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Patterns of Health Modernity among Urban Women: A Cross-sectional Study

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Abstract
Health is an essential aspect of human life and Health Modernity is one of the important pillars of health. Both health and health modernity of a person are affected by his socio-economic determinants and these determinants are defined as the 'non-medical factors of health'. Several studies on socio-economic determinants of health are done but the studies on how these determinants influence health modernity of people are scanty. Hence, the present study is planned to explore the patterns of health modernity among women based on socio-economic determinants in Meerut city of Uttar Pradesh. This study employs an exploratory research design. Purposive sampling technique is used to select 100 women as study sample so that it includes respondents from diverse socio-economic and educational backgrounds. Pre-designed interview schedule is used as data collection method and appropriate statistical techniques are used for data analysis. The findings of the study show that maximum numbers of respondents belong to young age group (21-30 years), are unmarried, are educated, and belong to higher social class. Physical health, reproductive health, and child care parameters scores assign a maximum numbers of participants in the medium to high scores category of health modernity extent. While in two parameters viz. nutrition & diet and family planning, majority of the participants fall in high scores category followed by medium one. It highlights that socio-economic determinants of women have little significant influence on their health modernity. Thus, this study underscores the critical role of socio-economic determinants in shaping health and health modernity among women. There is a string need to provide correct and scientific knowledge regarding health matters through health training programmes at grass-root level.
Keywords: *Health, Health Modernity, Social Epidemiology, Socio-economic Determinants, Urban Women.*

Introduction
Good health is a pre-requisite for the adequate functioning of any individual or any society. If our health is sound, we can engage in numerous types of activities. But if we are ill,

or distressed, or injured, we may face the curtailment of our usual round of daily life (Cockerham, 1998). In other words, health may be defined as 'the absence of any disease or injury or infirmity'. Generally, to be healthy means having a sense of well-being. But Talcott Parsons, an American sociologist, gave definition of health in sociological terms. He defines health as 'the state of optimum capacity of an individual for the effective performance of the roles and tasks for which one has been socialized' (Cockerham, 1998).

Health modernity is one of the most important determinants of health. Generally health modernity is viewed as an extensible form of modernity. Because health is the core of modernity and development, so along with social, economic, and political development, health is an essential and pre-requisite for overall development of human-being. A.K. Singh has introduced the concept of health modernity. He has defined health modernity in the following terms as "scientifically correct information, attitudes, and behavior in relation to health and its various parameters". These different parameters include physical health, mental health, reproductive health, diet and nutrition, breast-feeding, family planning and child care, personal hygiene and environmental sanitation, and such other issues that are essential and pre-requisite for healthy living and, therefore, necessary for human and social development" (Singh 1984). Thus, from the above definition of health modernity, it is clear that modernity is a prerequisite for social, economic, and political development; in the similar ways, health modernity is the prerequisite for human development (Singh, 2011).

In the current study, the health modernity is measured through a scale which is called Health Modernity Scale (HMS). It includes various parameters of health such as, physical health, reproductive health, nutrition & diet, family planning, and child care. Each parameter has five different items related to each theme. The score range is from 5-25 and the responses are coded as high extent with score 20 and more on each parameter. One who scores 15 and less on each parameter has low extent, while score occurs between 15 and 20 shows medium extent of health modernity. Thus, the main focus of this study is on assessing the influence of socio-economic determinants on health modernity of urban women.

Now it is necessary here to talk about Social Epidemiology. It is considered that social epidemiology has its root in medical epidemiology. Social epidemiology refers to 'the study of the causes and distribution of health, disease, and impairment throughout a population (Akram, 2014). In other words, it focuses mainly on socio-economic determinants associated with health and disease. Socio-economic determinants play crucial role in the determination and distribution of health and disease among population. In simple terms, these determinants have been defined as 'the non-medical factors of human health which affect an individual's health'. These are the most important and consistent predictors of person's health. World leading organization in the field of health, World Health Organization (WHO) defines Social Determinants of Health (SDOH) as the conditions in which people are born, grow, work, live, and age and the interactions of forces that shape the conditions of one's daily life (Arun & Prabhu, 2023). Women constitute a significant part of our society. Women's health inextricably bound up with social, cultural, and economic factors that influence all aspects of their lives, and it has consequences not only for women themselves but also for the well-being of their children particularly females. Women's health is intrinsically linked to their status in society (Hariharan, 2016).

Overview of Selected Literature

Several researches have been conducted studies about socio-economic determinants of health and related to other aspects from diverse viewpoints in different regions as carried out by (Singh, 1984; Suraj, 1992; Kenchappanavar, 1997; Gangadharan, 2004; Cowling et al., 2014; Vo et al., 2023 and so on). A brief discussion about previous studies is given below:

A.K. Singh (1984) found that only 23% of study subjects had health modernity i.e. had correct scientific attitudes to and knowledge of health and disease. K.R. Suraj (1992) has revealed that majority of the participants had low level of health modernity. It was found that there was no influence of urban dwelling, caste, religion, income, and education on the health modernity level of the participants. R.N. Kenchappanavar (1997) observed that percentages of modern scorers in the sample were below 50% on all the dimensions and on total health modernity. The results had revealed that education and socio-economic status influenced the level of health modernity. But there was no influence of marital status on health modernity level.

T. Gangadharan (2004) analyzed the influence of socio-economic determinants on health modernity awareness among the people of Lakshadweep. The results of the present study showed that age had influenced their awareness in the areas of mental health, reproductive health, child care, and attitude to the female. While sex had influenced the areas of mental health, reproductive health, nutrition & diet, breast-feeding and family planning; on the other side, educational status had influenced only in the areas of nutrition & diet and child care. The influence of marital status had on mental health, reproductive health, child care, and attitude to the female. Family size had significantly influenced awareness in the areas of physical health, mental health, reproductive health, nutrition & diet, breast-feeding, family planning, and attitude to females.

S.B. Shetgovekar (2007) showed that health modernity was better among goans than fisher folk sub-groups. Education level, religion, urban dwelling, and marital status had significant influence on health modernity of the study subjects. A.S. Dey and A. Shrivastava (2011) showed that 40% of women had ‘very poor’ health modernity and women believed certain myths or misconceptions and ignorance with regard to health matters. Yellaiah and Ramakrishna (2012) identified the socio-economic determinants of demand for health insurance in India taking Hyderabad as the case. It concluded that the main determinants of demand for health insurance were the occupation, income, health expenditure, and awareness. The other variables such as the age and education were positively associated with demand for health insurance but were not statistically significant. Cowling et al. (2014) assessed the levels and trends in major social determinants of health in India from 1990 onwards and explored inequities by state, gender, caste, and urbanicity. The results concluded that air pollution (indoor and outdoor), child under-nutrition, unimproved sanitation, employment conditions, and gender inequality were priority areas for public policy related to social determinants of health in India.

Muhammad et al. (2021) attempted to understand the associations between socio-economic and health-related variables with preference for the separate living among older adults in India. The findings revealed that physical proximity to kin and health conditions, in addition to economic conditions, substantially determined the swing towards separate living among older adults in India. Arun & Prabhu (2023) studied various social & personal

determinants of health that affect women's well-being. The findings revealed that a lack of social support, time, and stable housing were the most pressing determinants of health preventing the women from maximizing their health outcomes. Vo et al. (2023) highlighted that all 9 selected social determinants of health (SDOH) variables had statistically significant impact on population health outcomes. It also showed that 4 SDOH risk factors significantly affect population health outcomes in all groups. It revealed that population density and political affiliation were effective delineations for separating how the SDOH affected health outcomes. Joshi et al. (2024) showed that more than half of women could not seek medical care immediately, and two-third were not aware of various government health schemes.

Moreover, from the above discussion of previous studies, it reveals that there are several studies on the influence of socio-economic determinants on diverse aspects of health, but there are few studies which assess the influence of socio-economic determinants on health modernity. Thus, it is clear that there is need to conduct a study about socio-economic determinants and health modernity. Therefore, the current study primarily investigates the relationship between socio-economic determinants and the health modernity among urban women.

Objectives of the Study

The first objective of this study is to find out socio-economic determinants of urban women and second objective is to explore the patterns of health modernity among women based on socio-economic determinants in terms of education, marital status, and social class.

Methodology of the Study

This cross-sectional study is conducted in Meerut city of Uttar Pradesh and employed exploratory research design. 100 participants have been included in this study. The women participating in the study range in age from 21 to 50 years and are selected through a purposive sampling method to achieve the representation of different sections of the population. Before collecting the data, the researchers have obtained verbal consent from the respondents. Data have collected through pre-designed and structured interview schedule which contained questions regarding socio-economic determinants such as age, marital status, education level, occupation, class etc. There were also questions regarding health modernity extent. Obtained data have analyzed with the help of appropriate statistical techniques. Descriptive statistics are applied and the results are represented in suitable tables.

Results

A total of 100 participants include in the present study. In the light of the objectives of this study, the findings are describing in the following ways:-

1. **Socio-economic Determinants**

In this study, a pre-dominant proportion (67%) is in age-group 21-30 years and majority (55%) participants are unmarried. Majority (97%) respondents are educated and majority (75%) respondents are either unemployed or house-wife. Majority of the participants i.e. 49% belong to higher class. A substantial number of women (64%) live in nuclear family (Table-1).

Table-1: Distribution of urban women according to their socio-economic determinants

Variables	Category	Frequency (n=100)	Percent (%)
	21-30	67	67.0

ıge-group	31-40	16	16.0
	41-50	17	17.0
Marital Status	Unmarried	55	55.0
	Married	45	45.0
Education level	Uneducated	03	3.0
	Educated	97	97.0
Occupation Status	Working	25	25.0
	Not working/Housewife	75	75.0
ocial Class	ower (Up to Rs. 10,000)	15	16.0
	Middle (Rs. 10.001-30,000)	36	36.0
	Higher (Above Rs.30,000)	49	48.0
Family Type	Nuclear	64	64.0
	Joint	36	36.0

2. Influence of Socio-economic Determinants on Health Modernity

Basically, socio-economic determinants are non-medical factors of health. These are among the strongest and consistent predictors of human health. In this way, the influence of socio-economic determinants can be seen directly on human health. In the present study, the influence of socio-economic determinants on health modernity of urban women is measured. Here, these determinants include educational level, social class, and marital status. Thus, the patterns of health modernity based on socio-economic determinants are discussed in the following tables:

Table-2: Distribution of Urban Women into high, medium, & low levels of physical health parameter of health modernity based on socio-economic determinants

Socio-economic determinants	Physical health parameter			
	High, n(%)	Medium, n(%)	Low, n(%)	Total
Education Level				
Uneducated (3)	-	3(100)	-	03
Educated (97)	22(22.7)	57(58.8)	18(18.6)	97
Total	22(22)	60(60)	18(18)	100
Social Class				
Lower(15)	3(20)	9(60)	3(20)	15
Middle(36)	7(19.4)	25(69.5)	4(11.1)	36
High(49)	12(24.5)	26(53.1)	11(22.4)	49
Total	22(22)	60(60)	18(18)	100
Marital Status				
Unmarried(55)	13(23.6)	32(58.2)	10(18.2)	55
Married(45)	9(20)	28(62.2)	8(17.8)	45
Total	22(22)	60(60)	18(18)	100

Table-2 displays the overall distribution of respondents into low, medium, & high levels of physical health parameter of health modernity based on socio-economic determinants. In our sample, we noted that all three uneducated women fall under medium category. About 22 (22.7%) educated women fall under high category of physical health, whereas 18 (18.6%) educated women fall under low category and 57(58.8%) educated women fall in medium category of physical health parameter. Table-2 also explains the distribution of respondents into low, medium, & high levels of physical health parameter of health modernity based on social class and marital status. Among the 15 lower class respondents, 3(20%) fall under the low category, 3(20%) under high, and 9(60%) in medium category. Out of 36 middle class respondents, 4(11.1%) fall in the low category, 7(19.4%) under high, and 25(69.5%) in medium category. Among 49 high class respondents, 11(22.4%) fall under the low category, 12(24.5%) in high, and 26(53.1%) under medium category. Further, table-2 shows that among 55 unmarried respondents, 10(18.2%) fall in the low category, 13(23.6%) under high, and 32(58.2%) in medium category. Among all 45 married respondents, 8(17.8%) fall under low category, 9(20%) in high and 28(62.2%) under medium category of physical health parameter. Thus, it is seen from above details that maximum numbers of respondents fall into medium category of physical health parameter of health modernity.

Table-3: Distribution of Urban Women into high, medium, & low levels of reproductive health parameter of health modernity based on socio-economic determinants

Socio-economic determinants	Reproductive health parameter			
	High, n(%)	Medium, n(%)	Low, n(%)	Total
Education Level				
Uneducated (3)	-	3(100)	-	3
Educated (97)	33(34.1)	53(54.6)	11(11.3)	97
Total	33(33)	56(56)	11(11)	100
Social Class				
Lower(15)	4(26.7)	9(60)	2(13.3)	15
Middle(36)	14(38.9)	18(50)	4(11.1)	36
High(49)	15(30.6)	29(59.2)	5(10.2)	49
Total	33(33)	56(56)	11(11)	100
Marital Status				
Unmarried(55)	10(18.2)	37(67.3)	8(14.5)	55
Married(45)	23(51.1)	19(42.2)	3(6.7)	45
Total	33(33)	56(56)	11(11)	100

Table-3 reveals the overall distribution of respondents into low, medium, & high levels reproductive health parameter of health modernity based on socio-economic determinants. As the table shows that all three uneducated respondents fall in medium category of reproductive health parameter. Out of 97 educated respondents, maximum 53(54.6%) fall under medium category, 33(34.1%) in high, and 11(11.3%) under low category. Among 15 lower class respondents, maximum 9(60%) fall under medium category, 4(26.7%) under high and

2(13.3%) in low category of reproductive health parameter. Among all 36 middle class respondents, half of the respondents 18(50%) come in medium category, 14(38.9%) in high and 4(11.1%) in low category. Out of 49 high class respondents, 29(59.2%) fall under medium category, 15(30.6%) in high, and 5(10.2%) fall under low category. Further, table-3 reveals that among 55 unmarried respondents, 37(67.3%) come in medium category, 10(18.2%) under high, and 8(14.5%) under low category. Out of 45 married respondents, 23(51.1%) fall in high category, 19(42.2%) under medium and 3(6.7%) under low category. It is revealed from above table that maximum respondents fall into medium category of reproductive health parameter of health modernity.

Table-4: Distribution of Urban Women into high, medium, & low levels of Nutrition & diet parameter of health modernity based on socio-economic determinants

Socio-economic determinants	Nutrition & Diet parameter			
	High, n(%)	Medium, n(%)	Low, n(%)	Total
Education Level				
Uneducated (3)	1(33.3)	2(66.7)	-	3
Educated (97)	75(77.3)	18(18.6)	4(4.1)	97
Total	76(76)	20(20)	4(4)	100
Social Class				
Lower(15)	11(73.3)	3(20)	1(6.7)	15
Middle(36)	26(72.2)	8(22.2)	2(5.6)	36
High(49)	39(79.6)	9(18.4)	1(2)	49
Total	76(76)	20(20)	4(4)	100
Marital Status				
Unmarried(55)	41(74.5)	10(18.2)	4(7.3)	55
Married(45)	35(77.8)	10(22.2)	-	45
Total	76(76)	20(20)	4(4)	100

Table-4 explains the overall distribution of respondents into low, medium, & high levels of nutrition & diet parameter of health modernity based on socio-economic determinants. Out of 33 uneducated respondents, 1respondent falls under high category and remaining 2 respondents into medium category. Among 97 educated respondents, maximum 75(77.3%) fall in high category, 18(18.6%) under medium, and 4(4.1%) in the low category of nutrition & diet parameter. Out of 15 lower class respondents, maximum 11(73.3%) fall under high category, 3(20%) in medium and 1(6.7%) in low category. Among all 36 middle class respondents, maximum 26(72.2%) fall in high category, 8(22.2%) in medium, and 2(5.6%) in the low category. Out of 49 high class respondents, maximum 39(79.6%) fall under high category, 9(18.4%) in medium, and 1(2%) in the low category of nutrition & diet parameter. Table-4 shows that out of 55 unmarried respondents, maximum 41(74.5%) come in high category, 10(18.2%) in medium, and 4(7.3%) in the low category. Among all 45 married respondents, maximum 35(77.8%) fall in high category, and 10(22.2%) in the medium category. None of the married respondents fall in the low category of nutrition & diet parameter. Thus, from the above description, it is clear that maximum number of respondents fall in high category of

nutrition & diet parameter of health modernity.

Table-5: Distribution of Urban Women into high, medium, & low levels of family planning parameter of health modernity based on socio-economic determinants

Socio-economic determinants	Family planning parameter			
	High, n(%)	Medium, n(%)	Low, n(%)	Total
Education Level				
Uneducated (3)	-	3(100)	-	3
Educated (97)	48(49.5)	40(41.2)	9(9.3)	97
Total	48(48)	43(43)	9(9)	100
Social Class				
Lower(15)	4(26.6)	10(66.7)	1(6.7)	15
Middle(36)	18(50)	14(38.9)	4(11.1)	36
High(49)	26(53.1)	19(38.8)	4(8.1)	49
Total	48(48)	43(43)	9(9)	100
Marital Status				
Unmarried(55)	28(50.9)	19(34.6)	8(14.5)	55
Married(45)	20(44.4)	24(53.4)	1(2.2)	45
Total	48(48)	43(43)	9(9)	100

Table-5 displays the overall distribution of respondents into low, medium, and high levels of family planning parameter of health modernity based on socio-economic determinants. All the three uneducated respondents fall in medium category of family planning parameter. Among all 97 educated respondents, maximum 48(49.5%) respondents fall in high category, 40(41.2%) in medium category and 9(9.3%) in the low category of family planning parameter. Out of 15 lower class respondents, maximum 10(66.7%) fall in medium category, 4(26.6%) in high and 1(6.7%) in the low category. Among all 36 middle class respondents, half 18(50%) respondents fall in high category, 14(38.9%) in medium, and 4(11.1%) in the low category. Out of 49 high class respondents, maximum 26(53.1%) fall in high category, 19(38.8%) in medium, and 4(8.1%) in the low category. Table-5 also shows that out of 55 unmarried respondents, maximum 28(50.9%) fall under high category, 19(34.6%) in medium, and 8(14.5%) in the low category. Among all 45 married respondents, maximum 24(53.4%) fall in medium category, 20(44.4%) under high, and 1(2.2%) in the low category of family planning parameter. In this way, the above details describe that maximum number of respondents fall in high category of family planning parameter of health modernity.

Table-6: Distribution of Urban Women into high, medium, & low levels of child care parameter of health modernity based on socio-economic determinants

Socio-economic determinants	Child care parameter			
	High, n(%)	Medium, n(%)	Low, n(%)	Total
Education Level				
Uneducated (3)	-	3(100)	-	3
Educated (97)	38(39.2)	55(56.7)	4(4.1)	97
Total	38(38)	58(58)	4(4)	100

Social Class				
Lower(15)	3(20)	10(66.7)	2(13.3)	15
Middle(36)	17(47.2)	18(50)	1(2.8)	36
High(49)	18(36.7)	30(61.2)	1(2.1)	49
Total	38(38)	58(58)	4(4)	100
Marital Status				
Unmarried(55)	20(36.4)	31(56.4)	4(7.2)	55
Married(45)	18(40)	27(60)	-	45
Total	38(38)	58(58)	4(4)	100

Table-6 reveals the overall distribution of respondents into low, medium, & high levels of child care parameter of health modernity based on socio-economic determinants. All the three uneducated respondents come under medium category. Out of 97 educated respondents, maximum 55(56.7%) fall in medium category, 38(39.2%) in high, and 4(4.1%) in the low category of child care parameter. Among all 15 lower class respondents, maximum 10 (66.7%) fall under medium category, 3(20%) in high, and 2(13.3%) in the low category. Out of 36 middle class respondents, half 18(50%) respondents fall under medium category, slightly less than half 17(47.2%) in high, and 1(2.8%) under low category. Among all 49 higher class respondents, maximum 30(61.2%) fall in medium category, 18(36.7%) in high, and 1(2.1%) in the low category of child care parameter. Table-6 also shows that among 55 unmarried respondents, 31(56.4%) fall in medium category, 20(36.4%) under high, and 4(7.2%) in the low category. Out of 45 married respondents, maximum 27(60%) fall in medium and 18 (40%) in high category. None of the married respondents fall in the low category of child care parameter. Thus, it is clearly seen from this description that maximum number of respondents falls in medium category of child care parameter of health modernity.

Discussion

The present study reveals that out of five parameters of health modernity, education level has influenced largely nutrition and diet parameter, followed by family planning one. In align these findings, T. Gangadharan (2004) reported similar results in his study among people of Lakshadweep. Other studies like J.S. Budihalmath (1992), R.N. Kenchappanavar (1997), and S.B. Shetgovekar (2007) reported that education level had significantly influenced health modernity. While, K.R. Suraj (1992), in his study in Karnataka, showed that education had no significant influence on health modernity of the respondents. In the current study, social class of the respondents is determined through their family's income. It is found that most of the respondents belong to higher class but their health modernity extent is low on different parameters except on nutrition & diet and family planning. It can be assumed that social class does not substantially influence health modernity extent of the respondents. K.R. Suraj (1992) in his study of Karnataka reported similar findings. Whereas A.K. Singh (1984) and R.N. Kenchappanavar (1997) showed that high socio-economic status people had higher health modernity.

Of the five parameters of health modernity, married respondents with high health modernity are ahead of the unmarried only in reproductive health parameter. T. Gangadharan (2004) in his study among people of Lakshadweep reported similar findings. The results of the

present study show that marital status has a less significant influence on health modernity of the respondents. Similar results had shown in his study by R.N. Kenchappanavar (1997). But J.S. Budihalmath (1992) and S.B. Shetgovekar (2007) found that marital status had influenced the health modernity of the study subjects. This study has been conducted in an urban area. The findings show that urban residence has no significant impact on women's health modernity. Similar findings came from a study carried out by K.R. Suraj (1992) there was no positive impact of urban dwelling on health modernity of the participants. In contrast to the findings of the present study, a study conducted by S.B. Shetgovekar (2007) in Goa which showed that urban dwellers had significantly higher health modernity as compared to rural ones.

Thus, in this study the researcher has observed that majority of respondents are educated, belong to higher class, are unmarried, are not indulged in income earning activities, and live in nuclear family. But their health modernity is low. That is why women's health and their health behaviour always remain under question. Health modernity is one of the important determinants of women's as well as men's health. From the above description of findings, it is clearly seen that education level, social class, and marital status have little significant influence on the different parameters of health modernity of the respondents. Thus, it can be concluded that in the present study, the socio-economic determinants have less significant influence on health modernity of women in urban area.

Conclusion

The present study aimed to assess the patterns of health modernity among women on the basis of socio-economic determinants in urban area. The research results revealed that most of women were literate, unmarried, either not working or housewives, belonged to higher class, and lived in nuclear families. Physical health, reproductive health, and child care parameters scores assign a maximum numbers of participants in the medium to high scores category of health modernity extent. While in two parameters viz. nutrition & diet and family planning, majority of the participants fall in high scores category followed by medium one. Yet the patterns of health modernity among most women were low which clearly showed that socio-economic determinants did not significantly influence health modernity of women. Therefore, it is concluded that socio-economic determinants of urban women have little influence on their health modernity and many women had myths and wrong perceptions regarding health matters. Thus, there is a need to tackle such myths and wrong perceptions, so that they can get correct and scientific knowledge related to health and its different aspects. Although there are lots of health care facilities and centers in urban area, health modernity of most of the respondents is still low. Therefore, women should join these health care centers so that they can improve their scientific knowledge and get training regarding health matters. This will improve their extent of health modernity.

References

1. Akram, M. (2014). *Sociology of Health.* Rawat Publications.
2. Arun, A., & Prabhu, M.P. (2023). Social Determinants of health in rural Indian women and effects on intervention participation. *BMC Public Health, 23:921.* https://doi.org/10.1186/s12889-023-15743-3
3. Cockerham, W. C. (1998). *Medical Sociology.* Prentice Hall.

4. Cowling, K., Dandona, R., & Dandona, L. (2014). Social Determinants of health in India: Progress and Inequities across states. *International Journal of Equity in Health, 13:88.* http://www.equityhealthj.com/content/13/1/88
5. Dey, A.S., & Shrivastava, A. (2011). Health Modernity and Utilisation of Health Services. In S. Lahiri, B. Paswan and K.C. Das (Eds.) *Migration, Health and Development* (pp. 384-408). Rawat Publications.
6. Gangadharan, T. (2004). *A Study of the Health Modernity Awareness among People of Lakshadweep* [Doctoral dissertation, University of Kerala]. Shodhganga@INFLIBNET. http://hdl.handle.net/10603/394217
7. Hariharan, R. (2016). Health Status of Rural Women in India: An Overview of Literatures. *International Journal of Research in Economics and Social Sciences, 6(8), 109-119.*
8. Joshi, G.S., Gurav, R.B., & Samel, D.R. (2024). Health care seeking behaviour and its socio-demographic determinants among women in rural area: A community based cross-sectional study. *International Journal of Community Medicine and Public Health, 11(6), 2349-2353.* https://dx.doi.org/10.182033/2394-6040.ijcmph20241497
9. Kenchappanavar, R.N, (1997). *Health Modernity and Educational Intervention* [Doctoral dissertation, Karnataka University]. Shodhganga@INFLIBNET. http://hdl.handle.net/10603/95245
10. Muhammad, T., Balachandran, A., & Srivastava, S. (2021). Socio-economic and health determinants of preference for separate living among older adults: A cross-sectional study in India. *PLoS ONE, 16(4): e0249828.* https://doi.org/10.1371/journal.pone.0249828
11. Shetgovekar, S.B. (2007). *Health Modernity Assessment: A Case Study for Educational Intervention* [Doctoral dissertation, Karnataka University]. Shodhganga@INFLIBNET. http://hdl.handle.net/10603/95418
12. Singh, A.K. (1983). Health modernity education in India. *Social Change, 13(2), 27-34.*
13. Singh, A.K. (1984). *Health modernity and its correlates in South Bihar.* ICMR, Report, Department of Psychology, Ranchi University.
14. Singh, A.K. (2011). Health Modernity: Concept and Correlates. In A.K. Dalal & G. Mishra (Eds.), *New Directions in Health Psychology* (pp.357-388). SAGE Publications.
15. Suraj, K.R. (1992). *Health Modernity in Anganwadi Workers: A Sociological Study* [Doctoral dissertation, Karnataka University]. Shodhganga@INFLIBNET. http://hdl.handle.net/10603/94651
16. Vo, A., Tao, Y., Li, Y., & Albarrak, A. (2023). The Association between Social Determinants of Health and Population Health Outcomes: Ecological Analysis. *JMIR Public Health Surveillance, 9:e44070.*
Doi: 10.2196/44070
17. Yellaiah, J., & Ramakrishna, G. (2012). Socio-economic determinants of health insurance in India: the case of Hyderabad city. *International Journal of Development and Sustainability, 1(2), 111-119.*