized the health care services much more than the illiterates and low income level. The influence of SES on maternal health has been indicated in Indian Council of Medical Report (ICMR). The report says that 20% of the pregnant women in the low SES group ended up with abortions, or still-births and for which malnutrition was the main reason (ICMR, 1977). Banerjee (1982) asserts that improvement of health status of the population is very essential for economic, political and social issues.
A research project sponsored by University Grants Commission (UGC) was carried out by Halyal (1990a) in Dharwad Taluka of Northern Karnataka. The study covered a total of 2755 men and women belonging to the reproductive age group. The main aim of this project was to obtain the health status profile and to identify the dark areas in various sample sub-groups, with an intention of making intervention programme more appropriate and effective. The health modernity questionnaire was used to measure the health modernity of the sample sub-groups. The study reports that men were significantly more modern than women. SES was proved very influential i.e., higher the SES, greater the modernity. Religion had contributed to the variation in the modernity scores i.e., Christians are significantly higher in health modernity than the other religious groups. Mass media had profound influence on health modernity. The misconceptions were greater in the rural, low SES and uneducated group, misconceptions were more on dimensions like mental health and mental retardation. It was found that SES, education and occupation had greater influence on the health modernity of the people. He strongly pleads for health education to the vulnerable groups.

Another research was carried out by the same author covering 900 women in three talukas of Dharwad district. The study covered 367 Anganwadi Centres to measure the impact of Integrated child development services (ICDS) in terms of health modernity. It was found that majority of the samples had misconceptions in dimensions like mental health, mental retardation and child care. SES, Religion and education had great influence on the health modernity. Significant aspect of this research was that the women of ICDS
covered areas were more modern than the non-ICDS areas. Halyal (1990b) strongly advocates that education to the vulnerable group will bring about the desired changes in health knowledge, attitudes and practices of the people.

Studies conducted by Rajyalaxmi (1991), Halyal (1990a, 1990b) reveal that age had no effect on health modernity of women. Urban domicile is also an important correlate of modernity and health modernity and this is highlighted by studies of Inkeles and Smith (1974), Seth (1969), Schnaiberg (1971), Singh (1984) and Jayaswal (1985). But studies conducted by Sahay and Singh (1989) and Halyal (1990a) reveal that urban/rural domicile had no significant influence on health modernity of the people.

Attempts were also made by several scientists to measure the influence of marital status on the health modernity of the people, particularly the women i.e., whether the changed status from unmarried to married would impose any change related to health aspects. It is believed that the married women have more knowledge and positive attitude to health related issues. The study also supports this belief i.e., studies conducted by Halyal (1990a) revealed that married women had modern attitude than the unmarried.
Economic prosperity is essential for human development, but that itself is not enough to improve quality of life of individual. But what is important is the whole some development in every aspect of the individual.

The earlier studies in modernity have indicated that education, industrialization, place of residence and marital status have greater impact on health modernity. Singh (1983), Halyal (1990). Therefore it is clear that absence of these factors will affect the health awareness and health knowledge of the people. It is also a fact that education and economic stability cannot be provided to everybody at once. Poverty and illiteracy will be prevailing in this society for quite some time. Hence, people cannot be kept in illhealth till the economic improvement is brought about. Therefore, the intervention programme becomes inevitable.

Health of an individual cannot be determined by any single factor, it is dependent on several combination of personal, social and cultural factors and also health modernity is dependent on number of its correlates like education, industrialization, urbanization, SES and so on. Any attempt of suggesting intervention programme should be based on evaluation of these factors. Any target group for which the intervention is prepared should take into account number of socio-cultural factors and their influence on their health modernity. Therefore, the present investigation attempts to suggest appropriate intervention programme based on a kind of dark areas and
misconceptions in the population and the lowest sample sub-group in terms of extent of health modernity. Hence with the help of HMS (Health Modernity Scale), dark areas will be assessed and the group which is lowest in extent of health modernity will be ascertained.

The main objectives of intervention programme will become more appropriate and meaningful.

Research Questions:

The following research questions are raised and attempts are made to answer them:

1. What is the extent of health modernity in men and women sample sub-groups?

2. What is the extent of health modernity in three levels of educational groups.

3. What is the influence of education on health modernity of men and women?

4. Is there any influence of marital status, age and domicile on health modernity of men and women?
Objectives of the Study:

The main objectives of the present research are:

1. To assess the extent of health modernity of the educated and uneducated men and women.
2. To identify the dark areas in health awareness.
3. To study the correlates of health modernity in the sample area.
4. To formulate the strategies of health modernity intervention.