CHAPTER X

SUMMARY AND CONCLUSIONS
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India presents a unique case in terms of sheer size of its population characterized by heterogeneity in respect of physical, economic, social and cultural conditions. For developing the country's vast human resources and for accelerating the socio-economic development and attaining improved quality of life, health care is accepted as one of the main instruments of action. Health is a pre-requisite as well as an integral part of human development and neglecting the health component can lead to deterioration in all aspects of the quality of life. India is a signatory to the Alma Ata Declaration of 1978 and is committed to attaining the goal of health for all by the year 2000 A.D., through the primary health care approach. Despite efforts to restructure and re-orient health care programmes from time to time for attaining the objectives of the national health policy for "Health for all" by 2000 A.D., the models and the strategies of health services adopted are not suitable and have failed miserably. Hence we are forced to take a fresh look at the priorities and alternative approaches.

Attempts to change the priorities and search for alternative approaches have been necessitated because of the seriousness of the kind of health problems. Inspite of a number of developmental programmes to improve the
quality of life of women and children in India, the health status of these two segments is distressingly low. A high infant and maternal mortality rate, high level of morbidity high incidence of malnutrition and so on clearly indicate that we have failed to protect the two most important segments of population. These two segments are important not merely because of their numbers but because of the fact that they are the crucial segments which determine the quality of life of the entire community.

Several factors are responsible for such a dismal health status of our women and children. Poverty and illiteracy are identified as the two most important causes of such a poor health status. However recent breakthrough in preventive medicine has increased the range of simple and inexpensive clinical treatments and practices. But if the full benefits of scientific advances are to be realized then health education, particularly of women is the most important factor. Health education offers one of the most promising strategies for the larger aim of health for all. The core content and an integral part of health education is health modernity education. Health modernity may be thought of as scientific knowledge and attitudes to health and diseases leading to behaviour conducive to
better physical and mental well-being. Health modernity education is a cost-effective intervention which contributes to the acquisition of knowledge and the development of skills and values which help individuals to gain a critical understanding of health issues and base their judgements, decisions and behaviours on rational facts and factors. It aims at promoting changes in outlook, attitudes and behaviour in individuals and groups towards health related issues with a view to contributing to the improvement of the quality of life. Providing health modernity education to women could be a powerful lever in its own right for raising the levels of child health because for almost all children the most important health care taker is the mother. A vast majority of these mothers are poor and illiterate in India. Hence opportunities for acquiring knowledge and information on health related issues has to be provided to them outside the formal educational system. This can be very effectively done through Health Modernity Education Intervention programme (HMEIP).

Hence in this study an attempt is made to evolve and intervene with a HMEIP and find out if it leads to significant improvement in the knowledge and information level, attitudes and behaviours of the sample women
exposed to it. But before going for the HMEIP the study also made attempts to assess the influence of various factors that could influence the health modernity of the sample women. The areas of ignorance and misconceptions existing in the sample women were also assessed. Based on these misconceptions and dark areas an HMEIP was evolved and introduced to the sample women.

This is an experimental study using a Before and After design with a control. The total sample comprised of 200 rural women selected randomly from 4 villages of Dharwad taluk, Dharwad District, Karnataka. The women belonged to the reproductive age group because of the significance of the HMEIP. The intervention will be most effective if directed to reproductive age group since it is these women who need information on how to regulate their fertility and to take other decisions related to the quality of their life especially prevention of maternal and infant mortality and prevention of HIV/AIDS etc. Equal number of educated, uneducated, married and unmarried women were included in the sample. Using the health modernity scale, benchmark data was collected from the entire sample of 200 women. The extent of health modernity was ascertained in the sample sub-groups and the various factors that influenced the health modernity of these women were analysed. Item-wise
analysis was done to identify the areas of ignorance and misconceptions in the sample women. Then the total sample was split into two groups—100 women from 2 villages formed the Control group and 100 women from two other villages formed the Experimental group. These two groups were matched on demographic variables like education, marital status and socio economic conditions before Intervention. Using benchmark data the two groups were compared on the level of health modernity and found to be on the same level of health modernity to begin with. Then HMEIP was evolved and introduced to the Experimental group. An attempt was then made to evaluate the impact of HMEIP on the health modernity of the women exposed to it. Health modernity is a dependent variable in the present study. The following important trends were observed.

1. First the extent of health modernity was assessed in the entire sample of 200 women. It was found that the sample on the whole was very low on health modernity. The extent of health modernity was then assessed in the sample women by taking into consideration the mean scores on various dimensions. There is a variation in the health modernity of women in the selected dimensions of health modernity. The highest mean score is on the dimension of cancer (35.6) and
the lowest mean score is found on the dimension of child care (22.8). However on the rest of the dimensions, variations do exist but are not very glaring.

2. The extent of health modernity was then assessed in the sample sub-groups taking into consideration 3 educational levels (highly educated, moderately educated and uneducated), 3 SES levels and 2 marital status (married and unmarried), to identify those groups of population who are caught in the grip of social factors which are detrimental to the growth of health modernity. It was observed that uneducated women belonging to low SES are significantly low in their health modernity. Women belonging to Middle SES also are significantly lower in health modernity. These are the segments of population who need HMEIP the most. Efforts should be made to educate these groups of women to bring them on par with the groups who have higher health modernity.

3. Item-wise analysis was done to assess the dark areas and misconceptions existing in the sample women. On issues like mental health, physical health, mental retardation, child care inclusive of immunization,
ORT and family planning, spread of AIDS, etc., women have a lot of misconceptions and wrong notions. Of course there are misconceptions in other dimensions too but they are fewer. Based on these areas of ignorance the HMEIP was evolved. If this is not done the intervention may miss its direction and lose its effectiveness. The content of HMEIP should cover the dark areas so that women will have adequate knowledge to overcome the wrong notions and consequently adopt healthy practices to improve their health. The HMEIP not only aims to eradicate the misconceptions of the sample women but also to strengthen the existing positive and desirable attitudes towards health and related issues.

4. The study also reveals the various positive influences of different factors on health modernity. SES and education are two important factors that influence the health modernity of women. Higher education and higher SES are associated with higher health modernity. Thus in the absence of formal education, health modernity education, could have a lot of positive impact in overcoming some of the barriers to improve the health status of people. An attempt was also made to study the contribution of education and SES to health modernity in the presence
of other factors. It is found that SES has contributed the most to the percent variance of health modernity followed by Education. Thus the study notes that health education programmes in terms of health modernity education are very necessary to improve the health status of women.

5. As per the design, the impact of HMEIP was studied using; Experimental and Control groups, using health modernity as a dependent variable. The experimental and control groups were matched in all respects. The HMEIP was introduced only to experimental group. The study revealed that there is a significant impact of HMEIP on the health modernity of sample women exposed to it. HMEIP had a significant impact on the total health modernity as well as on all the dimensions of health modernity of the sample women.

6. The study also attempted to find out which group of the sample women benefitted most by HMEIP. This was analysed with respect to 3 educational levels, 3 SES levels and 2 marital status. It was found that uneducated and moderately educated women belonging to lower and middle socio economic status were the women who benefitted the most. Hence the researcher opines
that interventions of such type should be directed to these groups.

The present study thus provides significant insight into the health modernity of different samples sub-groups. It not only furnishes scientific information about the areas of ignorance and misconceptions in dimensions of health modernity but also has evolved an HMEIP to eradicate these misconceptions. It has also succeeded in showing that HMEIP can significantly improve the knowledge, information, attitudes and behaviours of the sample women towards health and related issues. It has also indicated the group of women who have benefitted the most from HMEIP thereby suggesting the segments of population to whom such interventions shall be directed.

The following main conclusions may be drawn from the results obtained:

1. The percentages of 'modern' (4-5) scorers in the sample are below 50% on all the dimensions and on total health modernity.

2. There is a variation of health modernity on all the dimensions of health modernity scale in the sample.

3. There are areas of ignorance and misconceptions in health modernity of each sample sub-group.
4. The misconceptions are greater in physical health, mental health, mental retardation, child care, and AIDS dimensions of health modernity.

5. There is a significant influence of education on health modernity of women. Higher the level of education greater the health modernity.

6. SES has a significant influence on the health modernity of women. Higher the SES greater the health modernity.

7. High SES women have significantly higher health modernity than middle SES and low SES groups.

8. There is no significant influence of marital status on the health modernity of educated women. However in case of uneducated women marital status has a significant influence on total health modernity and on dimensions of nutrition and diet, breast feeding, family planning, mental retardation, cancer and AIDS.

9. SES is the highest contributing factor to the percent variance of health modernity of the sample.
10. HMEIP has a significant impact on the health modernity of women exposed to it.

11. The health modernity of women exposed to HMEIP has significantly increased on the total health modernity as well as on all the dimensions of health modernity.

12. Significant impact of HMEIP is observed in uneducated and moderately educated women.

13. The HMEIP has significantly influenced the health modernity of women belonging to low SES and middle SES.

14. There has been a significant impact of HMEIP on both married and unmarried women alike.

15. Uneducated and moderately educated women belonging to low SES and middle SES have benefitted the most from HMEIP.

16. HMEIP, if adopted as a strategy in the National health policy should be directed to the above groups of women.
17. The knowledge, attitudes and practices on health related issues can be significantly improved by scientifically conducted interventions using target appropriate educational materials.

18. A series of HMEIPS are needed for sustainable development.