CHAPTER VII

HEALTH AND MODERNIZATION

High health consciousness and medical awareness is associated with high modernization. Health is a process of living rather than a static entity[1]. It is the process of " well-ness ", and disease is the process of " ill-ness "[2]. In other words, 'health' is 'ease' and illness is 'desease'.

Household modernization of health, in the context of this study, means a household in which people go to a medical practitioner in times of illness, get vaccinated regularly, give polio, tripple and B.C.G.doses to their children, use soap and take bath every day, drink clean water, provide for the disposal of garbage, erect an independent and separate cattleshed and have an independent latrine.

In this chapter the association between modernization of health and other modernization variables has been examined in the light of the hypotheses discussed earlier.

1) Measurement of Modernization of Health:

On the basis of the index of household modernization in health the position of each household has been measured in terms of (i) " static ", (ii) " low transitional ", (iii) " high transitional," and (iv) "modern" household.

"Static household" on health modernization is taken to mean a household with no health consciousness and medical awareness, i.e., a zero per cent health consciousness.

"Low transitional household" is referred to mean a household with less health consciousness and medical awareness, i.e., consciousness from 1 to 33 per cent.

"High transitional household" means a household with more health consciousness and medical awareness, i.e., awareness from 34 to 66 per cent.

"A modern household" is defined as a household with high health consciousness and medical awareness, i.e., awareness from 67 to 100 per cent.

2) Modernization of Health in the Selected Village:

It will be seen from Table No.23 and figure 4 that out of the 50 sample households from the selected village, Bahirewadi, not a single household was found to be static, with no health consciousness and medical awareness, almost 14 per cent were low transitional, i.e.,less health and medical conscious; nearly 48 per cent were high transitional, i.e., more health conscious; and the remaining 38 per cent were modern i.e., highly health conscious.

2.1) Modernization of Health and Caste:

It will be evident from Table No.24, that out of the

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50 sample households from the selected village, 80 per cent belonged to upper caste-group; while the remaining 20 per cent belonged to lower caste-group.

In the 80 per cent upper caste-group households from the selected village, almost 10 per cent were low transitional, nearly 36 per cent were high transitional, and the remaining 34 per cent were modern in health.

In the 20 per cent lower caste-group households from the selected village, almost 4 per cent were low transitional, 12 per cent were high transitional and the remaining 4 per cent were modern in health.

Modernization of health appears to be relatively more linked with upper caste-group in the selected village.

2.2) Modernization of Health and Landholdings:

It will be seen from Table No.25 that out of the 50 sample households from the selected village, 58 per cent belonged to smaller landholdings group of households, and the remaining almost 42 per cent belonged to larger landholdings group.

In the 58 per cent smaller landholding group of households from the selected village, a little over 14 per cent were low transitional, almost 34 per cent were high transitional, and the remaining 10 per cent were modern in health.

In the 42 per cent larger landholding group of households from the selected village, none was static and low transitional, 14 per cent were high transitional, and the remaining 28 per cent were modern in health.

In the low transitional stage in health smaller landholding group appears to be predominant in the selected village, but low transitional stage is not indicative of high modernization, as low transitional stage can be associated with almost static stage.

Wherever more and high health consciousness is there, it appears to be relatively more associated with larger landholding group in the selected village.

Thus, modernization of health, wherever it is, and however, little it is, appears to be relatively more associated with larger landholding group of households in the selected village.

2.3) Modernization of Health and Income-Groups:

From Table No.26 it will be seen that out of the 50 sample households from the selected village, a little over 20 per cent belonged to lower income-group, a little above 60 per cent belonged to middle income-group, and the remaining about 20 per cent belonged to higher income-group.

In the 20 per cent lower income-group households

from the selected village, almost 8 per cent were low transitional, a little over 10 per cent were high transitional, and almost 2 per cent were modern in health.

In the 60 per cent middle income-group households from the selected village, almost 6 per cent were low transitional, 36 per cent were high transitional, and the remaining 18 per cent were modern in health.

In the 20 per cent higher income-group households from the selected village, almost 2 per cent were high transitional, and the remaining 18 per cent were modern.

Wherever health modernization is there, it appears to be linked with either middle or higher income-groups in the selected village.

Thus, modernization of health appears to be relatively more associated with middle and higher income-groups in the selected village.

2.4) Modernization of Health and Cropping Pattern:

From Table No.27 it will be seen that out of the 50 sample households from the selected village, a little over 40 per cent belonged to cash crop producing group of households, and the remaining almost 60 per cent belonged to non-cash crop producing group.

In the 40 per cent cash crop producing group of

households from the selected village, almost 2 per cent were low transitional, 10 per cent were high transitional, and the remaining 28 per cent were found to be modern in health.

In the 60 per cent non-cash crop producing group of households from the selected village, 12 per cent were low transitional, 38 per cent were high transitional, and the remaining 10 per cent were modern.

All health modernization appears to be linked with cash-crop producing group of households in the selected village.

Thus, modernization of health appears to be relatively more associated with cash-crops producing group of households, than non-cash crop producing group, from the selected village.

2.5) Modernization of Health and Irrigation:

It will be seen from Table No.28 that out of the 50 sample households from the selected village, 28 per cent belonged to perennially irrigated group of households, and the remaining almost 72 per cent belonged to seasonally or rainfall irrigated group.

In the 28 per cent perennially irrigated group of households from the selected village, 2 per cent were low transitional, 8 per cent were high transitional, and the remaining 18 per cent were found to be modern in health.

In the 72 per cent seasonally or rainfall irrigated group of households from the selected village, almost 12 per cent were low transitional, 40 per cent were high transitional, and the remaining 20 per cent were modern in health.

2.6) Modernization of Health and Education:

It is evident from Table No.29 that out of the 50 sample households from the selected village, almost 2 per cent were totally uneducated, 36 per cent were less educated, 58 per cent were more educated, and the remaining 4 per cent were modern in health.

In the 2 per cent totally uneducated households from the selected village, all were found to be low transitional in health.

In the 36 per cent less educated households from the selected village, a little above 8 per cent were low transitional, 18 per cent were high transitional, and the remaining 10 per cent were found to be modern in health.

In the 58 per cent more educated households from the selected village, almost 4 per cent were low transitional, 30 per cent were high transitional, and the remaining 24 per cent were modern.

In the 4 per cent highly educated households from the selected village, all were found to be modern in health.

Modernization of health appears to be relatively more associated with relatively highly educated households.

2.7) Modernization of Health and Agricultural Development:

From Table No.30 it will be seen that out of the 50 sample households from the selected village, not a single household was found to be totally undeveloped, a little less than 14 per cent were less developed, 32 per cent were more developed, and the remaining 54 per cent were highly developed in agriculture.

In the 14 per cent less developed households in the agriculture from the selected village, 2 per cent were low transitional, 10 per cent were high transitional, and the remaining 2 per cent were found to be modern in health.

In the 32 per cent more developed households in agriculture from the selected village, almost 12 per cent were low transitional, 14 per cent were high transitional, and the remaining 6 per cent were modern in health.

In the 54 per cent highly developed households in agriculture from the selected village, 24 per cent were high transitional, and the remaining 30 per cent were found to be modern in health.

In the selected village, health modernization appears to go hand in hand with agricultural modernization, i.e., more developed households in agriculture also appear to be more health conscious, and highly developed households in agriculture also appear to be either highly health conscious or more health conscious.

The extent to which health modernization appears to be linked with agricultural development, it can be said that agricultural development does not appear to be linked with health modernization, i.e., wherever agricultural development appears to be there, health modernization does not appear to be there; but wherever health modernization is there, agricultural development also appears to be there.

Thus, health modernization appear to be relatively more associated with relatively more agricultural development.

Conclusion:

Modernization of health and sanitation appears to be relatively more associated with upper caste-groups, larger landholdings, middle or higher income-groups, larger landholdings, middle or higher income-groups, cash crop producing group of households, irrigation either seasonal or perennial, highly educated households, and more agricultural development.

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REFERENCES

1) Robert N.Wilson, " The Sociology of Health ": An Introduction, p.4; J.E.Park and K.Park, Text book of preventive and social Medicine: A Treatise on Community Health, p.13.

2) Robert N.Wilson, op.cit.p.6.

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