BLOCK 2

PSYCHOLOGICAL, BEHAVIOURAL AND SOCIAL ISSUES IN PUBLIC HEALTH AND MANAGEMENT

UNIT 5 INFLUENCE OF SOCIAL FACTORS ON HEALTH AND ILLNESS*

Contents

Learning Objectives

After reading this Unit, you would be able to:

- Discuss broad definition of health;
- Understand terms like determinants, health outcome, health disparity, health inequality and health equity;
- Understand about determinants of health with special focus on social, psychological, cultural and economic determinants of health; and
- Appreciate the role of these determinants in promoting health or ill-health (disease) in a population.

5.0 INTRODUCTION

Health is a broad concept that includes a broad range of meanings that ranges from narrow technical definitions to all embracing philosophical definitions. Health is often described as "devoid of illness" and as a state of wellbeing. These are created and maintained by a set of factors, which are known as determinants of health. In this Unit we will discuss in detail about different determinants of health.

Different population group has different health status, for example if we take the case of life expectancy as an indicator of health, a person born in Japan has an average life expectancy of 88 years where as Indian average life expectancy is 68.56 years. If you consider only Indians, then for men it is 67.3 years and

* Contributed by Dr. Lekha D Bhat, Department of Epidemiology and Public Health, Central University of Tamilnadu, Neelakudy.

women it is 69.6 years. Have you ever thought what factors are responsible for these stark differences? Determinants of health will be the answer you reach at.

5.1 DEFINING HEALTH

We will begin the discussion with a positive and comprehensive definition of health. According to World Health Organisation (WHO, 1948) "Health" is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". In the context of Medical Anthropology, David Landy (1997) defined health as the condition of an organism that permits it to adapt to its environmental situation with relative minimal pain and discomfort, achieve at least some physical and psychic gratification and possess a reasonable probability of survival.

Health is not just the physical well-being of an individual but also the social, emotional and cultural well-being of the whole country in which each individual is able to achieve their full potential as a human being, thereby bringing about the total well-being of their community (Aboriginal Health and Medical Research Council of New South Wales, 2012).

Different medical systems conceptualise health in different ways. For example, Ayurveda considers health as a balance between body, mind, spirit and social wellbeing.

Box 5.1: Definitions of Health

Selective Definition of Health	• Health as absence of disease • Health as socio psychological adaptation or adjustment to circumstances • Health as a functional capacity to fulfil essential life functions.
Universal Definition of Health	• Health as growth • Health as independence, the exercise of autonomy and self determination • Health as well being • Health as the realization of potential • Health as empowerment • Health as wholeness.

(**Source:** Procter S 2000, Caring for Health, Macmillan Press, London)

If we consider the broad comprehensive definitions of health, we can identity that it covers not only physical health but also include mental, social and even spiritual dimensions of well-being. Hence it is developed and maintained by a number of determinants.

5.2 HEALTH DISPARITY, HEALTH OUTCOME AND HEALTH INEQUALITY

A Health Disparity is a difference that is closely linked with social, economic and or environmental disadvantage in achieving health or health outcomes. Health disparities adversely affect group of people who have systematically experienced

greater obstacles to health based on racial group, religion, economic, cultural, gender, age, sexual orientation etc.

A health disparity is the differences in the incidence and prevalence of health conditions and health status between groups based on race, gender, socio-economic status, disability status etc.

Health Outcome is the changes in health that results from measures or specific health care investments or interventions. It is the change in the health of an individual, group or community which is attributable to an intervention or a series of interventions. For example, immunization programme has brought down Infant mortality considerably in the last fifteen years. For example Niti Aayog (2020) data shows that in 2000, IMR was 68 and in 2016 it is 34. Here immunization is the medical intervention and reduction in IMR is the health outcome.

Health Inequality is observable health differences between subgroups within a given population; it can be measured and monitored. These are unjust and avoidable differences in people's health status between subgroups; health inequalities are against the principle of social justice, because they are mostly avoidable. Different study findings reveal that the degree of health inequalities escalates when the rising average income levels of the population are accompanied by rising income inequalities.

Some health inequalities are attributable to biological variations or free choice and others are attributable to the external environment and conditions mainly outside the control of the individuals concerned. In the first case it may be impossible or ethically or ideologically unacceptable to change the health determinants and so the health inequalities are unavoidable. In the second, the uneven distribution may be unnecessary and avoidable as well as unjust and unfair, so that the resulting health inequalities also lead to inequity in health (WHO, 2018).

5.3 SOCIAL DETERMINANTS OF HEALTH

Social determinants of health can be defined as the conditions in the social, physical and economic environment in which people are born, live, work and this include access to health care. They consist of policies, programmes and institutions and other aspects of the social structure including the government and private sectors as well as the community factors. Social determinants affect the health of the population through the social and physical environment (Healthy People, 2000)

They are considered as the life-enhancing resources such as food supply, housing, economic and social relationships, transportation, education and health care whose distribution across the population effectively determines the length and quality of life.

Let us see some examples on how social determinants of health increase or decrease health inequality:

Education: Mother education emerges as the single most important determinant of child health care utilization in India when the influences of other intervening factors are controlled (Govindasamy and Ramesh, 1997). The empirical results

show that a higher level of maternal education results in improved child survival because health services that effectively prevent fatal childhood diseases are used to a greater extent by mothers with higher education than by those with little or no education.

Sex Ratio: According to NITI Aayog Data Number of females per 100 males in Haryana is 831 whereas for Kerala it is 967. The reason for this stark difference is attributed to education of women, employment of women, patriarchal status that is followed in the society etc., over all India's sex ratio is on decline where women are at disadvantage over the last few decades.

Figure 5.1 explains about various determinants of health in a comprehensive manner. This model is developed by Whitehead M and Dahlgren G and first appeared in their article titles "What can be done about inequalities in Health" in the Lancet in 1991.

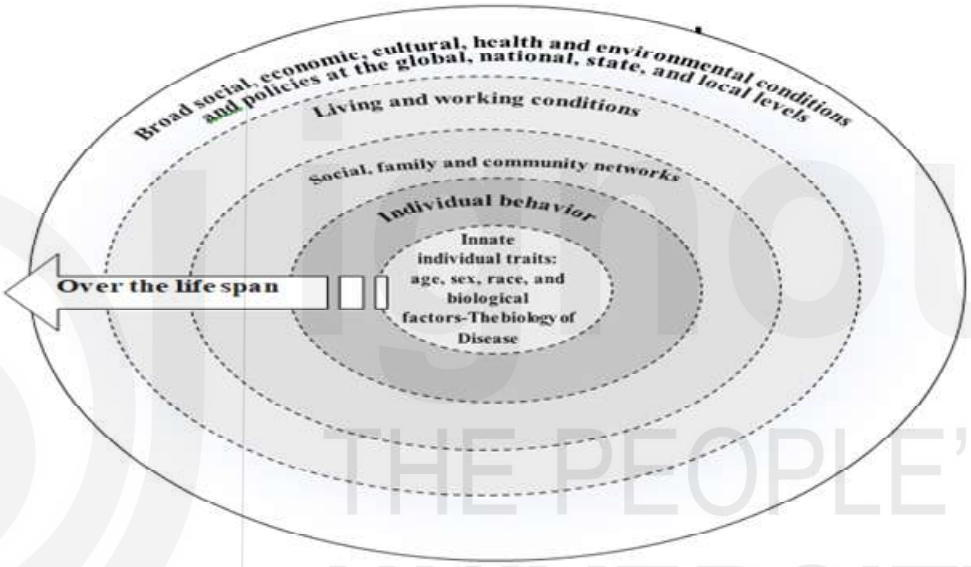


Fig. 5.1: Determinants of Health

(**Source:** Dahlgren, G. (1995) European Health Policy Conference: Opportunities for the Future. Vol. 11 – Intersectoral Action for Health. Copenhagen: WHO Regional Office for Europe).

We shall discuss eight social determinants of health in detail in this section.

a) **Family, Friends and Communities**: Studies show that social isolation and loneliness are associated with increase in the risk of heart disease and stroke. People who are socially connected to their family, friends and community are generally happier and live healthier lives with fewer physical and mental health problems than people who are less well connected.

b) **Money and Resources**: An inadequate income can cause poor health because poor access to resources bring in stress and it affects physical and mental health. Money is essential to have access to good food, water, immunization etc., poverty damages health.

c) **Housing***:* Studies show children living in congested rooms and houses have more than twice likelihood to suffer from respiratory problems rather than children living in spacious- aired houses.

d) **Education and Skills**: Good education and skills can help build strong foundations for support. Accessing good work, lifelong problem-solving ability, develop lifelong healthy habits, afford good quality of life, live and work in healthy environment all this is possible only if good education is ensured to the people.

e) **Good Work/ Employment**: Employability offers stability, security and regular income. It provides good wages and in turn ensures access to quality health care system. Good employment ensures that the person can afford basic living standard, ensure feel of self-esteem and worthiness, which all in turn has impact on the health of the person.

f) **Transport**: A healthy transport system can provide opportunities to improve air quality; also help people travel and access health care services like hospitals.

g) **Physical Surroundings**: Clean surroundings, spaces and buildings are essential for people's physical and mental health. For example, well maintained and easy to access green spaces in a city makes it easy for the people to be physically active.

h) **Access to Food**: Poor diet is one of the biggest risks for ill health. Healthy food needs to be affordable, available and accessible within the available resources at disposal.

Figure 5.2 explains the linkages between various social determinants and how policy formulation, interventions and health outcomes are linked with each other in a continuously monitored and evaluated health system.

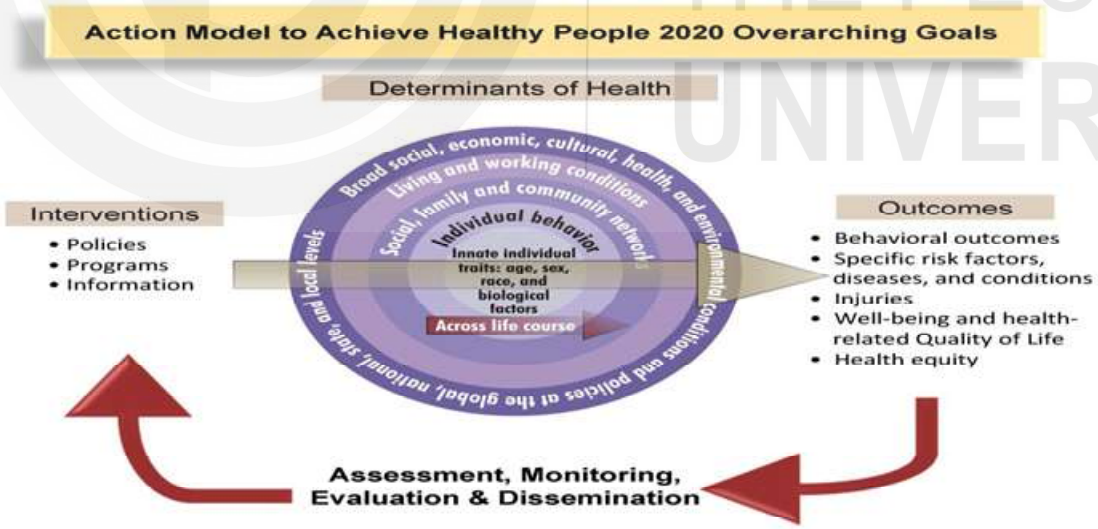


Fig. 5. 2: Action Model to Achieve Healthy People

(**Source:** Healthy Campus 2020: Determinants of Health and Evidence-Based Actions)

5.3.1 Commission on Social Determinants of Health

Commission on Social Determinants of Health was formed by World Health Organization in 2003. The Commission released its final report in 2008, and this document serves as a guiding principle to policy makers in developing countries like India to shape health policies and programmes that acknowledge the role of

social determinants of health. It acknowledged and identified that marked inequities in health care caused by a) *Structural Determinants* (for example: unequal distribution in power, money, goods and services globally, nationally and locally) and b) *Conditions of Daily Life* (for example: consequent unfairness in the immediate conditions in people's lives — access to school, education, health care, conditions of work, leisure time etc.)

The Commission made three major recommendations as follows:

1) Improve daily living conditions.

2) Tackle the unequal distribution of power, money and resources.

3) Measure and understand the problem of health inequality and assess the impact of interventions continuously.

Another Important work in this area by Micheal Marmot and his team (2010) suggest that reducing health inequalities requires a series of objectives to be met and they are as follows:

a) Giving every child the best possible start in life.

b) Creating job opportunities and fair working conditions for all

c) Ensuring healthy standard of living for whole of the population

d) Develops pro-healthy physical environment

e) Empowering communities

f) Strengthening disease prevention.

Exercise 5.1

1) Identify how are resources like food shops, housing, hospitals, nursing homes distributed within your locality?

2) Compare this with the surrounding communities and see whether there are stark differences in health outcomes?

Check Your Progress

1) Differentiate between health outcome, health disparity and health inequality.

.....

.....

.....

.....

2) Define Social determinants of health and discuss eight social determinants that have impact on Health in Indian Context.

.....

.....

.....

.....

5.4 CULTURAL DETERMINANTS OF HEALTH

Culture is a system of thoughts and behaviours shaped by a group of people. Our cultural backgrounds have tremendous impact on our lives especially on our health. Culture varies from one local group to another. It endures and evolves as well as is valued for itself.

Anthropologists have focused on both artistic as well as behavioural dimensions. Herskovits (1948) tells us that, "Culture is the man-made part of the environment," and Margaret Mead (1953) says culture "is the total shared, learned behaviour of a society or a subgroup." These dimensions are combined in Malinowski's (1931) formulation: "Culture is a well organized unity divided into two fundamental aspects — a body of artefacts and a system of customs."

Cultural determinants of health incorporate the cultural aspects that promote resilience, allow a sense of identity and support good mental and physical health for individuals, families and communities. These norms, values, beliefs, customs and practices are shaped, supported and protected through traditional cultural practice, art, song, dance, traditional healing etc.

United Nations Declaration on the Rights of Indigenous People considers the following cultural determinant elements as very important to shape health culture of the community.

a) Self Determination

b) Freedom from discrimination

c) Individual and Collective Rights

d) Freedom from assimilation and destruction of culture

e) Protection from relocation

f) Protection and promotion of traditional knowledge and indigenous intellectual property rights.

The cultural beliefs of a community shape the health care practices and develop locally believed ideas about illness. Any health intervention for community members must be made sensible in the context of local beliefs and practices. Understanding the beliefs and customs of a community is important to acknowledge and appreciate the differences between groups of people. For example, how Indian women understand and handle pregnancy and newborn care is entirely different from that of women from western developed countries.

Every culture has its own customs which influences the disease pattern. It plays important role in the matters of personal hygiene, family planning, seeking early medical care, immunization etc. in short it has strong influence in the way of lives of people. Not all customs and beliefs are bad. Some are based on evidences (like rest after childbirth) where as some are harmful (like female genital mutilation).

Box 5.2: **Culture has impact on all the following areas as far as health is concerned with**

1) Concept of Etiology and Cure (example, considering smallpox/ worship of goddess Shitala)
2) Environment Protection and Sanitation (Belief that latrines are meant for city people where there are no open fields, protecting water bodies as part of religious beliefs)
3) Sexuality and Family Planning
4) Food Habits (vegetarian or non-vegetarian for religious reasons, considering certain food as hot/cold, fasting on special occasions; avoidance/consumption of certain food items in illnesses)
5) Mother and Child (prolonged breast feeding, oil bath and sun exposure to the new born)
6) Personal hygiene (not taking haircut or cutting nails on certain days; prohibition of haircare on certain days)

Exercise 5.2

Identify the assumptions and practices related to childbirth in your community? And reflect upon your ideas about the following questions.

- At what age is it appropriate for a woman to become mother?
- To whom do children belong?
- How many children should a family have?
- Where should women deliver and who should be involved?
- Who should be involved in child rearing thereafter?

Discuss your ideas with your fellow classmates; and analyze how the cultural background in which you are brought up shaped your ideas/ views on pregnancy and childbirth which is different from fellow students' ideas.

5.5 GENDER AND HEALTH

Gender refers to the socially (as well as culturally) defined roles and responsibilities of men and women. The gender roles are learned through socialization in different social institutions. Gender inequality is the discrimination based on the person's sex in terms of opportunities in the allocation of resources/ benefits or access to the services.

Gender equality means the absence of discrimination, based on a person's sex, in opportunities, in the allocation of resources or benefits or in access to services.

Gender equity means fairness and justice in the distribution of benefits and responsibilities between women and men and often requires women-specific projects and programmes to end existing inequities.

In many societies, women systematically fail to achieve or fail to use some basic human rights according to men. Most of the time, women's health status and problems related to affect the mortality, morbidity and disability rates.

Let us discuss three examples.

1) Women's subordinate status in society means that they are often in violent relationships that are both physically and emotionally abusive. This affects their mental health (Sharma and team 2019).

2) Women are twice likely as men to suffer from depression- largely because of poor self-esteem (Orth and Team 2008).

3) Indian women are prone to be anaemic than their male counterparts this is mainly because of their poor eating habits (eating all left over) and less access to nutritious balanced diet (Imrana Qadeer 1998).

There are specific gender barriers that women face while accessing adequate health care services. They are:

1) Limited control over sex and reproduction: In India traditionally, women do not have the right to decide when to get married; how many children to have; spacing between children etc. In these situations, women participation in decision making are almost absent which consequently have tremendous impact on women's body and mind.

2) Time constraints: In the social-cultural contexts of Indian societies, most often, women accord less time to their health and well-being maintenance as household work and child rearing get the main priority both for working or non-working women. Thus diet, personal exercise, meditation or taking care of own health are mostly the least important aspects of women's life. Similarly, seeking health care services (like consulting a doctor) will be postponed as far as possible till the symptoms become intolerable. Hence early detection chances of various diseases are poor among women.

3) Lack of support from health care workers: Health care workers lack of understanding about gender disparities and role gender plays in health ensures that they do not alert women to their reproductive and sexual rights; these gender insensitive approaches discourage many women from seeking specific treatments.

5.5.1 Gender Inequality in Relation to Health

For Indian women the lower status/social value in the household affect their health outcome. Cultural factors such as lack of female health providers in the community and health facilities hinder their physical access to hospitals and nursing homes. Lower literacy rates and reduced access to information makes the situation worse for women. Social division of labour considers women as informal care provider at home hence it takes toll on her physical and mental health. Issues like violence, alcoholism, smoking and life style related problems are having public health implications and this makes the gender based health inequality very complicated in Indian Context.

WHO Technical Paper on gender and health (1998) cites the main criticism of women empowerment policies as being that they continue to define women themselves as the problem, who need welfare and special treatment if improvements in their circumstances are to be made. The underlying reasons of women are largely unexplored and no explanation is offered for the systematic devaluation of their work or the continuing constraints on their access to resources.

The following table 5.1 gives an idea about certain problems that Indian women face which has huge impact on their physical and mental health.

Table 5.1: Problems faced by Indian Women impacting their Physical and Mental Health

Childhood	Adolescence and Adulthood	Old Age
• Sex selective abortion • Female mutilation • Nutrition problems	• Unwanted pregnancies, STDs • Sexual harassment/ abuse • Forced Sex • Smoking and substanee abuse	• Increase in morbidity / problems on quality of life • Early years health is not taken care off; so minor aliments and health conditions like diabeteis

(**Source:** World Health Organisation, 2009)

As per WHO recommendations, women should: (World Health Organisation 2009).

- Be able to access information on and be able to choose from a range of methods to control their fertility (Example: use of services like contraception, abortion etc.).
- Have access to screening of different non communicable diseases including breast and cervical cancer prevention.
- Be able to decide when and with whom to have sexual relationships.
- Be able to protect themselves against STI and HIV.
- Be protected from harmful traditional practices such as female genital mutilation (context of African continent).
- Be able to access psycho-social counseling as a support in case of domestic violence, sexual abuse etc.

Exercise 5.3: Reflect upon the following questions and discuss with your mentor

- In India why sex ratio and child sex ratio becoming more unfavourable to females over the last few decades?
- How do socioeconomic position, race, and other dimensions of social status interact with gender to produce variations in gender inequity and its health consequences?

5.6 BEHAVIOURAL DETERMINANTS OF HEALTH

Behaviour is associated with health and disease. Health related behaviour of an individual is very important to ensure good health for him/ her. For example a person maintaining personal hygiene is health related behaviour and it affects his/ her health. Behaviour of one individual leaves impact on another person's

health (for example impact of passive smoking). Behaviour of groups influence physical and social environment which ultimately has an impact on health. For example, when a community decides to use car pooling system to travel to workplace it has an impact on environment pollution and pollution levels come down which ultimately improves our health.

Health behaviour is any behaviour that has or might have implications for health of an individual. The actions or reactions of an individual to a situation and this can be conscious or unconscious, voluntary or involuntary (Warwick Medical School, 2016).

Gochman (1988) considers that the personal attributes such as beliefs, expectations, motives, values, perceptions influence a person's health behaviour. Personality characteristics, actions and habits also influences a person's health behaviour. The Lifestyle Diseases are on rise in India, which has strong connection with the behavioural determinants of health. Life style includes "the way that people live reflecting a range of social values, attitudes and activities. This is constituted of cultural and behavioural patterns and lifelong personal habits (for example alcoholism) that are developed through the process of socialization. Life styles are learnt through social interactions and mass media. Many of the current health problems/ health conditions like cancer, obesity etc., are associated with life style that the individual follows. We need to focus on the indirect behaviour route of disease. This is because as per the study by Niaura and Abrahams (2002). Behaviour contributes to 50% of the leading cause of disease, which is followed by 20% causes from environment, 20% causes from biology (genetics) and rest 10% due to poor access to health care services.

Box 5.2: Classification of Behaviour

1) Health Seeking Behaviour and Illness behaviour.
2) Adaptive Behaviour and Maladaptive behaviour.
3) Prevention Behaviour and Detection Behaviour.
4) Public Behaviour and Private behaviour.
5) Service Use Behaviour and Self Care Behaviour.

Individual behaviours vary depending upon three factors as follows:

1) Emotional Dispositions: They are the psychological processes involved in both the experience and expression.
2) Generalized expectancies: Psychological processes involved in formulating expectation in relation to the future outcomes (locus of control, self-efficacy etc.).
3) Explanatory styles: psychological processes involved in explaining the causes of negative events (optimism, attribution styles etc.).

Key Health Behaviours*:* Numerous studies have examined the relationship between health behaviours and health outcomes and have demonstrated their role in both morbidity and mortality. One of the first such studies identified seven features of lifestyle which were associated with lower morbidity and higher subsequent long-term survival: not smoking, moderate alcohol intake, sleeping

7–8 hour per night, exercising regularly, maintaining a desirable body weight, avoiding snacks, and eating breakfast regularly (Belloc and Breslow 1972). Smoking is the health behaviour most closely linked with long-term negative health outcomes. Morbidity and mortality from coronary heart disease (CHD) are increased among smokers. The impact of diet upon morbidity and mortality are well established. In the Third World, the problems related to diet and health is ones of under-nutrition; in the First World, the problems are predominantly linked to overconsumption of food. The potential health benefits of engaging in regular exercise include reduced cardiovascular morbidity and mortality, lowered blood pressure, and the increased metabolism of carbohydrates and fats, as well as a range of psychological benefits such as improved self-esteem, positive mood states, reduced life stress and anxiety. Individuals may seek to protect their health by participating in various screening programmes which attempt to detect disease at an early, or asymptomatic, stage. Thus, health screening seeking is also a key aspect of health behavior.

Box 5.3: Case Study

A woman aged 32, mother of three, after her recent childbirth is seen in a psychiatric clinic because she feels depressed. The patient refuses to take medicines as she feels people will corner her as "madwoman". She feels exhausted with double burden of role of mother and a bank employee. She is sad about the unkind behaviour of her husband and indifferent attitude of in-laws. She tells the counsellor that her only comfort is from prayers to God and "the saints".

As a part of a multi-disciplinary team in a hospital, how would you help manage this patient's depression considering determinants of health framework? Before helping the woman try to answer the following questions:

1) What is (are) the possible cause(s) of depression?
2) How do social and psychological factors influence her present state?
3) Can you suggest a plan to the psychiatrist so as to accommodate socio-cultural influences into treatment?

5.7 ECONOMIC DETERMINANTS OF HEALTH

Different countries/continents of the world are not equally developed; this is because of the difference in resources, differences in culture, and differences in political and economic systems of the country. The health of a person is primarily dependent up the level of socio-economic development. Examples are per capita income, Gross National Product, employment and housing conditions have tremendous impact on an individual's life. The economic progress of many countries has been a major factor in reducing the mortality, morbidity rates; it also increased life expectancy, family size reduced drastically and there was a decrease in the communicable disease rates.

Health is closely linked with the economic system of a country. Often the main obstacles to the implementation of superior technology in health care in a country are not technical but are economic and political hurdles.

The economic system and economic stability of a country decides whether to make health care free for all or it should be charged. What per cent of Gross Domestic Product is to be spending on public health is also dependent upon the economic system and economic prospectus of that country. For example in the USA, health care is predominantly based on health insurance coverage. Hence health care is too expensive in that country. India, though devote only 1.5% of GDP into health we have, both government and private health care coexisting and people are free to choose from these available health care systems. Hence health care seems to be more accessible and affordable, though technology wise it is not as superior as in the USA.

5.7.1 Globalization and its Impact on Health

Globalization impacted on the trade relations and movements between countries. The competition and search for new markets, technological developments and agreements and cooperation between countries through international organizations (World Trade Organisation, World Bank) mediations make this process a reality.

Globalization is defined as the processes that are changing the ways in which people interact across boundaries, notably physical (such as the nation-state), temporal (such as instantaneous communications) and cognitive (such as cultural identity). The result is a redefining of human societies across many spheres, economic, political, cultural, technological and so on (Lee K and his team 2002).

Health achievements are critical international development goal. Globalization is helping to develop new knowledge and skills; promote policy coherence. This also contributes to global public goods for health, global health funds, international standards/ rules are developed for health.

However, some of the specific concerns in a globalized world that has direct/ indirect impact on health are:

1) Food safety
2) Environmental degradation and its impact on health
3) Access to Drugs
4) Health Care Service Availability
5) Emerging issues like Genetically Modified Food's impact on health
6) Increasing Life Style Disease burden.

Globalization has left negative impact on local knowledge, local resources and traditional whereby global knowledge, resources exert hegemony in the power system. The increase in Food chains like MacDonald, KFC and its popularity over Indian food among adolescents/ urban folks is an example to mention. This fast food culture leave impact on health and life style diseases like PCOD and obesity is on increase amongst this age group.

Check Your Progress

3) Discuss the role of cultural determinants on health of a community. Cite suitable examples.

.....

.....

.....

.....

4) "Globalization has both positive and negative impact on Health" Justify.

.....

.....

.....

.....

5.8 SUMMARY

Many factors combine together to affect the health of individuals and communities. These include determinants of health and his/ her biological/ genetic characteristics. Whether people are healthy or not, is determined by their circumstances and environment. The determinants of health include the social and economic environment, the physical environment, and the person's individual characteristics and behaviours.

The context of people's lives determines their health, and so blaming individuals for having poor health or crediting them for good health is inappropriate (WHO, 2019). Individuals are unlikely to be able to directly control many of the determinants of health and hence it is the responsibility of society, state and health care workers to develop determinants of health to such a level that they influence people's lives in a positive way, promoting health and well-being.

5.9 REFERENCES

Dahlgren, G. (1995). European Health Policy Conference: Opportunities for the Future. *Intersectoral Action for Health*, *11*, Copenhagen.

Govindasamy, P., & Ramesh, B. M. (1997). Maternal Education and the Utilization of Maternal and Child Health Services in India.

Healthy Campus (2020). Determinants of Health and Evidence-Based Actions, Ganeva. Accessed as https://www.acha.org/HealthyCampus/HealthyCampus/Action_Model.aspx on 12th Sep 2019.

Kleinman, A. (2004). Culture and Psychiatric Diagnosis and Treatment. *The Trimbos Lecture.*Harvard University.

Kleinman, A., & Benson, P. (2006). Anthropology in the Clinic: The Problem of Cultural Competency and How to Fix It. *PLoS medicine*, *3*(10), e294.

Lovell, N., &Bibby, J. (2018). What makes us healthy? An Introduction to the Social Determinants of Health. *Health Foundation*, New York.

Marmot, M., Allen, J., Goldblatt, P., Boyce, T., McNeish, D., Grady, M., & Geddes, I. (2010). The Marmot Review: Fair Society, Healthy Lives. *The Strategic Review of Health Inequalities in England Post-2010*, London.

Procter, S. (2000). *Caring for Health*. London: Macmillan Press.

Smith, R. D., Beaglehole, R., Woodward, D., &Drager, N. (2003). *Global Public Goods for Health: Health Economic and Public Health Perspectives*. Oxford University Press.

K K Sharma et al (2019). Mental health effects of domestic violence against women in Delhi: A community-based study. Journal of Family Medicine and Primary Care. Jul; 8 (7): 2522–2527.

Orth, U., Robins, R. W., & Roberts, B. W. (2008). Low self-esteem prospectively predicts depression in adolescence and young adulthood. *Journal of personality and social psychology*, 95(3), 695. DOI: https://doi.org/10.1037/0022-3514.95.3.695

Qadeer, Imrana (1998) Reproductive Health: A Public Health Perspective. *Economic and Political Weekly*. Oct 10, 1998. 33s(41). p.2675-2684.

World Health Organisation (2009). Women and Health: Today's Evidence and Tommorow's Agenda. Ganeva. Accessed as https://www.who.int/gender/women_health_report/full_report_20091104_en.pdf on 16th Aug 2019.

Niaura R and Abrahams DB (2002). Smoking cessation: Progress, priorities, and prospectus. *Journal of Consulting and Clinical Psychology.* 70(3). 494-509.

5.10 ANSWERS TO CHECK YOUR PROGRESS

1) A Health Disparity is a particular type of health difference that is closely linked with social, economic and or environmental disadvantage. *Health Outcome* is the changes in health that results from measures or specific health care investments or interventions. Health Inequality is observable health differences between subgroups within a given population; it can be measured and monitored. For details refer section 5.2.

2) Social determinants of health can be defined as the conditions in the social, physical and economic environment in which people are born, live, work and age and this include access to health care. The eight social determinants that have impact on Health in Indian Context are: a) Family, Friends and Communities; b) Money and Resources; c) Housing; d) Education and Skills; e) Good Work/ Employment; f) Transport; g) Physical Surroundings; h) Access to Food. For details refer section 5.3.

3) Cultural determinants of health incorporate the cultural aspects that promote resilience, allow a sense of identity and support good mental and physical health for individuals, families and communities. For details refer section 5.4.

4) Globalization helps to develop new knowledge and skills; promote policy coherence and it also contributes to global public goods for health, global health funds and in developing international standards/rules for health. On the other hand, Globalization has left negative impact on local knowledge, local resources and traditional whereby global knowledge, resources exert hegemony in the power system. For details refer section 5.7.

UNIT 6 THEORY AND METHODS OF PUBLIC HEALTH*

Contents

Learning Objectives

After reading this Unit, you would be able to:

- Discuss the importance of health behaviour theories and interventions to improve health outcomes of a population;
- Define what is a theory, model and identify various broad categorisations of health behaviour theories;
- Discuss and describe nine major theories (by explaining the key constructs, application, advantages and challenges) that are commonly used in public health intervention;
- Identify and appreciate the relevance of various health behaviour theories and models to address public health problems; and
- Identify the most important considerations in choosing the correct theory to address a public health problem in a given social context.

* Contributed by Dr. Lekha D Bhat, Department of Epidemiology and Public Health, Central University of Tamilnadu, Neelakudy.

6.0 INTRODUCTION

Public health uses various methods and approaches to address public health issues. Health behaviour modification, health promotion, outbreak investigation, health research etc., are the important components of public health methods and strategies.

The unit specifically deals with health behaviour theories and how these theories can be used to improve health status of a population. The most frequent causes of death worldwide are chronic non-communicable diseases that include heart diseases, lung diseases and cancer (Yach et al 2004). Behavioural factors like tobacco use, diet, alcohol consumption and avoidable injuries are among the prominent contributors to this mortality (Schroeder 2007). At the same time, in many parts of the world, including India, infectious diseases continue to pose grim threats; malaria, diarrheal diseases, Tuberculosis, HIV/AIDS are major threats to the poorest people around the world (PLoS Medicine Editors 2007). Both communicable (infectious) and non-communicable disease burden can be influenced by changing the important and crucial health behaviour of the people. Positive changes in a person's health behaviour would help to bring down substantial suffering, premature mortality and medical costs. Reports and policy documents of Government of India emphasises on health education and promotion as one among the strategy to combat health problems. To promote health education and health promotion, first, we need to develop understanding about health behaviour, various theories, its applicability and its limitations.

6.1 HEALTH BEHAVIOUR AND CLASSIFICATION

In the simplest sense, health behaviour includes any activity undertaken for the purpose of preventing disease or detecting disease or for improving health and well being.

6.1.1 Definition

Gochman (1997) defined health behaviour as those personal attributes such as beliefs, expectations, motives, values, perceptions and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behaviour patterns, actions and habits that relate to health maintenance to health restoration and to health improvement. In the broadest sense health behaviour refers to the actions of individuals, groups and organisations, as well as their determinants, correlates and consequences, including social change, policy development and implementation, improved coping skills and enhanced quality of life (Parkerson and others 1993).

Box 6.1: Some Examples of Key Health Behaviours

1) A man avoids smoking to bring down risk of lung cancer.
2) An adolescent does daily exercise to remain physically fit.
3) A middle-aged woman following a correct diet to control thyroid.
4) An elderly woman doing appropriate health screening as per the age.
5) A commercial sex worker ensures protected sexual behaviour/acts to avoid the risk of HIV/AIDS and other sexually transmitted infections.

6.1.2 Classification of Health Behaviour

Kasl and Cobb (1966) discuss about three categories of health behaviour. They are:

a) Preventive health behaviour: Any activity undertaken by an individual who believes himself (herself) to be healthy, for the purpose of preventing or detecting an illness in an early state (example — a mother getting her daughter immunised against cervical cancer as a preventive measure) or a simpler example of vaccinating children against an array of diseases in childhood (diphtheria, measles, whooping cough, Tuberculosis, encephalitis, small pox, etc.) In the present context of COVID 19, to prevent this disease, we are directed to cover face with mask, maintain social distancing and wash hands frequently. This is an example of preventive health behaviour.

b) Illness behaviour: Any activity undertaken by an individual who perceives himself/ herself to be ill, to define the state of health and discover a suitable remedy (example — a person consulting a doctor with the fever taking it as a symptom of tuberculosis and acting as per the instructions of doctor to undergo further diagnosis).

c) Sick role behaviour: Any activity undertaken by an individual who considers himself/ herself to be ill, for the purpose of getting well (example — a doctor prescribing drugs and bed rest after being diagnosed with viral fever and the patient follows it).

Check Your Progress

1) Define Health behaviour. Differentiate between different types of health behaviours.

.....

.....

.....

.....

.....

6.1.3 Characteristics of Health Behaviour

Health Behaviour is complex in nature. This is because it is influenced by beliefs, environment and emotional state/ traits. Further, health behaviour is strongly influenced by psychological, cultural, social and environmental factors.

The second feature of health behaviour is its dynamic nature. That means, along with time, place, age, social-physical environment it undergoes changes and alterations. For example, a person does not smoke when he or she is in home where he or she will be judged, but smokes when he or she moves out to the city for a job.

Next, health behaviour is considered as a process, rather than discrete entity or fixed trait. As time and circumstances changes it will evolve. For example, a person does not become addicted to alcohol suddenly. But it is a gradual process

whereby he or she is introduced to alcohol, slowly increase its consumption due to various reasons and gradually reaches the state of addiction.

Finally, any health behaviour is motivated by a stimulus. This means, any health behaviour, to occur needs a trigger and this trigger leads to its manifestation or happening.

6.1.4 The Relationship Between Knowledge, Values, Attitudes and Beliefs to Health Behaviour

As we already discussed, any health behaviour is shaped by four factors-knowledge, attitudes, beliefs and values. Having appropriate or correct knowledge is one important prerequisite of developing health behaviour. It refers to the knowledge people have about health-related issues. Individuals are not always knowledgeable about the good or bad outcomes of health behaviour. But, imparting correct knowledge alone will not always guarantee changes in an individual's behaviour. This is because change of knowledge into action is dependent on a wide range of internal and external factors, which includes attitude beliefs and values.

Values are acquired through socialization and are those emotionally charged beliefs which make up what a person thinks are important. A belief represents the information a person has about an object or action. It links the object to some attribute. Attitudes are value-ladened social judgments which possess a strong evaluative component. Sometimes, people do not follow a good healthy behaviour despite having correct knowledge. This knowledge-action gap can be explained by attitudes and values that he or she upholds.

For example, in India most adults who smoke, are aware of the hazards of smoking, but continue to smoke. This is because either their attitude, value or belief is having more influence on the behaviour than the knowledge component.

Implication

When the health intervention strategies are planned the first and foremost thing is imparting correct knowledge. The intervention should also focus on factors like beliefs, attitudes and values to bring the desired change in the subject.

6.1.5 Introduction to the Theories and Models of Health Behaviour

Theories and models of human behaviour originate from all disciplines of social sciences. Disciplines like Anthropology, Psychology and Sociology offer considerable insight especially in relation to the factors such as habits and rituals having an impact on health.

Theories of behaviour change?

A theory is a set of interrelated concepts, definitions and propositions that present a systematic view of events or situations by specifying relations among variables, in order to explain and predict the events or situations. The notion of generality (broad application) is important as is the testability (Kerlinger, 1986).

Theories of behaviour change are comprehensive answers to the question "why does behaviour change". They incorporate a variety of constructs, interventions and methods to explain relationships or causes that influence behaviour (Michie et al 2008).

Broad Classification

Different theories of health behaviour emphasise and focus on different aspects. Based on the way health behaviour is conceptualised or defined the theories can be broadly divided into three categories.

a) **Theories of Individual Behaviour and Behaviour Change**

A wide range of health professionals focus all or most of their efforts on changing the health behaviour of individuals. The primary focus is on the *individual*. These theories consider the behaviour as an outcome of competing influences balanced and decided upon by the individual. 'Health Belief Model', 'The Theory of Reasoned Action' and 'The Theory of Planned Behaviour' are some examples of theories that focus on the individual himself or herself.

b) **Theories and Models of Interpersonal Health Behaviour**

These models emphasise that the interpersonal interactions influence the individual's cognitions, beliefs and behaviours. Other people influence our behaviour by sharing their thoughts/ ideas/ feelings and by providing emotional and social support. Social Cognitive Theory, Community level theories are some popular and widely accepted theories in this category. Diffusion of Innovation theory is an example of community level theory. Unlike the theories of individual behaviour, the second category of theories shifts the focus from *individual to the behaviour itself*. These theories also stress upon relationship between behaviour and the individual and social/ physical environment.

c) **Theories and Models that Focus on Behaviour as an Outcome**

The third set of theories focus on *behaviour as an outcome* of complex inter-relationships and shared social practices. In these theories, environment and object both become active in the production of particular behaviour. 'Social Practice Theory' is the most cited example.

6.2 THEORIES AND MODELS OF INDIVIDUAL HEALTH BEHAVIOUR

During 1940-50s, research focused on how individuals make decisions about health and what determines health behaviour. In 1950s in the USA American Psychological Association studied why individuals did or did not participate in screening programme for TB. This work led to the development of health belief model. In the last twenty years value expectancy theories were proposed that include both the Health Belief Model and the theory of Planned Behaviour and the Theory of reasoned Action. The Trans theoretical Model also known as Stages of Change model grew initially from the work of Prochaska, Diclemente and their team of researchers during the period 1970-90.

6.2.1 The Health Belief Model

Health Belief Model explains people's beliefs about the severity of a disease and their susceptibility to it. This belief will influence their willingness to take a preventive action. Example: a group of social psychologists trying to explain why people do not use health services like immunisation though it is provided free of cost and is accessible. Health Belief model, proposed by Rosenstock and Becker in 1974, considers behaviour as an outcome of perceived susceptibility, perceived severity, perceived barriers, perceived benefits, cues to action and self-efficacy. Box 6.2 explains these constructs in detail and Figure 6.1 narrates the relationship between these constructs. The major advantage of this theory is that it is amongst the oldest theories that helped to understand health behaviour. Its simplicity enabled researchers to identify the reasons behind many health problems like why people do not adhere or accept public health programmes.

Box 6. 2: Major Constructs of Health Belief Model

Perceived susceptibility: The degree to which a person feels at the risk of health problem.

Perceived Severity: The degree to which a person's belief that the consequences of health loss will be severe in terms of both health and societal consequences (like loss of job etc.).

Perceived susceptibility together with the perceived severity is called as Perceived Threat.

Perceived Benefits: The person's beliefs regarding the benefits provided he or she prevent or treat the disease on time.

Perceived Barriers: The negative aspects of a health action

Self-Efficacy: The conviction that one can successfully execute the behaviour required to produce the outcome (Bandura 1997)

Cues to Action: This triggers the actual adoption of a certain (preventive) behaviour. This might be an individual or an incident.

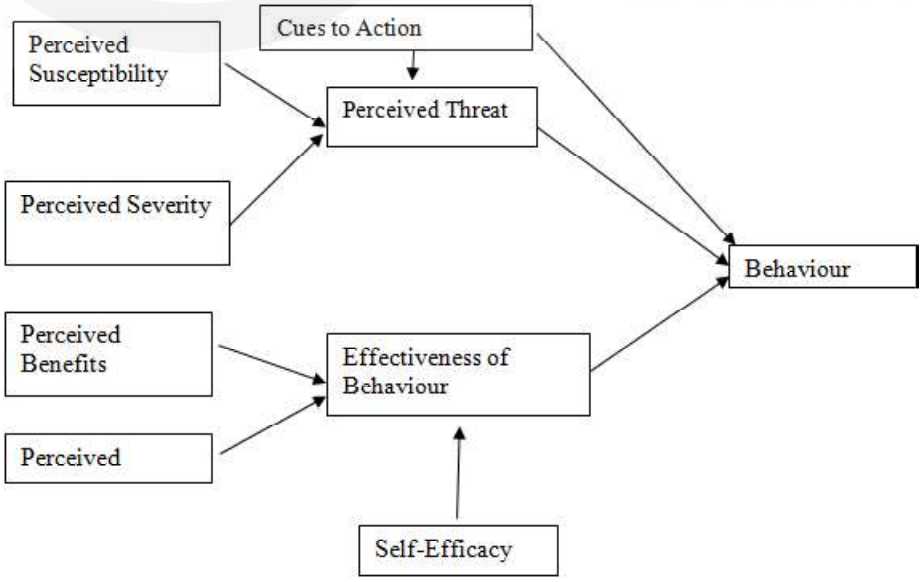


Fig. 6. 1*:* Depicting the relationship between various constructs of health belief model

*(***Source:** Becker, M. H. & Maiman, L. A., (1975). Socio-behavioral determinants of compliance with health and medical care recommendations. Medical Care, 134(1), 10-24. Figure 1, p. 12.

Box 6.3: Case Study

Health Belief Model (HBM) in Breast Cancer Screening: HBM predicts that woman will be more likely to adhere to screening tests like mammography, if they feel perceived threat to breast cancer as high and perceived barriers (like expenditure, accessibility of service, fear) as low. Perceived benefits (like continuing in good health, advantages of early detection in increasing recovery chances) etc., should also be clearly explained. Self-efficacy of women also plays a major role in deciding the behaviour/ action. Cues to action can be a mass campaign exposure where women became suddenly conscious about the need to undergo a screening. When the perceived benefits are more than the perceived barriers the person will take the step and seek a mammography/ screening test.

Take the example of COVID 19. When the cases were initially reported from China the perceived threat in India was low; so, people did not take preventive steps like covering face with mask. However, as cases are reported in India or in own state/district people become more cautious as perceived risk is more. Government has announced that all COVID infected cases will be treated by Government hospitals; this is to bring down the perceived barrier level to low so that infected person will seek treatment and will cooperate to break the chain.

Researchers cite two major limitations about HBM which are: 1) This model is based on cognitive component and it completely ignores the emotional component of behaviour, 2) There is no major research done about "cues to action" construct and it's role is not clearly explored.

Check Your Progress

2) Discuss Health Belief Model and its applicability in altering health behaviour of alcohol addict person.

.....

.....

.....

.....

.....

6.2.2 The Theory of Reasoned Action, Theory of Planned Behaviour and the Integrated Behaviour Model

The Theory of planned behaviour is the most widely cited and applied behaviour theory in the field of public health. It adopts a cognitive approach to explain behaviour that centres on individual attitudes and beliefs. The Theory of Planned Behaviour (TPB) is an extension of the Theory of Reasoned Action (TRA) which includes an additional construct called 'perceived control over the performance of behaviour'. The Theory of Planned Behaviour was proposed by Icek Ajzen in 1985) and later in 1986 Icek Ajzen and Madden refined it.

In recent years a group of psychologists led by Fishbein have further expanded TRA and TPB to include more components from behaviour theories and have proposed the use of an Integrated Behaviour Model (IBM).

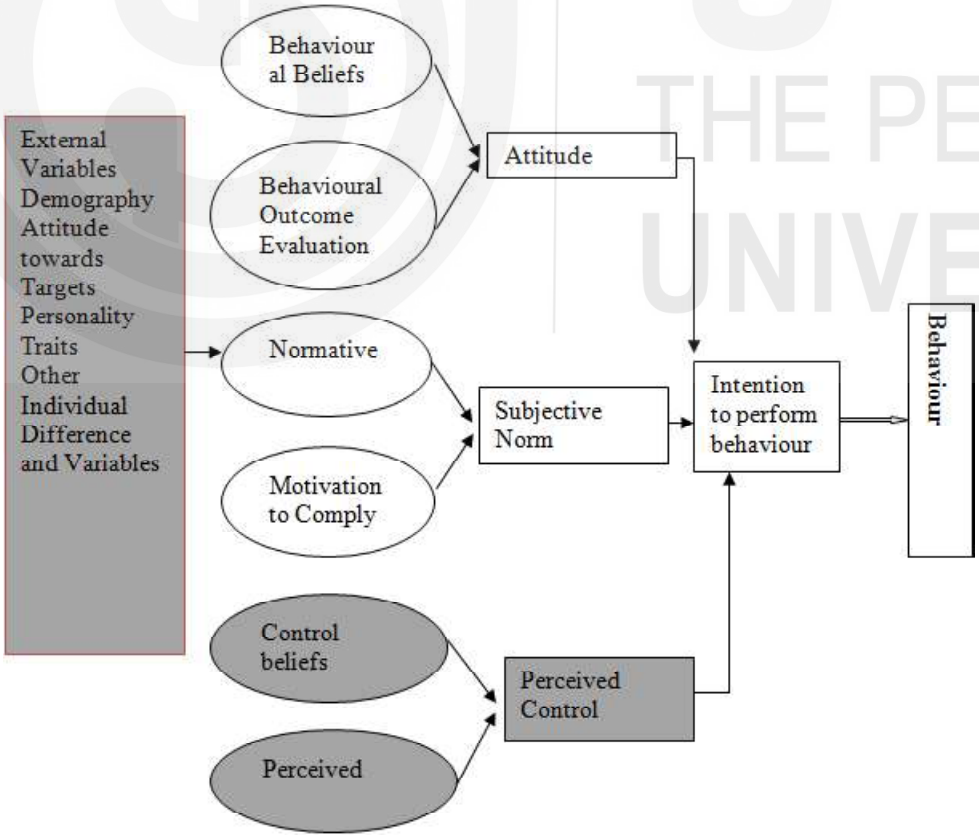
Theory of reasoned Action and the Theory of Planned Behaviour both argue that the best predictor of behaviour is *behavioural intention.* This behavioural intention is shaped by a) attitude towards the behaviour, and b) social-normative perceptions. TRA used these two constructs and later TPB added a third set of factors affecting intention as –*perceived behavioural control*. This is the perceived ease or difficulty with which the individual will be able to perform or carry out the behaviour.

How attitude towards behaviour is shaped? It is determined by the individual's beliefs about outcomes or attributes of performing behaviour. The health decisions are influenced by a person's view about that action and whether the significant others (like family and friends) would approve it.

These models are very useful to study why some people change health behaviour after health education programmes and why some others do not change. Figure 6.2 represents TRA and TPB thematically.

Key Constructs are:

The individual's attitude, or personal opinion, on whether a specific behaviour is good or bad, positive or negative, favourable or otherwise. The attitude must be specific, since this specificity will allow the prediction in the resulting behaviour.



***Note:** Light area shows the TRA and the Entire figure shows TPB

Fig. 6.2: Representing TRA and TPB

(**Source:** Montano& Kazprzyk TRA , TPB and Integrated Model in the Book Health Behaviour and Health Education Theory, Research and Practice, Ed Glanz.K ,Rimer , B. And Viswanath K, Wiley Imprint , 2008,San Fransisco, pp.70)

The prevailing subjective norms, or the social pressure arising from other people's expectations, as seen from the individual's point of view. This, in turn, has two components:

The individual's normative beliefs, or what he perceives to be what other people want or expect; and

The individual's motivation, or need, to comply with what other people want or expect.

The perceived behavioural control of the individual, or his perception of his ability to perform a specific behaviour.

An Integrated Behavioural Model

This model integrates the constructs of the TRA and the TPB along with constructs from some other behavioural theories. Apart from the most important component of 'behavioural intention', the integrated model points out four other components that directly affect behaviour.

They are listed as follows:

1) Even if a person has a strong behavioural intention, he or she needs knowledge and skills to carry out that behaviour.
2) There should be no or few environment constraints.
3) Behaviour should be salient to a person.
4) Experience of performing the behaviour may make it habitual so that the intention becomes less important.

Box 6.4: Case Study — Integrated Behavioural Model

If a woman has a strong intention to get a mammogram, it is important to ensure that a) she has sufficient knowledge about health care system, b) No environment constraints like lack of transportation or limited clinic hours that prevent her from getting the tests done, c) for an action that is carried out at longer interval (example mammography is generally performed once in a year for screening purpose) the behaviour must also be made salient (cued) so that the woman will remember to carry out her behaviour intention.

6.2.3 The Trans-Theoretical Model and Stages of Change

The Trans theoretical model also known as the Stages of Change (SoC) Model was first developed by James O Prochaska in 1978. This model was first developed based on health behaviour studies on smoking.

Assumptions:

1) Stages of behaviour Change: It's a cognitive model of health behaviour that divides individual between first categories that represent different "levels of motivational readiness". The behaviour change is a process that unfolds over time, with progress through a *series of six stages*. These six stages are (i) Pre-contemplation, (ii) Contemplation, (iii) Preparation, (iv) Action, (v) Maintenance, and (vi) Termination.
2) The Process of Change is important in SoC model. These are the covert and overt activities people use to progress through stages. (i) Consciousness

raising, (ii) Dramatic relief (like media campaigning), (iii) Self-revaluation, (iv) Self-liberation, (v) Stimulus control are some of the important process of change.

3) Decisional Balance: An individual weigh the pros and cons of change systematically and logically before initiating a behaviour change. Self-efficacy is also the factor that decides the behaviour change. It is the situation specific confidence that the person has that he or she can cope with the situation without any relapse.

4) The individuals at the same stage should face similar problems and barriers and thus can be helped by the same type of intervention.

5) The movement or transition between these stages is driven by two key factors — self-efficacy and decisional balance.

6) Relapse: Moving backwards through the stages is common and acceptable.

The Trans-Theoretical Model is showing good results when applied for interventions like substance abuse control programmes. Large number of TTM related intervention studies have focused on smoking cessation. The major limitations of this model is it's complete focus on the self and misses the structural, economic, social and environment factors which affect an individual's ability to change the behaviour. Another limitation is that the model has not shown promising results with children and adolescents because culture specific aspects are not acknowledged/ taken care of.

Box 6.5: Stages of Behavioural Changes-Trans Theoretical Model

Precontemplation: It is the stage in which the person does not intend to take any action in the near term, usually the next six months.

Contemplation: The person intends to take action soon usually within next six months.

Perception: The person intends to take action soon usually within next one months.

Action: The person has taken specific, overt modifications in their lifestyles within the past six months.

Maintenance: It is the stage in which the person has made specific overt modifications in their lifestyle and are working to prevent relapse.

Termination: In this stage the person has zero temptation to relapse and has 100% self-confidence about this.

Box 6.6: Case Study TTM

Let us apply TTM to develop an intervention for an entire high-risk group for cardio-vascular diseases like smokers. The intervention should identify where the person presently located in the stages of behaviour. The programme should help the participant to progress through the stages of change in a systematic manner. The transition from one stage to another should be progressive and smooth. Relapse to previous stage is commonly seen and this should be accepted. A matching process of change should be selected depending upon everyone's interest.

6.3 THEORIES AND MODELS OF INTERPERSONAL HEALTH BEHAVIOUR

These models in general emphasize that interpersonal relationships and interactions influence the individual's cognitions, beliefs and in turn decide behaviour. Contrary to the previous theories (discussed in Section 3) the focus shifted from individual to behaviour itself and the influence of interpersonal relations on the behaviour. We will discuss three important theories here:

1) Social Cognitive Theory (SCT)
2) Social Networks and Social Support Model
3) Stress, Coping and Health Behaviour Model

6.3.1 Social Cognitive Theory (SCT)

This theory was proposed by Albert Bandura 1960s and developed as Social Cognitive Theory in 1986 and the key term proposed is *reciprocal determinism.* The theory argues that, both individuals and their environment interact and influence each other which he termed as reciprocal determinism. This results in changes both at individual and social level. SCT was first known as social learning theory (SLT), later it was renamed as SCT when concepts from cognitive psychology were integrated to accommodate the growing understanding about human information processing. With further developments, SCT has embraced concepts from sociology and political science.

This theory used the following five constructs:

1) Psychological determinants of behaviour: This includes outcome expectations and self-efficacy. People act (or behave) in a way to maximise benefits and minimise costs. Self-efficacy is the person's belief about his/ her capacity to influence the events that affect his or her life.
2) Observational Learning*:* This is the capacity of a person to observe something and learn-repeat that behaviour. For example, access to family peer and media models determines what behaviour a person is able to observe and learn.
3) Environmental Determinants of Behaviour*:* No amount of observational learning will lead to behaviour change unless the observers' social and physical environment support the new behaviour.
4) Self-Regulation*:* SCT emphasises the human capacity to endure short-term negative outcomes in anticipation of important long-term positive outcomes. Self-regulation does not depend on a person's willpower but instead on his or her acquisition of concrete skills for managing himself/ herself.
5) Moral Disengagement*:* When people learn moral standards for self-regulation this will lead them to avoid violence and cruelty to others.

Application

Social Cognitive Theory provides a comprehensive and well supported conceptual framework to understand many health behaviours and how to alter health

behaviours. SCT based intervention focuses on changing behaviour by increasing self-efficacy, social modelling, verbal persuasion etc., are the ways in which self-efficacy can be improved. While designing intervention programmes importance is given to the aspects like self-monitoring, self-reward, goal setting, feedback and social support. The advantage is that SCT is very broad and ambitious in that it seeks to provide explanations for virtually all human phenomena. This, broad nature of theory also brings in the limitation that since it is too broad it has not been tested comprehensively. Another problem with SCT based interventions is the constructs are difficult to measure and manipulate.

6.3.2 Social Networks and Social Support Models

The social network and social support-based models assume that social relationships have powerful influence on health behaviours, health status and health decision-making.

Social network refers to the web of social relationships that surround individuals. Social networks give rise to various social functions like social influence, social control, social companionship and most importantly social support. These social networks may or may not provide *social support*. Social networks, through social support provide emotional support, instrumental support, information support and appraisal support.

By 1990s, a new concept, *social capital* has been introduced. Jane Jacobs used this term in her writings to mention about value of networks. In the late 1990s the concept gained popularity, serving as the focus of a World Bank research programme. It refers to certain resources and norms that arise from social networks. Social support is provided consciously. It is always intended to be helpful thus distinguishing it from intentional negative interactions. Enhancing existing social linkages (like training members for skill development), developing new social network linkages (like developing self-help groups, peer groups) and enhancing networks using indigenous natural helpers and community health workers are the health intervention examples based on social network and support model.

Example: There is research evidence that shows, negative interpersonal interactions such as those characterised by mistrust, hassles, criticisms and domination are more strongly related to such factors as negative mood and depression. It also accelerates risky health behaviour like substance abuse.

Check Your Progress

3) Examine the relevance of social network and social support model in altering adolescents' behaviour.

.....

.....

.....

.....

.....

6.3.3 Stress, Coping and Health Behaviour Model

This model considers stress and the coping skill as the most important determinants of health behaviour. Stress may have a negative physiological effect on health or contribute indirectly to behaviour that are not conducive to good health. For example, smoking might be a way for a person to cope with stress. Interpersonal interactions and communications play a crucial role in helping people copes with stress by providing social support potentially mitigating the impact of stress or providing ways to cope with it.

Transactional Model of stress and coping is a framework for evaluating process of coping with stressful events. Stressful experiences are constructed as *person-environment transactions*. When faced with a stressor, a person evaluates potential threats or harms (this is termed as *primary appraisal*) as well as his or her ability to alter the situation and manage negative emotional reactions (*secondary appraisal*). Actual coping efforts aimed at problem management and emotional regulation, give rise to *outcomes* of the coping process. Figure 6.3 represents the transactional model of stress and coping in more detail.

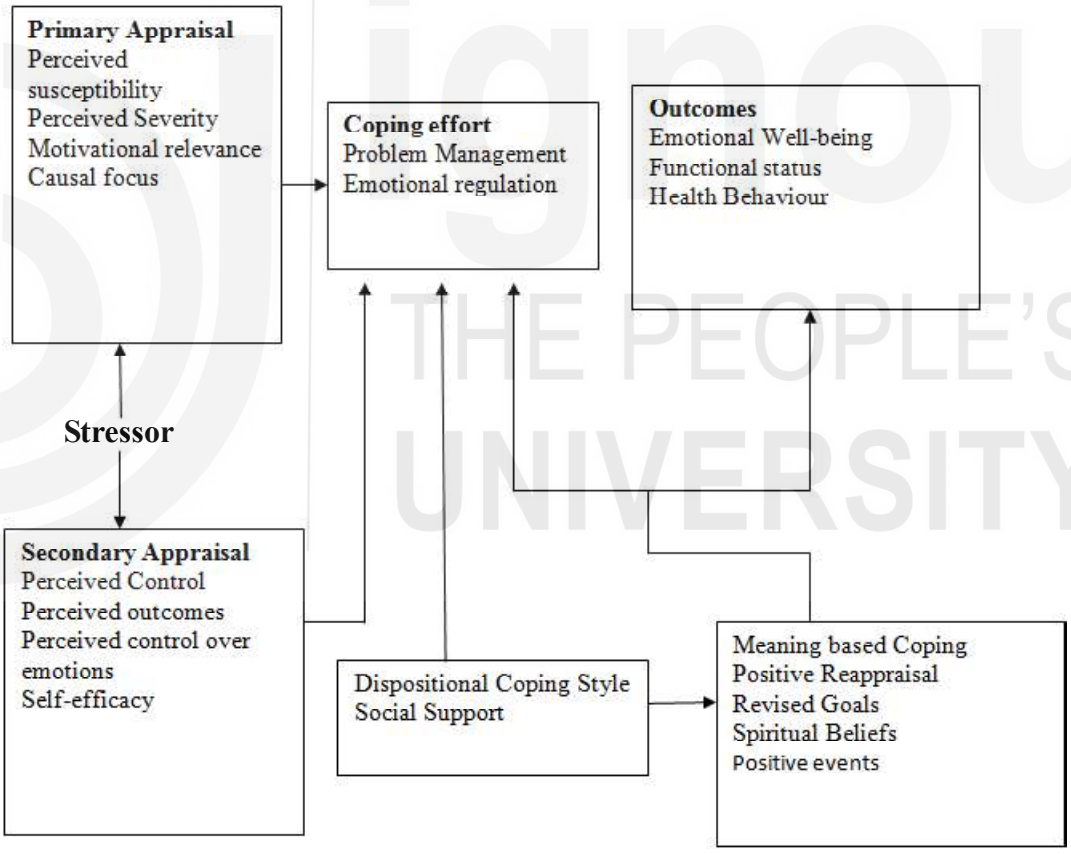


Fig. 6.3: Represents the Transactional Model of Stress and Coping

(**Source:** Prochaska, J., Redding, C and Evers, K. The Trans theoretical Model and Stages of Change, in the Book Health Behaviour and Health Education Theory, Research and Practice, Ed Glanz. K, Rimer, B. And Viswanath K, Wiley Imprint, 2008, San Fransisco, pp.112)

Applicability of transactional model: The transactional model has been applied to public health issues such as the effect of racism on health disparities. Studies examining relationship between perceived racism and hypertension have found positive associations. A variety of techniques to manage stress, improve coping and reduce deleterious effects of stressors on health have been developed. Relaxation strategies, cognitive behavioural stress management etc., are the approaches that are developed from transactional model.

6.4 COMMUNITY AND GROUP MODELS OF HEALTH BEHAVIOUR CHANGE

Groups, organisations and large-scale organisations and communities play a vital role to health improvement. The collective well-being of the communities can be fostered by creating structures and policies that support healthy lifestyles and by reducing or eliminating health hazards. Health concerns like substance abuse, HIV/AIDS, obesity can't be addressed adequately through individual or small group interventions alone. Rather health professionals need to review and health behaviour in the context of large communities and social institutions.

Improving health through 'Community Organisation and Community Building', and 'Diffusion of Innovations' are the main two models in this category.

6.4.1 Diffusion of Innovations

The development of diffusion studies has emerged from works of Rogers (1995) later developed by Wejnert (2002).

Key concepts of the Diffusion of Innovations are the following:

1) Diffusion is defined as the overall spread of an innovation. The process by which an innovation is communicated through certain channels over the time.
2) Five stages of Diffusion. Any innovation is diffused into a society through five stages viz. Adoption, Implementation, maintenance, sustainability and institutionalisation.
3) The following characteristics of innovations affect diffusion: Relative Advantage, Compatibility, Complexity, Triability, Observability.
4) Any community has five type of people viz. Innovators, early adopters, early majority, late majority, and laggards. The adoption of ideas and its diffusion in the person is different in the community depending upon which category he or she falls.

Check Your Progress

4) What are the different stages that diffusion theory proposes? Discuss.

.....

.....

.....

.....

Limitation of the diffusion theory is that it has stressed a lot on pro-innovation orientation. Individual blame bias is another problem of this theory where the individual is held responsible for the problem rather than society or community. The application level of the theory is that when public health professionals plan for some interventions, where the person is located in these five stages has to be located. Similarly, for community level health interventions we need to identify the innovators and early adapters and channelize the communication through them.

Box 6.7: Five Types of People in a Community

Innovators: Introduction of a new idea is always picked up first by this group. They have features like independent, adventure and risk taking. They will come forward to accept any new health behaviour that public health professional introduces.

Early Adopters: They are very interested in the innovation, but they are not the first to sign up. They wait until the innovators are already involved to make sure the innovation is useful. They will be mostly respected people of that community.

Early Majority: They are interested in the innovation but will need external motivation to become involved.

Late Majority: are next and it will take more time to get them involved for they are skeptical and will not adopt an innovation until most people in the community have done so.

Laggards: are not very interested in innovation and would be the last to become involved. They are very traditional and are suspicious of innovations.

Five stages of diffusion of any idea related to health:

Adoption: Uptake of the programme or innovation by the target audience.

Implementation: The active, planned efforts to implement an innovation within a defined setting.

Maintenance: The on-going use of an innovation over time.

Sustainability: The degree to which an innovation or programmes of change is continued.

Institutionalisation: Incorporation of the programme into the routines of an organisation or broader policy and legislation.

6.5 SELECTION OF THEORY TO CHOOSE WHILE PLANNING HEALTH INTERVENTIONS

After learning about various theories and models of health interventions, you might be having this question in mind "How to pick one theory over another"? The simple answer to this question is that there is no superior or inferior theory. Some theories are intuitively appealing than others, matching people's naïve ideas of the motivators of health behaviour. Other theories are quite complex and are applicable to specifically health domain. In the absence of a good research-based evidence on which theory is better, researcher and practitioners should

select theories based on their assessment, merits and appropriateness of the theories to the cultural and social context of the targeted group/ community. The readers should consider integrating theories from more than one level and using theories to design and evaluate (and also understand) health behaviour interventions.

6.6 SUMMARY

Theories that emphasize individual health behaviour have an important role to play in our understanding of how to improve human health. One must nearly always consider the social and community context to understand where beliefs come from and to find ways to change both beliefs and external constraints. Health professionals to consider the nature of the health problem or condition on which they wish to intervene and select the appropriate theory, sometimes employing multiple theories to permit intervention at multiple levels.

6.7 REFERENCES

Becker, M. H., & Maiman, L. A. (1975). Socio behavioral Determinants of Compliance with Health and Medical Care Recommendations. *Medical Care*, 10-24.

Gochman, D. S. (1997). "Health Behavior Research: Definitions and Diversity." In D. S. Gochman (ed.), *Handbook of Health Behavior Research, Vol. I. Personal and Social Determinants.* New York: Plenum Press.

Kasl, S. V., & Cobb, S. (1966). Health behavior, illness behavior and sick role behavior: I. Health and illness behavior. *Archives of Environmental Health: An International Journal*, *12*(2), 246-266.

Kerlinger, F. N. (1986). *Foundations of Behavioral Research.* (3rd ed.) New York: Holt, Rinehart & Winston.

Montano, D. E. & Kazprzyk, D. (2008). "TRA, TPB and Integrated Model" In Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). *Health Behaviour and Health Education Theory, Research and Practice*, (pp. 70). San Francisco: Wiley Imprint.

Parkerson, G. R., Connis, R. T., Broadhead, W. E., Patrick, D. L., Taylor, T. R., & Tse, C. K. J. (1993). Disease-specific versus generic measurement of health-related quality of life in insulin-dependent diabetic patients. *Medical care*.

PLoS Medicine Editors. (2007). Thirty Ways to Improve the Health of the World's Poorest People.

Prochaska, J. O., Redding, C. A., & Evers, K. E. (2015). The Transtheoretical Model and Stages of change. In Glanz, K., Rimer, B. K., & Viswanath, K. (Eds.). *Health Behaviour and Health Education Theory, Research and Practice, (pp.* 125-148). San Francisco: Wiley Imprint.

Rogers Everett, M. (1995). Diffusion of innovations (4th ed.). *New York*: Free Press.

Schroeder, S. A. (2007). We can do better-improving the health of the American people. *New England Journal of Medicine*, *357*(12), 1221-1228.

Wejnert, B. (2002). Integrating models of diffusion of innovations: A conceptual framework. *Annual review of sociology*, *28*(1), 297-326.

Yach, D., Hawkes, C., Gould, C. L., & Hofman, K. J. (2004). The global burden of chronic diseases: overcoming impediments to prevention and control. *Journal of the American Medical Association*, *291*(21), 2616-2622.

6.8 ANSWERS TO CHECK YOUR PROGRESS

1) Health behaviour refers to the actions of individuals, groups and organisations, as well as their determinants, correlates and consequences, including social change, policy development and implementation, improved coping skills and enhanced quality of life. For more details refer sub-section 6.1.2.

2) Health belief model explains people's beliefs about the severity of a disease and their susceptibility to it. This belief will influence their willingness to take a prevention action. For more details refer sub-section 6.2.1.

3) Social networks, through social support provide emotional support, instrumental support, information support and appraisal support. For more details refer sub-section 6.3.2.

4) Any innovation is diffused into a society through five stages viz. Adoption, Implementation, maintenance, sustainability and institutionalisation. For more details refer sub-section 6.4.1.

UNIT 7 MANAGEMENT OF HEALTH CARE PROGRAMMES BY INDIAN GOVERNMENT AND NGO'S*

Contents

Learning Objectives

After going through this Unit, you would be able to:

- Understand about health care delivery in India — its structure, organisation and functions;
- Discuss various health programmes and policies implemented by the Government of India, with focus on the post-independence era;
- Understand the role of NGOs in the health sector in Indian context; and
- Summarise India's key achievements and major challenges in Public Health.

* Contributed by Dr. Lekha D Bhat, Department of Epidemiology and Public Health, Central University of Tamilnadu, Neelakudy.

7.0 INTRODUCTION: HEALTH CARE SYSTEM IN INDIA

Health is clearly not the mere absence of disease. Good health condition ensures that the person is free from any disease and this gives him/ her ability to work and realise his/ her full potential. Good health confers on a person or groups' the freedom from illness and the ability to realise one's full potential. Health is best understood as the indispensable basis for defining a person's sense of well-being. In ensuring good health, a country's health care plays a major role. Health care covers not merely medical care; all aspects like preventive and curative and rehabilitative care are given due importance. It includes both public and private sector health care institutions; health promotion-prevention of disease- curative-rehabilitative elements is given representation in an ideal health care system.

Under the Indian Constitution, health is a state subject. Each state therefore has its own health care delivery system in which both public and private actors operate. While states are responsible for the functioning of their respective health care systems, certain responsibilities fall on the federal (central) government, namely policy making, planning, guiding, evaluating, assessing, assisting to the respective state governments and providing funding to implement the national health programmes. India's health care system is characterised by multiple systems of medicine which include not only Allopathy (western medicine) but also Ayurveda, Sidhha, Unani, Yoga and Sowa Rigpa type of medical systems. In India, apart from various national programmes targeting different diseases, we have both public (Government) owned hospitals and private hospitals and clinics.

Check Your Progress

1) Discuss India's health care system with special emphasis to its structure.

.....

.....

.....

.....

.....

7.1 HEALTH CARE: BASIC CONCEPTS

Health care is defined as a multitude of services rendered to individuals, families or communities by the agency of the health services or professions, for the purpose of promoting, maintaining, monitoring or restoring health (Park and Park, 2015).

7.1.1 Health Care and Public Health

Health care services are the set of institutions with adequate infrastructure; work force and funding that ensure the delivery of public health facilities/programmes in the country.

According to Monica Das Gupta (2006) public health services are conceptually different from medical services. They have a key goal in reducing a population's

exposure to diseases; for example, assuring food safety, vector control, waste management, health education etc., are important elements of health care along with the medical (curative) oriented facilities. Public health services produce "public goods" of incalculable benefit for facilitating economic growth and poverty reduction.

7.1.2 Main Characteristics of Health Care

The main characteristics of health care can be summarised as follows:

- **Appropriateness** (relevance) i.e. whether the service is needed at all in relation to essential human needs.
- **Comprehensiveness** i.e. whether there is an optimum mix of preventive, curative and promotional services.
- **Adequacy** i.e. if the service is proportionate to the requirements like doctor-patient ratio.
- **Availability** i.e. ratio between the population and the health facility
- **Accessibility** i.e. geographic, economic and cultural accessibility
- **Affordability** i.e. expenses involved in availing the health care services.

7.1.3 Levels of Health Care

Indian Health Care Services are usually organised at three levels as follows:

Primary Health Care: This is the first level of contact between the individual/ community and the health system, where "essential" health care is provided. A majority of prevailing health complaints, minor ailments, and common infections along with preventive services can be satisfactorily dealt with at this level. In India, Village Health Guides, ASHA Workers followed by the Sub-centres and the Primary Health Centres together constitute the primary level health care providers. Sub Centres and Primary Health Centres also provide reproductive health/ family planning services along with immunisation for children. Most of the vertical programmes use this level as the base of service provision.

In a PHC, a doctor along with ANM will be posted and they can handle a normal delivery; whereas the cases that require Caesarean section will be referred to CHC or secondary health care facility like district hospital where an Obstetrics and Gynaecology specialist is posted and other facilities like blood transfusion is available.

Secondary Health Care*:* At this level, more complex health problems are dealt with that are not effectively dealt at the primary level. It is essentially curative service oriented. It is provided by the district hospitals and the community health centres. They are also the first referral level in the health system. Facilities like X-Ray, CT/ MRI Scan, Blood bank etc., will be available and specialist doctors will be posted here. Various departments like, Obstetrics and Gynaecology, Ophthalmology, ENT, Oncology etc., will be functioning in these hospitals.

Tertiary Health Care*:* This level offers specialist and super specialist care. These institutions also do planning, developing managerial skills and teaching/ training the medical/ paramedical staff. Medical colleges and super speciality hospitals

are included in this category. They are generally referral hospitals where highly specialised treatments are available.

7.1.4 Components of a Just and Efficient Health Care System

Having a good network of health care is not adequate; but the system should be 'Just and Efficient' so that the services reach to the most marginalised and poor people of the society.

Understanding health as a human right creates a legal obligation on states to ensure access to timely, acceptable, and affordable health care of appropriate quality as well as to providing for the underlying determinants of health, such as safe and potable water, sanitation, food, housing, health-related information and education, and gender equality. The right to health must be enjoyed without discrimination on the grounds of race, age, ethnicity or any other status.

Right to Health and Components

The right to health (Article 12) was defined in General Comment 14 of the Committee on Economic, Social and Cultural Rights – a committee of Independent Experts, responsible for overseeing adherence to the Covenant. The following are the components of Right to Health.

1) **Availability:** The health care services are available to all irrespective of the ability to pay, caste, class, religion, gender etc.

2) **Accessibility:** The health care services are physically and economically accessible to all. The accessibility to information is also part of accessibility.

3) **Acceptability:** Relates to respect for medical ethics, culturally appropriate, and sensitivity to gender. Acceptability requires that health facilities, goods, services and programmes are people-centred and cater for the specific needs of diverse population groups and in accordance with international standards of medical ethics for confidentiality and informed consent.

4) **Quality:** The services provided must be scientifically and internationally accepted. Safety, effectiveness, efficiency and timely nature of services are covered in this aspect.

According to Srinivasan (2006) the following four criteria are important to consider/evaluate a health care system as Just and Efficient.

a) Universal access, access to an adequate level and access without excessive burden.

b) Fair distribution of financial costs for access and a constant search for improvement to a more efficient system.

c) Training providers for competence, empathy, accountability, cost-effective use of resources etc.

d) Pay special attention to the vulnerable groups such as disabled, aged and children.

Frieden Thomas (2014) in his work lists six components that will ensure efficiency and success in public health care. They are:

a) Innovation to develop the evidence base for action.

b) A technical package of a limited number of high priorities, evidence–based interventions that together will have a major impact.

c) Effective performance management, especially through rigorous, real time monitoring and evaluation.

d) Partnerships and Coalitions.

e) Communication of accurate and timely information to the health community and civil society.

f) Political commitment to obtain resources and support for effective action.

Check Your Progress

2) List out important components of a Just and Efficient Health Care System.

.....

.....

.....

.....

.....

7.2 INDIA'S HEALTH CARE SYSTEM: AT A GLANCE

India's health care system can be classified into many categories based on various parameters.

Depending upon the function it addresses the Health Care system in India consists of four components. They are:

- Primary, secondary, tertiary institutions manned by medical and para-medical personnel;
- Medical colleges and para-professional training institutions to train the needed manpower and give the required academic input;
- Programme managers, managing on-going programmes at central, state and district levels; and
- Health management information system consisting of a two-way system of data collection, collation, analysis and response.

Depending upon the source of funds for operation and health resources (technology/work force) used, health care system is divided into five sectors as follows:

Public Health Sector — Include Primary health care (Sub-Centers and Primary Health Centres), Hospitals (Community Health Centres, Rural Hospitals, district Hospitals, medical colleges, specialist hospitals), health insurance schemes (ESI, Central Government Health Scheme) and other agencies health services (like defence hospitals, railway hospitals). Private Health Sector — This includes private hospitals, nursing homes, dispensaries, clinics etc.

Voluntary Health Agencies – which are not-for-profit organisations working in the field of health Depending Upon Type of Medical Systems we have

- Allopathy and AYUSH services are two broad categories. Indigenous System of Medicine consists of Ayurveda, Yoga, Unani, Siddha, Homeopathy, Sowa-Rigpa shortly termed as AYUSH. This has a separate ministry to provide fund, support Research and Development. Public hospitals, clinics and private hospitals/ clinics form part of this network.

- **Various National Health Programmes**

  National Health Programmes-they are vertical programmes, planned, developed, implemented and funded by the federal (central) government to combat particular diseases like malaria/leprosy etc. We will be studying more about these national programmes in detail in the following sections.

a) **Public Sector Health Care in India**

Primary Health Care in India forms the backbone of the health system, especially in rural areas. At village level, it consists of Village Health Guides, trained Dais and Anganwadi workers (From Integrated Child Development Scheme). This is supported and supervised/coordinated by the Sub-centres and the Primary Health Care Centres.

Accredited Social Health Activist (ASHA) is a woman who is selected from the village itself and she is trained to work as interface between the community and the public health system. ASHA will be a health activist in the community who will create awareness on health and its social determinants and mobilise the community towards local health planning and increased utilisation and accountability of the existing health services. She would be a promoter of good health practices and will also provide a minimum package of curative care as appropriate and feasible for that level and make timely referrals.

Village Health Guide*:* is a person who has an aptitude for social service and he or she is not a full-time government employee. He or she serves as a link between the community and the government health infrastructure. He or she is selected at the village level (1 for each 1000 rural population) and undergoes training in the nearest Primary Health Care Centre for three months. Primary responsibility of village health guide includes, helping the community with minor medical problems, ensure first aid, maternal-child health care, health education and sanitation.

Trained Birth attendants: Woman from village is selected and she undergoes a training of thirty working days at the Primary health care centre or maternal and child health centre. After the training she is provided with delivery kits, her main responsibility is to ensure safe delivery and promote small family norm.

Anganwadi Worker: Under the Integrated Child Development Scheme (ICDS) there is one Anganwadi worker employed for 1000 population. She is trained in various aspects of health, nutrition, primary education etc. and she plays a pivotal role in ensuring health access and health/ nutritional/ health supplements benefit to pregnant women, 0-6 year children, lactating mothers and adolescents.

Subcentre (SC): Government of India approves one SC for 5000 population in general and in hilly / tribal areas it is one per 3000 population. Two multi-purpose workers (shortly called as MPW — one male and one female) are employed here. They are responsible for all health service and health programme implementation in that area. Generally, the male MPW looks after programmes like malaria, Tuberculosis etc., whereas the female MPW will look after maternal and child health/ family planning services.

Primary Health Centre (PHC): One PHC is approved for 30000 population in rural/ plains whereas it is one PHC for every 20000 population in tribal/ hilly areas. The major functions of PHC includes health education, promotion of nutrition, sanitation, immunisation, MCH care, appropriate treatment of common diseases/ injuries, essential drug supply, implementing and supervising various national health programmes and referral services. PHC will have medical officers, staff nurse, nursing assistants, pharmacists and other supporting staff.

Angwanwadi Centers (Department of Women and Child Development): Nutritional needs of pregnant woman, nutritional needs of 0-6 year old children and adolescent girls' health requirements are met through anganwadi centers where food grains and medicines are distributed.

Secondary Level of Health Care consists of community health centres, rural hospitals, district hospitals and speciality hospitals.

Community Health Centres (CHC): One out of four PHC in a block is usually upgraded and recognised as a Community Health Centre (CHC). It should have 30 beds with specialists in surgery, medicine, gynaecology/ obstetrics and paediatrics. It also should have diagnostic facilities like X ray and laboratory facilities. One CHC usually covers a population of 80000-120000.

Health Insurance: No universal health insurance is mandatory in our country. However, two insurance-based programmes are well-implemented and managed in India. They are ESI and Central Government Health scheme. ESI was introduced in 1948 to provide medical care for people working in industries. Central Government Health Scheme was introduced in 1954 and it covers the employees of autonomous organisations, retired central government servants, retired judges, MPs of Parliament and their families. Ayushman India is a new scheme that was recently launched, and it aims to provide universal insurance coverage to the citizens of this country.

Other Agencies: This includes medical services provided by defence forces, through their hospitals/ medical colleges. Similarly, Indian railways also provide health care facilities for their employees and family members.

b) **Private Health Care in India**

This mainly consists of private hospitals, independent clinics, nursing homes etc. This sector is highly unorganised and is concentrated in urban areas. It provides mainly curative and immunisation services. Medical Council of India and Indian Medical Association regulate and control some aspects of the private health care sector.

c) **Ministry of AYUSH and its Health Care Institutions**

Ministry of AYUSH (which was initially the department of AYUSH), regulates, maintains and develop manpower, infrastructure, Research and Development, drugs etc., for AYUSH systems (Ayurveda, Yoga, Unani, Sidha, Homeopathy and Sowa-Rigpa). Both public sector institutions (primary level clinics, Ayurveda hospitals, Ayurveda/ homeopathy medical colleges) and private hospitals/clinics/colleges are under the control and supervision of Ministry of AYUSH.

d) **Voluntary Health Agencies**

Voluntary health institutions are not-for-profit organisations usually registered under the Societies Registration Act or the Trust Act. International level organisations like Red Cross Society, World Health Organisation etc., are also part of this network, which provides specialised training, skill development, R&D support to the federal (central) government. Indian Council for Child Welfare, Voluntary Health Association of India, The All India Blind Relief Society etc., are some other important organisations that render their services in the area of health.

Thematic Diagrammatic Representation of Indian Health Care Sector

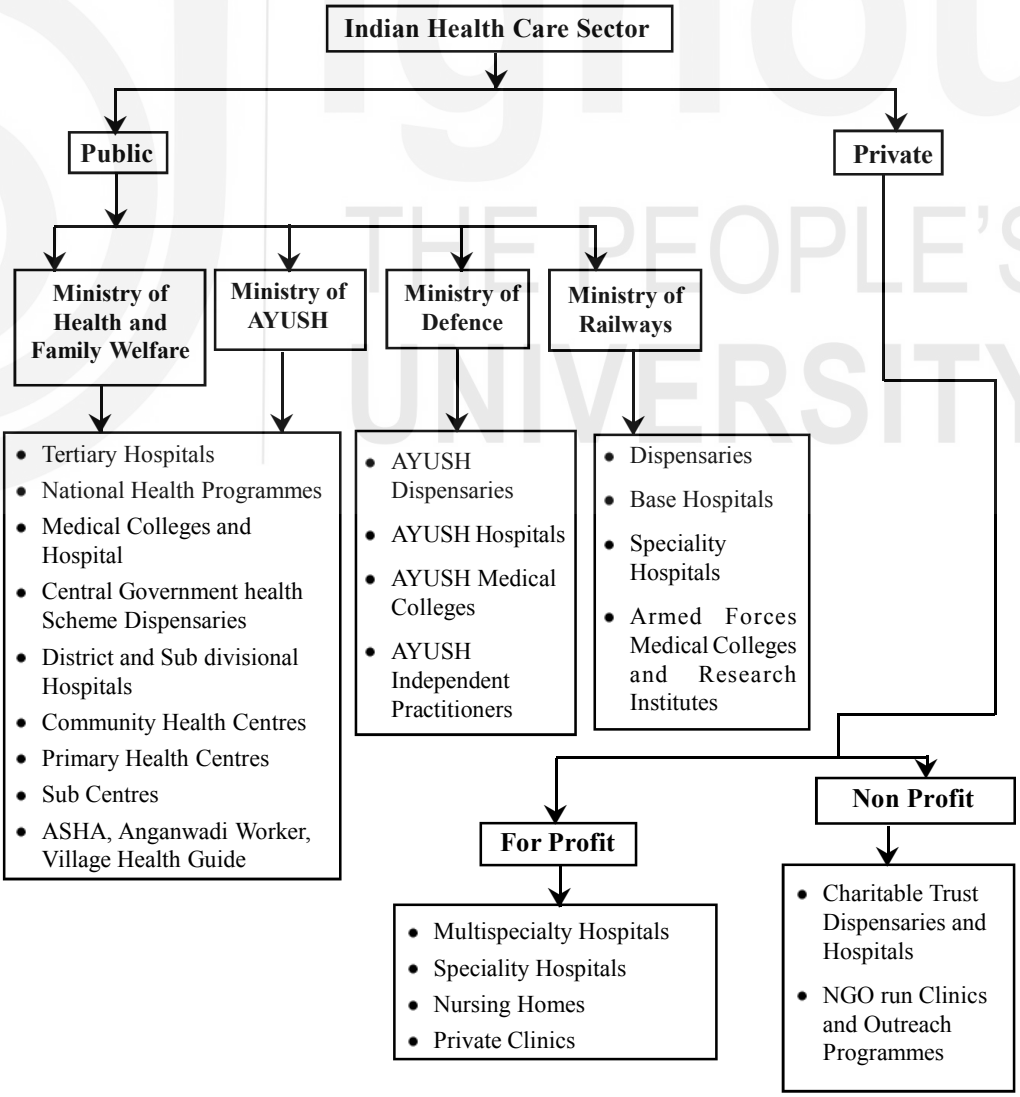


Fig. 7.1: The Indian Health Care Sector (Swedish Agency for Growth Policy Analysis (2014). India's Health Care System. Overview and Quality Improvements. Direct Response Report, pp.13).

7.3 NATIONAL HEALTH PROGRAMMES IN INDIA

The federal (central) government has undertaken several measures to improve the health of the people. Prominent among these measures are the National Health Programmes. Various international agencies like WHO, UNICEF, UNFPA etc., are also providing technical-material assistance in the implementation of these programmes. India, since independence has formulated and implemented couple of National Health Programmes and these programmes have helped the country to improve health status tremendously.

National Programmes has the following features in common:

- Targeting one disease — usually national health programme is shaped targeting one disease. For example, National Malaria Programme focused specifically malaria.
- Vertical in nature — i.e. each national programme has separate work force, fund allocation and research institutes etc., and the programme is usually not integrated with general health system. However, under the aegis of National Health Mission (NHM) almost all the national programmes are integrated with the general national health services.
- The impact of National health Programmes is constantly monitored through surveillance mechanism. This is to check the impact on the disease burden.
- They focus both preventive and curative aspects. Programme will have both curative and preventive elements integrated into the system.

In the following section, we will briefly discuss some of the important National health Programmes.

7.3.1 National Vector Borne Disease Control Programme (NVBDCP)

The NVBDCP is implemented in the States/ UTs for prevention and control of vector borne diseases namely malaria, filariasis, Kala-Azar, Japanese Encephalitis (JE), Chikungunya and Dengue. The Directorate of NVBDCP is the nodal agency to implement the programme. Now the programme is integrated with the National Health Mission (NHM). Under NVBDCP there are three strategies: a) Disease management including early case detection, complete treatment, strengthen the referral services and preparedness; b) integrated vector management; c) supportive interventions like behaviour change communication and capacity building.

National Malaria Control Programme was launched in 1953. In 1958, aim was to eradicate malaria. But in 1970s there was resurgence of malaria, and in 1999 the programme was renamed as National Anti Malaria Programme and in 2002 this national programme was integrated to NVBDCP.

National Filaria Control programme has been in operation since 1955. In India, in 1978 the operational component of this programme was merged with the Urban Malaria Scheme.

Kala-Azar which is now endemic to 31 districts of the country especially in West Bengal, Bihar and Uttar Pradesh received special attention, when a centrally sponsored scheme was launched in 1990-91. World Health Organisation is also supporting this programme by providing drugs free of cost.

Japanese Encephalitis (JE) is a disease with high mortality rate and those who survive do so with various degrees of neurological complications. JE vaccination is recommended for children between 1 to 15 years of ages.

Dengue in 1996 onwards often outbreaks of dengue are reported from across the states. Strategies used to combat this disease include identification and control of outbreak, demarcation of affected area, case management, vector control and Information Education Communication (IEC) activities.

Chikungunya is a debilitating nonfatal viral illness, remerging in the country after a gap of three decades. The diagnostic kits are developed and provided by the Institute of Virology, Pune. Vector control and IEC are the other strategies used.

All the above mentioned six diseases are vector borne and are integrated into NVBDCP, which stands presently implemented through the National health Services under National Health Mission (NHM).

7.3.2 National Leprosy Eradication Programme

The programme to combat leprosy was initially launched in 1955 and strategy was early detection of cases. By 1980 Central Government resolves to eradicate leprosy by the year 2000. In 1983, the programme was renamed as National Leprosy Eradication Programme and since 1993, the World Bank is supporting the programme. Decentralised, integrated leprosy services through general health care system, capacity building, use of IEC, medical rehabilitation are the components of the programme.

7.3.3 Revised National Tuberculosis Control Programme (RNTCP)

National Tuberculosis Programme (NTP) has been in operation since 1962. However, treatment success rates were unacceptably low, and death and default rates remained high. In 1993, the programme was renamed as the Revised National Tuberculosis Control programme and the strategy adopted DOTS (Directly Observed Treatment Short-Course) strategy. DOTS strategy ensured higher treatment completion rates. The organisation structure included state level offices, District Tuberculosis Centres, DOTS providers and microscopy centres.

7.3.4 National AIDS Control Programme

National AIDS Control programme was launched in India in the year 1987, immediately after the detection of the first case in 1986 in Chennai. National AIDS Control organisation (NACO) was set up as a separate organisation to plan, implement, and monitor and modify the components of the programme. At the state level, state AIDS control societies are established to implement the programme. The national strategy has the following components: a) establishment of surveillance centres to cover the whole country; b) identification of high risk

group and their screening; c) issuing specific guidelines for blood banks; d) IEC through mass media. Preventive, curative and rehabilitative services are provided. ICTC (Integrated Counselling and Testing Centres) and ART centres (Anti Retro Viral Therapy) are established integrated with general health services of the country.

7.3.5 Universal Immunization Programme

With the support of World Health Organisation (WHO) Indian Government launched expanded the programme on immunisation in 1974, against, six most common, preventable childhood diseases, viz. Diphtheria, whooping cough, tetanus, polio, tuberculosis and measles. Now UNICEF is also supporting the programme. Apart from this JE, rotavirus, Measles –Rubella, Chikenpox vaccinations is also available on optional-payment basis. Now, Universal Immunisation Programme is integrated with the general health system under the aegis of National health Mission and at Primary Health Centre level special emphasis is provided to achieve the universal coverage.

7.3.6 National Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (NPCDCS)

Cardiovascular diseases and other non–communicable diseases are surpassing the burden of communicable diseases in India. Considering this epidemiological risk, this programme was launched. The programme focuses on the health promotion, capacity building including human resource management and development, early diagnosis and management of these diseases with integration with the primary health care system. The programme is integrated with the general health services and is implemented through Primary Health Centres and Community Health Centres. Non-communicable disease clinics are established at Primary Health Centre and Community Health Centres. At district level, the work force is trained and deployed.

7.3.7 National Mental Health Programme

National Mental Health Programme was launched in 1982 with a view to ensure availability of mental health care services for all, especially for the risk groups and unprivileged section of the population. The aim of national mental health programme are: a) prevention and treatment of mental and neurological disorders and their associated disabilities; b) use of mental health technology to improve general services; c) application of mental health principles in total national development to improve the quality of life; d) streamlining / modernising mental hospitals; e) upgrading psychiatric department research and development.

7.3.8 Reproductive, Maternal, Neonatal, Child Health and Adolescents Programme (RMNCH+A)

This is the strategy based on a continuum of care approach and defines integrated packages of services for different stages of life. It aims to provide services from neo-natal stage to child, adolescent group to reproductive — maternal stages in a woman's life. Essential obstetric care, promoting anti-natal checkups, essential newborn care, family planning services and choices, HIV/AIDS, Sexually

transmitted Diseases (STD) support, immunisation, disease control among newborn and children, iron –calcium nutritional supply, supplementary nutrition to the lactating mothers, registration of all pregnancies, child birth and mortalities, adolescent health care etc., are the major components of this programme. Reproductive and Child Health Programme was launched in 1990s and had different phases before it is revamped and relaunched as RMNCH+A in 2013.

7.3.9 National Health Mission (NHM)

The Ministry of Health and Family Welfare is implementing various schemes and programmes to provide universal access to health care for its citizens. As a part of the plan to increase the efficiency of health care system, many programmes have been brought together under the overall umbrella of National Health Mission with National Rural Health Mission (NRHM) and National urban Health Mission (NUHM) as its two sub-mission. The NHM was approved in 2013. The main programmatic components include: a) health system strengthening in rural and urban areas; b) Reproductive-maternal-New Born-Child and Adolescent Health (RMNCH+A); c) control of communicable and non-communicable diseases.

7.4 ROLE OF NON-GOVERNMENTAL ORGANISATIONS IN HEALTH SECTOR OF INDIA

Apart from the federal (central) and state governments, there are other stakeholders who are working in improving the health status of people. Non-Governmental Organisations play an important role in reaching out to the most underprivileged sections of the society. NGOs have long history of active involvement in the promotion of human well-being. In particular, NGOs provide important links between the community and government. They possess certain strengths and characteristics that enable them to function as effective and dynamic agents in this process. Their programmes ranging from research to community-based-projects cover the wide spectrum of human concerns and often pioneer in the fields of health and developments.

7.4.1 Understanding of NGOs

Non-Governmental organisations are called by various names across the world, such as third sector organisations, non-profit organisation, voluntary organisation, charitable organisation and community-based organisation. In India, they are often called as not-for-profit institutions and officially defined as an organisation that are – a) not-for-profit and ; b) by law or custom do not distribute any surplus they may generate to those who own or control them; c) are institutionally separate from the government; d) are self governing; e) are non-compulsory in nature.

Check Your Progress

3) NGOs play an important role in providing health care to the poor. Comment.

.....

.....

NGOs generate funds from foreign funds, government grants, corporate social responsibility funds, NGOs own fund generating resources and other philanthropic/ individual charitable donations. Though the nature and focus of activities has changed over the time, NGOs have gained prominence in the wide spectrum of social life including health care. The World Health Organisation has acknowledged NGOs in terms of increasing recognition to complement government programmes and creating effective people's voice in respect of health service requirements and expectations.

7.4.2 Functions of NGOs in the Health System

The primary focus of NGOs in the health sector can be listed as follows:

- Establishing health care institutions;
- Fulfilling health and social needs of groups like women, elderly and vulnerable local communities;
- Dealing with specific health issues such as AIDS, alcoholism;
- Promoting Health Rights;
- Performing preventive health programmes; and
- Managing health finance/ funding and administration.

Some NGOs operate internationally and are concerned with global health issues. Some NGOs in India also play an important role in providing health care at the time of emergencies/ natural disasters.

7.4.3 The Health Activities of NGOs in India

NGO run hospitals are heterogeneous and vary in terms of ownership, financing and costs. In recent past, in about ten health–oriented projects of Ministry of Health and Family Welfare, NGOs have actively taken part as health service providers. All these NGO schemes are now under the provision of flexi pools of National Health Mission. Besides, some NGOs (especially the national counter parts of International NGOs) have their own health financing schemes.

In India, majority of these NGOs are covered under the Societies Registration Act or Indian Trusts Act. In addition, there are number of informal associations working at grassroots level without being registered in the legal level. The study by das and Kumar (PHFI, 2016) shows that one per hundred organisation primarily or subsidiarity is involved in health activities has a hospital. An overwhelming number of NGOs about 84% are found in outreach activities. The outreach activities are the main health activity in which generating awareness to targeted population is the major subcomponent of outreach for Indian NGOS.

Preventive care is the most common activity provided by the NGO sector in India. In most states, other than Kerala and Manipur maximum funds are directed towards preventive care. In Kerala maximum funds are spent for curative care with preventive care being the second highest. In Manipur, health system supportive services in terms of management and finance dominate other expenses.

Expenses for rehabilitative care are not significant except in few states like Karnataka.

According to Monica Das Gupta (PHFI, 2016) the health activities of NGOs in India can be broadly classified into nine groups as follows:

- Medical education
- Hospital services
- Rehabilitative clinics
- Outpatient clinics
- Ancillary services like lab and X Ray
- Nonclinical medical support like health system management
- Health insurance for targeted population
- Out-reach activities for preventive care
- Engagement in medical research

7.4.4 NGOs and Health Sector: Future

In a position paper by World Federation of Public Health Associations (2015) opined that the following are the areas in which NGOs can efficiently contribute to India's health care sector:

- At all stages, in the development of primary health care programmes NGOs can be more effective.
- NGOs can work for greater understanding and positive attitudes towards primary health care.
- NGOs can assist national policy formation in the areas of health care and integrate human development.
- NGOs can contribute to primary health care in many ways as follows by providing assistance to develop strengthen local capabilities; by further extending their capacity to work with poor, disadvantage and remote located population.

7.5 PROBLEMS, ACHIEVEMENTS AND PROSPECTS OF INDIAN HEALTH SYSTEM

Since independence, in the last seventy years India's health care system has developed at an impressive rate. We have large network of integrated primary-secondary-tertiary level services where both public and private providers co-exist. India's overall achievements regarding longevity and other key indicators are impressive but it is uneven across various states. For example, in Kerala Maternal Mortality Rate is 64 whereas national average is 165 and in states like Uttar Pradesh, it is still above 200 (NFHS IV data, 2015).

In the past seven decades, life expectancy has increased from 45 years to 68 years (2011 census). Infant mortality rate has come down from 230 during independence to below 40 in 2017. Crude birth rates have dropped to 26.1 and death rates to 8.7. India also successfully managed the population problem by effectively implementing the Family Planning Programme since 1950s. Reduction in IMR, under five mortality rates during the last seven decades is impressive.

Maternal Mortality Ratio reduced from 560 per 100,000 to 230 (Census 2011). This was achieved because of a cluster of services (anti-natal care, vaccinations, control of childhood diarrhoea and effective nutritional supply through anganwadi). India has also developed an impressive workforce and infrastructure in both public and private sector for health care. Further, diseases like smallpox stands eradicated, while other diseases like polio is near the elimination stage. Diseases like cholera, leprosy has reduced drastically. Disease burden of infectious diseases like tuberculosis, malaria etc., has marked reduction, whereas non-communicable diseases like cancer, hypertension, cardiovascular diseases, obesity etc., are rising. India is facing the epidemiological transition where the burden of communicable diseases is showing reduction whereas burden of non-communicable diseases is increasing. Recently, new diseases like Nipah, Zika etc., are also reported from India which is new public health threats for our country.

However, there are some limitations and challenges that the health care system of our country is facing. Some are listed below:

According to Monica Das Gupta (2016) it has long been accepted that the most effective approaches to improving population's health care are those that prevent rather than treat a disease. However, in India, public health policies and programmes have focused largely on the provision of curative care and personal prophylactic interventions such as immunisations; while other social determinants of health (like food, water, and sanitation) remains relatively neglected. This helps explain why India's health indicators are so much poorer than many other countries in East Asia.

The following are the reasons for the withering away of public health services in India (Das, 2016).

- Neglect of public health regulations and their implementation. Public Health Acts which constitute the legislative framework for public health provisions have not been updated and rationalised since the colonial era.
- Diversion of funds from public health services and general reduction of funds allotted to the public sector in health care.
- Organisational changes inimical to maintaining public health. The central government is the key actor in designing health policies and programmes because state budgets are highly constrained. However, the central government focuses on planning specific programmes. Therefore, the bulk of the funds allotted by the central government are tied to specific programme and the states are not free to reallocate the funds to the public health issues specific to the local priority.
- There is also inadequate inter-sectoral coordination. For example, health department has limited resources if the irrigation department generates malaria by leaving a canal half-finished and waterlogged.

The difference between rural and urban indicators of health status and the wide inter-state disparity in the health status needs further attention. The infrastructure and manpower developed is based completely on biomedicine (allopathy) and other AYUSH systems are not properly integrated to our health system. In fact, rural and tribal folk has more confidence and faith in AYUSH medical systems,

but this is not properly capitalised and the outlay for AYUSH streams was always negligible.

However, many encouraging trends are observed in the country's health system. There are many reasons to be hopeful that public health may receive more attention soon. Finance is available through large programmes; for example, National health Mission, Swach Bharat Mission etc., have huge fund allotments. Institutions are also being built at the local and national levels, which can play powerful roles in public health. For example, The Panchayathi Raj Act places emphasis on building local government and devolving health activities to them. Further recognising the importance of AYUSH a new ministry is established to promote the R& D and utilisation of these Indigenous Medical Systems.

Check Your Progress

4) Examine the challenges and prospects of Indian Health Care system.

.....

.....

.....

.....

.....

7.6 SUMMARY

Nearly 400 million people in India live on less than 1.25$ (PPP) per day and 44 per cent of all children are malnourished. Infant Mortality rate and Maternal Mortality Rate still unacceptably high despite earnest efforts by the government. There is a rise in infectious diseases as well as in non-infectious diseases. At the same time India's public spending on health is extremely low. In 2009, it amounted to just 1.1 per cent of GDP and National health Policy 2017 directs the State to gradually increase it up to 2.5 per cent of GDP by 2015. With a shrinking public health system, people have become dependent on private health care providers who currently handle 75 percent of outpatients. A country that aspires to be a developed one needs further strengthening of public health care and closer monitoring and regulation of private health care.

7.7 REFERENCES

Das Gupta, M. (2016). *Public Health in India: An overview*. Working Paper Series 3787. World Health Organisation.

Das, N. (2016). Role of Non-Governmental Organisations of India. Technical Report. US AID India & Public Health Federation India, Delhi.

Frieden, T. R. (2014). Six components necessary for effective public health program implementation. *American Journal of Public Health*, *104*(1), 17-22.

Park, J. E. & Park, K. (2015). *Textbook of Preventive and Social Medicine.* 23rd Edition. Jabalpur: Bhanot Publishers.

Srinivisan, R. (2006). *Healthcare in India*: Vision 2020, Issues and Prospects. New Delhi: Planning Commission.

Swedish Agency for Growth Policy Analysis (2014). *India's Health Care System. Overview and Quality Improvements*. Direct Response Report.

World Federation of Public Health Associations (1978). Non-Governmental Organisations and Primary Health Care. Position Paper Passed by the WFPHA General Assembly.

7.8 ANSWERS/HINTS TO CHECK YOUR PROGRESS

1) Under the Indian Constitution, health is a state subject. Each state therefore has its own health care delivery system in which both public and private actors operate. For details refer section 7.0.

2) According to Srinivasan (2006) four criteria are important to consider/ evaluate a health care system as *Just and Efficient.* (a) Universal access (b) Fair distribution of financial costs (c) Training (d) Special attention to the vulnerable groups. For details refer sub-section 7.1.4.

3) Non-Governmental Organisations play an important role in reaching out to the most underprivileged sections of the society. NGOs have long history of active involvement in the promotion of human well-being. For details refer section 7.4.

4) In India, public health policies and programmes have focused largely on the provision of curative care and personal prophylactic interventions such as immunisations; while other social determinants of health (like food, water, and sanitation) remains relatively neglected. For details refer section 7.5

ignou
THE PEOPLE'S
UNIVERSITY