Health is described and explained in various discourses that are socially constructed. The concept of ‘health,’ ‘mind’ and ‘body’ vary across time and place, but for all cultures they play a fundamental role in the experience of being human.

The word ‘Health’ is derived from Old High German & Anglo-Saxon words meaning ‘whole’, ‘hale’ and ‘holy’. Historically and culturally there are strong associations with concepts such as wholeness, holiness, goodness, hygiene, cleanliness, sanitarians, saintliness and godliness. There are equal strong associations between the concept of disease, disorder, disintegration, unsanitariness, insanity, badness, evil, evil spirits and satan. An emphasis on health as wholeness and naturalness was present in ancient China and classical Greece where health was seen as a state of ‘harmony’, ‘balance’ and ‘equilibrium’ with nature. These beliefs are found in many healing systems to the present day.

Galen (BC 200 – 129), the early Greek physician, followed the Hippocratic tradition in believing that hygiea (health) or euexia (soundness) occur when there is a balance between the not, cold, dry and wet components of the body. The four bodily humours were believed to be blood, phlegm, yellow bile and black bile that were hot and wet, cold and wet, hot and dry and cold and dry, respectively. Diseases were thought to be caused by external ‘pathogens’ that disturb the balance of the body’s four elements: hot, cold, dry and wet. Galen believed that body’s ‘constitution’, ‘temperament’ or ‘state’ could be put out in equilibrium by excessive heat, cold, dryness or wetness. Such imbalances might be caused by fatigue, insomnia, distress, anxiety or by the residues of food resulting from the wrong quality or quantity.

'Health' is one of such terms which most people find it difficult to define though they understand what it means. Defining health does not merely serve a nominal need of health analysis but has operational relevance for health practice. Social causes of illness are different from social origins of health because the latter determine our perceptions of health. Medical sociology takes a wider view of health by studying it in the light of values and social structure. Accordingly, such definition of health has differed across
cultures and over time. The distinguishing feature of these definitions and concepts is that they are all empirical, based on field knowledge about society’s beliefs and customs. In the empirical conception of health, there is nothing like a universal or absolute definition of health. Changing concepts of health are fundamentally associated with changing modes of health care delivery which include among other things the changing methods of treatment (Kulkarni, 1992). For example, a poor man’s concept of health will be narrower than that of a rich man; the one will give a negative definition of health while the other will go beyond negative conception to include positive aspects of health care. The wide ranging but also interacting conceptions of health are encapsulated in the following words: “Health and illness are conceived differently in different societies and in different historical periods depending on the prevailing healthiness of the population, its longevity, the effectiveness and availability of treatments, the social situations of individuals within the society and the dominant theories, epistemologies, or cosmologies of the society” (Park, 2002)

There are some negative aspects of health, which have been captured by some scholars. According to them, health is considered as an absence of disease or illness, and also as an area of sickness or suffering. Nevertheless, each of these aspects carries different conceptions. If medical conception of "health as absence of disease" relates to organic level of experience, identifying pathological abnormality in terms of sickness, a medical and psycho-social conception of "health as absence of illness", on the other hand relates to personal experience of pain and discomfort where one feels illness without having a disease. Similarly a conception of "health as absence of sickness" relates to a status requiring two fold professional attentions, namely exemption from normal social responsibilities and need for non-volitional attention for getting well. Further, the conception of "health as absence of suffering" is related to the growth of hospitalization with a purpose of reducing suffering.

A normative definition that "Health is optimum capacity to perform life roles" constitutes adequacy relative to capacities, feeling and biological functioning needed for performing life tasks. Functional fitness, which is the standard of positive health, is related to such capacity. Identification of health as status is a value-free approach to use
statistical norms for fixing the health of the individual. At present, there are no agreed
norms, i.e. the index of health status is sometimes social, sometimes non-social,
sometimes biological and medical indices are preferred. The definition is, however,
closely related to functional fitness. Health status can be normative as well as positive.

A state of perfect health is one which people strive for but do not expect to attain.
The ideal state is the absolute state; it is static and in some sense negative. Critics have
suggested that health should be viewed holistically i.e. as a state of functional fitness
comprising the negative as well as the positive aspects. The widely accepted definition of
health is that given by the WHO in the preamble to its Constitution, which reads as
follows: "Health is a state of complete physical, mental and social well being and not
merely an absence of disease or infirmity" (WHO, 1986). In recent years, this statement
has been amplified to include the ability to lead a 'socially and economically productive
life'. Through this definition, WHO has helped to move health thinking beyond a limited,
biochemical and pathology-based perspective to the more positive domain of "well being".
Also, by explicitly including the mental and social dimensions of well being, WHO has
radically expanded the scope of health, and by extension, the roles and responsibilities of
health professionals and their relationship to the larger society (Mann & Gastin, 1994).
On the other hand, the WHO definition of health has been criticized as being too broad.
Some argue that health cannot be defined as a "state" at all, but must be seen as a process
of continuous adjustment to the changing demands of living and of the changing
meanings we give to life. It is a dynamic concept. It helps people live well, work well and
enjoy themselves. The WHO definition of health is, therefore, considered by many as an
'idealistic' goal than a realistic proposition. It refers to a situation that may exist in some
individuals but not in everyone all the time; it is not usually observed in groups of human
beings and in communities (WHO 1981). The WHO definition of health is not an
operational definition, i.e. it does not lend itself to direct measurement. Studies of
epidemiology of health have been hampered because of our inability to measure health
and well being directly. In this connection an operational definition has been devised by a
WHO study group (Park, 2002)
In this definition, the concept of health is viewed as being of two orders. In a broad sense, health can be seen as "a condition of quality of the human organism expressing the adequate functioning of the organism in given conditions, genetic or environmental". In a narrow sense health means: (a) no obvious evidence of disease, and that a person is functioning normally, i.e. conforming within normal limits of variation to the standards of health criteria generally accepted for one's age sex, community, and geographic region and (b) the several organs of the body functioning adequately in themselves and in relation to one another, which implies a kind of equilibrium or homeostasis - a condition relatively stable but which may vary as human beings adapt to internal or external stimuli (Park, 2002).

Therefore the WHO's definition of health can be amended taking account of missing elements that is: "health is a state of well-being with physical, cultural, psychosocial, economic and spiritual attributes not simply the absence of disease.

Approaches to health

In most of the countries around the globe, health is understood using either the Western evidence-based medical approach or traditional indigenous approaches. In traditional systems, wide ranges of practitioners provide help. For example, in Sub-Saharan Africa, there are four types of traditional healers who provide health care: traditional birth attendants (TBAs); faith healers; diviners and spiritualists and herbalists. The TBAs focus on pregnancy-related problems and offer treatment to women. Faith healers, mostly men, use religious scriptures, prayers, and holy water in their treatment approach. Diviners, mostly women, seriously ill themselves prior to becoming healers, specialize in diagnosing illness through divination. They act as mediums between people and their ancestors and Gods. Spiritualists use supernatural forces in diagnosis and treatment. Herbalists, mostly men, apply herbal medicines in their healing approach. Even in the United States, health beliefs and health behaviors vary among cultural groups. The majority of the population of the United States is of European origin, with the largest ancestral roots being traceable to Germany (15%), Ireland (11%), the United
Kingdom (9%), and Italy (6%). Major racial and national minority groups include Hispanics, African American (either of U, S., African, or Caribbean parentage), Chinese, Filipinos, and Japanese (U.S. Census Bureau, 2004). According to the 2000 Census, it was estimated that European Americans comprised 75.1 percent of the population; Hispanics, 12.5 percent; African Americans, 12.3 percent; Asian and Pacific Islands, 3.7 percent; and Native Americans (American Indians, Eskimos, and Aleuts), 0.9 percent. Italian Americans in New York may have different traditional ways of approaching illness than do Polish Americans in Milwaukee. Women in New Mexico and men in Chicago may have the same physical problem, but their doctors must take into account the existing differences in their patients' social systems (differences in culture, beliefs, family structure, and economic class) and their patients' expectations of health care and health care workers to cure them.

These different approaches can explain variances in health behaviours. Remember that an effective health psychologist has to be ready to deal with the diversity of people and their beliefs. To help a person stay healthy and recover when sick, you must understand what his or her specific understanding of health and sickness is. Once you understand, you can use variations on the basic tools and theories to intervene and help. This section describes some of America's diverse ethnic and religious beliefs as they relate to health, focusing on contemporary views of the Chinese Taoist and East Indian Ayurvedic approaches to health, Latino fold medicine (curanderismo), and American Indian spiritualism.

Different cultures have different definitions of health. Each culture evolves with a unique understanding of the creation of human beings and our purpose in life. According to archaeological evidence, our ancestors probably believed that our bodies worked because of magic. Potions, rings, charms, and bracelets were devised to rid the body of the harmful demons and spirits that brought illness and suffering. Some of these ancient beliefs often find their way into popular literature and underlie our enchantment with heady fare such as the Lord of the Ring trilogy, the Chronicles of Narnia, and even the light and fanciful Harry Potter series. A person's eyes in particular were believed to be the sites of power and magic, whereas animal eyes routinely were used in a range of treatments.
Globally, health beliefs and practices are closed tied to religion and nationality, which are components of culture not given much attention in Western medicine. In predominantly Hindu countries such as India, for example, modern medical practitioners are complemented by traditional healers who offer treatment for physical and mental illness in rural villages. There are three types of these healers: Vaids, who are healers practicing indigenous systems of medicine; Mantarwadis, who are healers using astrology and charms for cure; and Patris, who are healers acting as mediums for spirits and demons. The Vaids practice Ayurveda – the traditional Indian medications. These Vaids believe that the illness is caused by “an imbalance between the natural elements” brought forth by environmental factors, certain diets, uninhibited sexual indulgence, and the influence of demons. These factors cause “excess heat, cold, bile, wind, or fluid secretions” leading to the development of physical and mental illness. In Muslim countries such as Pakistan, traditional healers sorcery.

The most common approach to medicine, Western biomedicine, is derived from the work of Greek physicians, such as Hippocrates and Galen. Western biomedicine is the practice of medicine that most Americans support. American medical schools, hospitals, and emergency rooms all use this Western approach. Egocentrically, most Americans refer to any other approach to health and wellness as complementary and alternative medicine. Chinese acupuncture is perhaps the most commonly known “alternative” medicine, but millions of Americans also practice other means to improve their health (e.g., the use of herbal supplements).

Western biomedicine, also referred to as modern medicine, conventional medicine, or allopathy, Western biomedicine is one of the most dominant forms of health care in the world today. Hallmarks of this approach are an increasing reliance on technology and the use of complex scientific procedures for the diagnosis and treatment of illness. Treatments using this approach are designed to cause the opposite effect as that created by the disease. If you have a fever, you are prescribed medication to reduce the temperature. Western biomedicine views the body as a biochemical machine with distinct parts. Often called reductionist, Western biomedicine searches for the single smallest unit responsible for the illness. Western doctors try to localize the cause of an illness to the parts directly surrounding the original point of the problem.
GREEK ROOTS

Western biomedicine often claims the fourth-century B.C. Greek, Hippocrates, as its “father”, primarily because he was the first to separate medicine from religion and myth and to bring scientific and analytical reasoning to health care. There were physicians before Hippocrates. In the third millennium B.C., physicians in ancient Mesopotamia (modern Iraq) developed an official medical system based on a diagnostic framework that derived from sources as varied as omens and divination techniques and the inspection of livers of sacrificed animals. Treatments were coordinated by a lead physician and combined religious rites and empirical treatments such as the use of drugs and practice of surgery. Similarly, in Egypt, the Pharaohs also had a line of physicians. There was Iri, Keeper of the Royal Rectum (the Pharaoh’s enema expert), and the most famous, Imhotep, chief physician to the Pharaoh Zozer, both of whom used large amounts of religious rituals to aid their curing. Essentially, secular medicine only appeared in the Greek-speaking world as practiced by the fifth-century B.C. Hippocratic doctors.

A few centuries later, Galen, the “emperor” of medicine under the Roman Empire, and much later the Italian artist Leonardo da Vinci (in the fifteenth to sixteenth centuries) and the Flemish physician Andreas Vesalius (sixteenth-century), greatly advanced Western biomedicine with their studies of human anatomy. William Harvey, an English physician, first described the circulation of blood and the functioning of the heart in 1628. Biomedicine had its first major boost with the discovery of the high-power microscope. The Dutch naturalist Antonius van Leeuwenhoek ground lenses to magnify objects 300 times. Compare this magnification to that of the electron microscope, invented in 1932, which magnifies specimens to a power of 5 million.

TECHNOLOGICAL INNOVATIONS

Western biomedicine has strong ties to technology. Once the microscope became widely used, blood, saliva, and other bodily fluids were closely examined, leading to a
better understanding of the structures and functions of a wide variety of cells. Louis Pasteur really took the next big leap for medicine. As one of the most significant events in the nineteenth century, Pasteur proved that viruses and bacteria could cause disease. In 1878, Pasteur presented his germ theory to the French Academy of Medicine. Just a few years later in 1885, the German scientist Wilhelm Roentgen discovered X-rays.

This technological advance enabled doctors to look into the body to see what was causing illnesses or problems and together with the microscope took the diagnosis of illness to new heights. More advances in the twentieth century, such as magnetic resonance imaging (MRI) and computerized axial tomography (CAT) scans, led to closer examinations of the body and bodily functions, especially the brain. Technology, by introducing the study of the cellular level, fueled the drive of Western medicine to find the answers to the causes of illnesses and death.

Cures and treatment, especially modern pharmacology, developed to attack ailments in the body. Medicines, using a biomedical approach can be defined as essentially concentrated purified chemical substances that target a particular aspect of the disease process. The chemical composition of some drugs (e.g., opioids) mirrors that of naturally occurring substances (e.g., opiates). For example, morphine, an opioid that was first extracted in 1805, is identical to chemicals produced by opiates in our body. as there are receptors that accept morphine in our brains. Other milestones in the development of drugs include the discovery of antibacterial sulfonamides in 1935 and the production of antibiotics such as penicillin in the 1940s (although it was first discovered in 1928). Many thousands of different drugs are available today for nearly every ache, pain, or irritation you may have.

TRADITIONAL CHINESE MEDICINE

Traditional Chinese Medicine (TCM) is probably used to treat more people than any other form of medicine (largely because China is the most populated country in the world). However, even in North America, there are a large number of TCM schools and
practitioners. In fact, acupuncture, one form of TCM, is covered by most health insurance policies.

In TCM, the body is treated as a whole. Each part of the body is intrinsically connected to other parts of the body and to what is happening around the person. Critical elements of a healthy life include a person's food choices, relationships, and emotional life. In TCM, everyone is a part of a larger creation and lives and flourishes in unison with it. In stark contrast to reductionist Western biomedicine that focuses on a cellular microscopic level of diagnosis, TCM in macroscopic. In TCM, humankind is viewed in relation to nature and the physical laws that govern it. Some interesting paradoxes are seen when we compare Western medicine with TCM. Although TCM does not have the concept of a nervous system nor does it recognize the endocrine system, TCM still treats problems the West cells endocrine and neurological disorders. TCM also uses terminology that may appear bizarre to a Westerner. For example, diseases are thought to be caused by imbalances in yin and yang or by too much “heat” or “wind”.

Two main systems categorize the forces identified in TCM that influence health and well-being; yin and yang and the five phases. According to one Chinese philosophy, all life and the entire universe originated from a single unified source called Tao (pronounced “dow”, like the stock market index Dow Jones). The main ideas about the Tao are encompassed in a 5,000-word poem called the Tao Te Ching written about 2,500 years ago that describes a way of life from the reign of the “Yellow Emperor” Haung Ti. In fact, Chinese medicine is based on the Yellow Emperor's Classic of Internal Medicine (approximately 100 B.C.). The Tao is in integrated and undifferentiated whole with two opposing forces – the yin and the yang – that combine to create everything in the universe.

Yin and yang are mutually interdependent, constantly interactive, and potentially interchangeable forces. As you can see in figure each yin and yang contains the seed of the other (the little dot in the center of each comma shaped component). The circle represents the supreme source, or Tao. Yin translates to “shady side of a hill” whereas yang translates to “sunny side of hill”. Yin is traditionally thought of as light, the sun, hot, and male. In TCM, 10 vital organs are divided into five pairs, each consisting of one “solid” yin organ and one “hollow” yang organ. TCM practitioners believe that the yin
organs -- the heart, liver, pancreas, kidney, and lungs -- are more vital than the yang organs, and dysfunctions of yin organs cause the greatest health problems. The paired yang organs are the gallbladder, small intestine, large intestine, large intestine, and bladder. A healthy individual has a balanced amount of yin and yang. If a person is sick, his or her forces are out of balance. Specific symptoms relate to an excess of either yin or yang. For example, if you are flushed, have a fever, are constipated, and have high blood pressure, you have too much yang.

The five phases or elemental activities refer to specific active forces and illustrate the intricate associations that the ancient Chinese saw between human beings and nature. Energy, or qi (pronounced "chee"), another critical aspect of TCM, moves within the body in the same pattern as it does in nature with each season and with different foods helping to optimize energy flow within the body. The five elements of wood, fire, earth, metal, and water each link to a season of the year, a specific organ, and a specific food. Each element has specific characteristics, is generated by one of the other forces, and is suppressed by another. For example, wood generates fire that turns things to earth that forms metals. The heart is ruled by fire, the liver by wood, and the kidneys by water. Fire provides qi to the heart and then passes on qi to the earth element and correspondingly to the stomach, the spleen, and pancreas.

In TCM, optimal health consists of balancing yin and yang and optimizing the smooth flow of qi through the body by the coordination of the five elements. Qi flows through the body in 12 precise, orderly patterns called meridians. Meridians translate from the Chinese term jing-luo to mean "to go through something that connects or attaches." In Chinese meridian theory, meridian channels are unseen but embody a form of informational network. The 12 meridians are associated with organs in the body. Two additional meridians unify different systems. Blocked meridians can cause illness by bringing about hyperactivity of certain organs and underactivity of others. Without the right amount of qi, the organs, tissues, and cells no longer eliminate waste and therefore, with the accumulation of such toxins, harbor more disease. Thus, many symptoms of diseases are interpreted as the body's efforts to cure itself.

The trained TCM physician focuses on both the physiology and the psychology of the individual. Yes, this is similar to the way health psychologists function but with
different tools and underlying assumptions. All relevant information, including the symptoms and patients' general life characteristics, such as whether they are happy with their jobs and what they are eating, are all woven together into a "pattern of disharmony." Instead of asking, what is causing what? The doctor asks, what is related to what? The aim of treatment is to settle the imbalance. The TCM practitioner prescribes massage, acupuncture or acupressure, herbs, dietary changes, and exercises such as qi gong as primary treatments. Qi gong combines movement, meditation, and the regulation of breathing to enhance the flow of qi in the body to improve blood circulation and to promote immune function.

There is a growing body of research being conducted on different TCMs. Some empirical studies suggest that TCMs are no more effective than Western medicines. For example, 620 cocaine-dependent patients took part in a randomized clinical trial where one third of the participants received acupuncture. The acupuncture group did not show significant reduction in drug use. There is a larger body of work supporting TCMs, though much of the research validating TCM was done without the use of robust Western scientific methodology. Part of the problem is that testing TCMs have special challenges.

The Chinese are beginning to use better research methodologies, and research results have begun to satisfy Western doctors. For example, a Western medical examination showed patients to have peptic ulcers, and a Chinese examination of the same patients yielded a diagnosis based on the five elements previously described. Doctors treated these patients with herbs based on TCM, and the patients showed significant recovery 2 months later. Treatment of patients with heart disease provides similar success stories. Much of the research conducted on TCM in America analyze the constituents of herbs used in treatment, and many such studies show that the Qi active ingredients of the herbs facilitate cures. The growing evidence notwithstanding, it will be some time before TCM is accepted widely, but its time may be sooner than we think.
AYURVEDA : TRADITIONAL INDIAN MEDICINE

You may be more familiar with Ayurveda, or traditional Indian medicine, than you realize. This is not American Indian medicine but the approach to health that came from the Indian subcontinent. Yoga is a part of Ayurvedic practices. Many herbal supplements in use today came into prominence because of ancient Ayurvedic writings, and various health care products on the market that tout natural bases (e.g., Aveda products) have roots in Ayurveda. Many Americans practice forms of Ayurveda. Ayurveda originated more than 6,000 years ago and was considered a medicine of the masses. In fact, the basic ideology underlying Ayurveda still influences how the billion inhabitants of India today view health. Many Indian Americans even use the prescriptions of Ayurveda in daily ilk (e.g., swallowing raw garlic is good for you and chewing on cloves helps toothaches), and many European Americans are using Ayurvedic practices such as yoga and natural supplements. The first two major Ayurvedic texts, the Charaka Samhita and the Sushruta Samhita, have been dated to 1000 B.C., although Ayurvedic practices are also referred to in the Vedas (3000 to 2000 B.C.), ancient Indian texts containing the wisdom of sages and sacrificial rituals. The Charaka Samhita has 120 chapters covering diverse areas such as the general principles of Ayurveda, the causes and symptoms of disease, physiology and medical ethics, prognosis, therapy, and pharmacy.

Approximately 2,000 years ago, Charaka, an Indian sage, developed Ayurveda, a traditional Indian holistic system of medicine. Charaka described four causative factors in mental illness: a) diet (incompatible, vitiated, and unclean food); b) disrespect to Gods, elders and teachers; c) mental shock due to emotions such as excessive fear and joy; and d) faulty bodily activity. Thus, Ayurveda considers a biopsy-chosocial approach in formulating causative factors in mental disorders. Charaka, while emphasizing the need for harmony between body, mind, and soul, focused on preventive, curative, and promotive aspects of mental health. Ancient Indian court physicians further developed Ayurvedic practices and were given vast resources because the health of the king was considered equivalent to the health of the state. Ayurvedic medicine was well developed by the time of the Buddha (500 B.C.) and the rise of Buddhism. Jivaka, the royal
physician to the Buddha, was so well known that people actually became Buddhists so he could treat them. When Alexander the Great invaded India in 326 B.C., he took Ayurvedic physicians back to Greece with him – one of the first times people of the two cultures were exposed to each other. The use of Ayurveda flourished until A.D. 900 when Muslim invaders came into India and created a new form of medicine called Unani, a combination of Greek and Ayurvedic medicine with Arabic medicine. Ayurveda continued in different forms even after European forces invaded India around A.D. 1500, bringing Western medicine with them.

TCM and Ayurveda share many similarities. Ayurvedic science also uses the notion of basic elements: five great elements form the basis of the universe. Earth represents the solid state, water the liquid state, air the gaseous state, fire the power to change the state of any substance, and ether, simultaneously the source of all matter and the space in which it exists. Each of these elements can either nourish the body, balance the body serving to heal, or imbalance the body serving as a poison. Achieving the right balance of these elements in the body is critical to maintaining a healthy state. These elements also combine to form three major forces that influence physiological functions critical to healthy living. Ether and air combine to form the Vata dosha, fire and water combine to form the Pitta dosha, and water and earth elements combine to form the Kapha dosha. Vata directs nerve impulses, circulation, respiration, and elimination. Pitta is responsible for metabolism in the organ and tissue systems as well as cellular metabolism. Kapha is responsible for growth and protection. We are all made up of unique proportions of Vata, Pitta, and Kapha that cause disease when they go out of balance. These three doshas are also referred to as humors or bodily fluids and correspond to the Greek humors of phlegm (Kapha) and choler (Pitta). There is no equivalent to the Greek humor blood, nor is Vata or “wind” represented in the Greek system. Similar to the meridians in TCM, the existence of these forces is demonstrated more by inference and results of their hypothesized effects than by physical observation.

In addition to diseases caused by the imbalances of the doshas, Ayurveda identifies diseases as having six other key causes. Some diseases are recognized as being due to natural changes in the body, genetic predispositions, trauma, gods or demons, due to the season, or due to deformities present at birth.
In general, Ayurvedic practitioners believe that health is a natural state and one maintained by keeping the body clear of toxins and the mind relaxed and stress free. The accumulation of toxins can occur when we are stressed and when waste is not effectively eliminated from the body. Consequently, some of the major Ayurvedic treatments involve detoxification and effective waste removal.

The Ayurvedic physician uses different methods to diagnose a disease: first, there is a complete inspection of the patient. This involves looking for abnormalities in the body (e.g., discoloration of the skin), listening for abnormal sounds (e.g., irregular breathing), and even smelling the patient because imbalances in diet and the body are thought to result in characteristic odors (especially in the urine). The physician also uses palpitation of the body to feel for problems and often thoroughly interrogates the patient to assess for any changes in lifestyle or routine. After a diagnosis is made, a number of treatments are prescribed.

There are many forms of treatment in the Ayurvedic system of medicine, and many of them have made inroads into the Western consciousness. Some of these treatments exist on the fringe of Western biomedicine as complementary.

**CURANDERISMO AND SPIRITUALISM**

The year 2003 signaled a major change in the cultural face of the United States of America. For the first time in the history of the United States, Americans of Latino descent became the largest minority group, narrowly edging out African Americans (U.S. Census Bureau, 2003). Latinos are present in every state in the United States, with large concentrations in California, Texas and Arizona. Latinos are a very diverse group of people. There are Latinos from Mexico, Puerto Rico, Cuba, the Dominican Republic, and, of course, from Spain (as suggested by the term Hispanic). The health beliefs of this large part of the North American population correspondingly become importance to consider. We will focus on the beliefs of the largest subgroup of Latinos, Mexican Americans.

Curanderismo is the Mexican American folk healing system that often coexists side by side with Western biomedicine. Coming from the Spanish verb curar meaning “to
heal,” curanderos are full-time healers. The curandero’s office is in the community, often in the healer’s own home. There are no appointments, forms, or fees, and you pay whatever you believe the healer deserves. This form of healing relies heavily on the patient’s faith and belief systems and uses everyday herbs, fruits, eggs, and oils. In studies beginning as early as 1959, researchers first focused on “Mexican American cultural illnesses,” such as mal de ojo (sickness from admiring a baby too much). More recent work focuses on the healers themselves, their beliefs, training processes, and processes for treatment. Surveys of Mexican Americans show that even among highly assimilated Mexican Americans, traditional and indigenous practices still persist.

The Mexican American cultural framework acknowledges the existence of two sources of illness, one natural and one supernatural. When the natural and supernatural worlds exist in harmony, optimal health is achieved, Disharmony between these realms breeds illness. Beyond this supernatural balance component, the curandero’s concept of the cause of illness parallels that of Western biomedicine. Like biomedical practitioners, curanderos believe that germs and other natural factors can cause illness. However, curanderos also believe that there are supernatural causes to illness in addition to natural factors. If an evil spirit, a witch, or a sorcerer causes an illness, then only a supernatural solution will be sufficient for a cure. Illness can also be caused if a person’s energy field is weakened or disrupted. Whether diabetes, alcoholism, or cancer, if a spirit caused it, supernatural intervention is the only thing that can cure it. Although curanderos seem to give the devil his due, they often are realistic in their searches for a cause.

Unlike Western biomedicine and TCM, the practices of curanderismo are based on Judeo-Christian beliefs and customs. The Bible has influenced ices curandcrismo through references made to the specific healing properties of natural substances such as plants. Curanderos’s healing and cures are influenced by the Bible’s proclamation that belief in God can and does heal directly and that people with a gift from God can heal in his name. The concept of the soul, central to Christianity, also provides support for the existence of saints (good souls) and devils (bad souls), the bad souls can cause illness anti the good souls, harnessed by the shamanism and sorcery of the curanderismo, can cure.
In a manner akin to that of health psychologists, curanderos explicitly focus on social, psychological, and biological problems. The difference is that they add a focus on spiritual problems as well. From a social perspective, the community where the curanderos work recognizes and accepts what the cutandro is trying to achieve. The social world is important to the curanderos who evaluate the patient’s direct and extended support system. The patient’s moods and feelings are weighed together with any physical symptoms. Finally, there is always a ritual petition to God and other spiritual beings to help with the healing process.

**AMERICAN INDIAN MEDICINE**

Many elements of the American Indian belief system and the approach to health are somewhat consistent with elements of curanderismo and TCM and provide a strong contrast to Western biomedicine. American Indians comprise about 1 percent of the population of the United States today. Although approximately 500 nationals of American Indians live in the United States, the main beliefs are relatively consistent across the groups. Four practices are common to most the use of herbal remedies, the employment of ritual purification or purging, the use of symbolic rituals and ceremonies, and the involvement of healers, also referred to as medicine men, medicine women, or shamans. Native Americans have utilized and benefited from these practices for at least 10,000 years and possibly much longer.

Similar to the ancient Chinese, American Indians believed that human beings and the natural world are closely interwined. The fate of humankind and the end fate of the trees, the mountains, the sky, and the oceans are all linked. The Navajos call this “walking in beauty,” a worldview in which everything in life is connected and influences everything else. In this system, sickness is a result of things falling out of balance and of losing one’s way the path of beauty.

Spiritual rejuvenation and the achievement of a general sense of physical, emotional, and communal harmony are at the heart of American Indian medicine. Shamans coordinate American Indian medicine and inherit the ability to communicate
with spirits in much the same way that Mexican American curanderus do. Shamans spend much of their day in listening to their patients, asking about their family and their behaviors and beliefs and making connections between the patient’s life and their illness. Shamans do not treat spirits as metaphors or prayers as a way to trick a body into healing. Shamans treat spirits as real entities, respecting them as they would any other intelligent being or living person.

Ritual and ceremony play a major role in American Indian medicine. One of the most potent and frequent ceremonies is the sweat lodge.

AFRICAN AMERICAN BELIEFS

There are additional belief systems both in Northern America and around the globe like the African American culture. For many members of this cultural group, health beliefs reflect cultural roots that include elements of African healing, medicine of the Civil War South, European medical and anatomical folklore, West Indies voodoo religion, fundamentalist Christianity, and other belief systems.

African American communities have become very diverse especially with the recent arrival of people from Haiti and other Caribbean countries and Africa. Similar to the American Indians, many people of African descent also hold a strong connection to nature and rely on inyangas (traditional herbalists) even today in Africa, hospitals and modern medicines are invariably the last resort in illness. The traditional African seeks relief in the herbal lore of the ancestors and consults theinyanga, who is in charge of the physical health of the people. When bewitchment is suspected, which happens frequently among the traditional people of Africa, or there is a personal family crisis or love or financial problem, the patient is taken to a sangotna (spiritual diviner or spiritual/traditional healer), who is believed to have spiritual powers and is able to work with the ancestral spirits or spirit guides. The sangoma uses various methods such as “throwing the bones” (amathambo, also known by other names depending on the cultural group) or going into a spiritual trance to consult the ancestral spirits or spirit guides to find the diagnosis or cure for the problem, be it bewitchment, love, or another problem. Depending on the response from the higher source, a decision will be made on what herbs
and mixes (*intelezis*) should be used and in what manner (e.g., orally, burning). If more powerful medicine is needed, numerous “magical rites” can or will be performed according to rituals handed down from sangoma to sangoma. In South Africa, there are more than 70,000 sangomas or spiritual healers who dispense herbal medicines and even issue medical certificates to employees for purposes of sick leave.

**DIMENSIONS OF HEALTH:**

The concept of health is multidimensional. The WHO definition envisions three specific dimensions - the physical, the mental and the social. Many more dimensions may be added, such as spiritual, emotional, vocational and political. As the knowledge base grows, the list may be expanding. Although these dimensions function and interact with one another, each has its distinct nature.

(A) **Physical, Mental and Social Dimensions:**

83. The physical dimension of health or the state of physical health implies the notion of "perfect functioning" of the body. It conceptualizes health biologically as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. At the community level, the state of health may be assessed by such indicators as death rate, infant mortality rate and expectation of life. Ideally, each piece of information should be individually useful and when combined should permit a more complete health profile of individuals and communities (Kulkarni, 1992)

Mental health is not mere absence of mental illness. Good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently, mental health has been defined as "a state of balance between the individual and the surrounding world, a state of harmony between oneself and others, a coexistence between the realities of the self and that of other people and that of the environment" (Sartorius, 1983). There is a behavioral, psychological or biological dysfunction and that the disturbance in the mental equilibrium is not merely in the relationship between the individual and society. Although mental health is an essential component of health, the scientific foundations of mental health are not yet clear.
Therefore there are no precise tools to assess the state of mental health unlike physical health (Park, 2002).

Social well being implies harmony and integration within the individual, between each individual and other member of society and between individuals and the world in which they live. It has been defined as the "quantity and quality of an individual's interpersonal ties and the extent of involvement with the community". The social dimension of health includes the levels of social skills one possesses, social functioning and the ability to see oneself as a member of a larger society. In general, social health takes into account that every individual is part of a family and of wider community and focuses on social and economic conditions and well being of the "whole person" in the context of his social network. Social health is rooted in "positive material environment" and "positive human environment" which is concerned with the social network of the individual (Park, 2002).

(B) Spiritual Dimension

Spirituality is the most important source of strength and direction in people's lives. It is a human phenomenon, which exists in almost all persons. The term spirituality generally used to denote certain positive inward qualities and perceptions while avoiding implications of narrow, dogmatic beliefs and obligatory religious observances (Wulff, 1996). Spirituality is a unified quality of mind heart and soul. It is concerned with individual subjective experiences, sometimes shared with others.

Spirituality is complex and has many dimensions, for example, Miller and Thorensen (2000) proposed three broad measurement domains : spiritual practices, beliefs and experiences, Spirituality can be assessed in a variety of ways like clinical interview, spiritual measures in three domains viz. belief, behaviour and experience. Spiritual life means the development of self-consciousness and the cultivation of one's own inner resources through personal efforts and personal choice.

The concept of spiritual health was introduced in 1978 by WHO. It is concerned with physical, interpersonal, psychological and mental dimensions of health. Spiritual health addresses the health of the whole person. The overall goal of this approach was to
enhance health, disease being considered as an unnecessary accident resulting from loss of cultural harmony and spiritual balance. Spirituality is positively related to health and help people to achieve their wellbeing is one of the most important dimension of health.

Studies on spirituality as an important resources in rehabilitation process is emphasized by researchers, such as disability rehabilitation (Bosewek et al., 2001) and coronary patients rehabilitation. In empowering persons and making appropriate health choices, spirituality is considered as valuable internal resource.

In today's materialistic world, difficult problems are arising. It is believed that the way to obtain peace is in spiritualism. Therefore, recently people have increasingly become more inclined towards spirituality (Reiki, Meditation Prayer etc.). More and more westerns have started coming to Eastern countries and especially India to find solace because the Indian subcontinent with its philosophies of "Karma" and compassion with its affinity for "Bhakti" and "Sufi thinking" is the most fertile soil for spiritualism to foster.

(C) Vocational Dimension:

The vocational aspect of life is a new dimension. It is part of human existence. When work is fully adapted to human goals, capacities and limitations, work often plays a role in promoting both physical and mental health. Physical work is usually associated with an improvement in physical capacity, while goal achievement and self-realization in work are a source of satisfaction and enhanced self-esteem (Kulkarni, 1992).

(D) Other Dimensions:

A few other dimensions have also been suggested. *Philosophical dimension* deals with issues like the concept of health, value systems affecting health and attitude towards illness, pain, ageing or death which, in the final analysis, determine the nature and quality of the health services; *cultural dimension* deals with life-styles of people which have far reaching consequences on the practice of health; *socio-economic dimension* deals with the social, economic and political organization of the society as a whole because this totality has a tremendous impact on the health of the people which,
after all, is a sub system of the society; *environmental dimension* deals with problems like public sanitation, pollution, water supply, housing or settlement patterns, with a view to create a physical environment that is promotive of health; *nutritional dimension* deals with the fundamental issue of making adequate quantities of food of the appropriate quality available to all (ICSSR and ICMR, 1981); *educational dimension* defines the role and responsibilities of individuals and families in maintaining a healthy society and the creation of adequate institutional structure to enable them to play these roles and to discharge these responsibilities; *preventive dimension* deals with problems relating to the prevention of avoidable suffering, disease or untimely death; and, *curative dimension* deals with measures for the provision of adequate and appropriate treatment when, despite all efforts, disease or ill health does manifest itself (Kulkarni, 1992).

These dimensions symbolize a huge range of factors to which other sectors besides health must contribute if all people are indeed to attain a level of health that will permit them to lead a socially and economically productive life.

4. DETERMINANTS OF HEALTH:

Health is multifaceted. The factors, which influence health, lie both within the individual and externally in the society in which they live. Thus, before analyzing the determinants of health, it is necessary to examine the factors which influence human health. These underlying influential factors become challenge to health and ultimately become the determinants of health. It is clear that these factors become either positive or negative determinants of health status. Some of the health determinants are as follows –

(A) Biological Determinant:

Biological determinant also referred to as "inborn" factors influencing health, are largely genetic. Human genetics is becoming a predominant health matter in our society and an individual's genetic composition, a progressively more important determinant of his health. Nowadays, medical genetics offers hope for prevention and treatment of a wide spectrum of diseases, thus the prospect of better medicine and longer, healthier life. This knowledge will help people achieve better health; the individual has the opportunity
to assert greater control over his life and long lasting suffering can be reduced and sometimes avoided. The benefits and disadvantages of screening programmes for individuals, families and societies will need to be carefully assessed. These advances will only be acceptable if applied in an ethical manner. The way public opinion perceives human genetics is varied and gives rise to polemics. One understands the difficulty of the community to grasp the real significance of genetic problems, and its concern about the achievements of the Human Genome Project, which in reality does not raise any new problem but contain, and magnifies the complexity of many basic ethical legal, and social issues (WHO, 1996).

The European Convention on Human Rights and Biomedicine (http://conventions.coe.int/treaty/en/treaties/html/1164.htm), signed by 22 Member states out of a total of 40 of the CE on 4 April 1997, is the first international legal instrument that specifically prohibits any discrimination against a person on the basis of his genetic heritage and only authorizes predictive testing for genetic disease with a medical objective. The Universal Declaration on the Human Genome and Human Rights (www.lumn.edu/humanrts/instree/udhrhg.htm), adopted unanimously by the General Conference of UNESCO on 11 November 1997, strikes a balance between safeguarding respect for human dignity, freedom and HR and the need to ensure freedom of research, while emphasizing the prohibition of all forms of discrimination based on genetic characteristics. The successful cloning of an adult sheep by a team of scientists in Scotland in March 1997, although offering interesting opportunities to advance biomedical research on diagnosis and treatment of diseases affecting human beings, raised great concern the world over, because of the potential implications of cloning procedure is human reproduction. The same year, the World Health Assembly adopted by consensus resolution WHA 50.37 affirming that: "the use of cloning for the replication of human individuals is ethically unacceptable and contrary to human integrity and morality" (Pinet, 1998).

In October 1997, the "Scientific and Ethical Review Group of WHO's Special Programme of Research, Development and Research Training in Human Reproduction" was convened with representatives of UNESCO, IARC, and the CE, as there was felt a
need to develop international guidelines covering the technical and ethical issues of cloning in human health. In January 1998, 17 Member States of the CE signed an Additional Protocol to the Convention on Human Rights and Biomedicine banning cloning of human beings. Today remarkable developments in the biological disciplines and future progress will together ensure that the 'inborn' determinants of health continue to increase its importance.

(B) Behavioral Determinant:

Behavior is of importance to health, either directly through learned lifestyles or indirectly in the environmental and socio-economic context. Health requires the promotion of healthy lifestyle. In the last 20 years, a considerable evidence has accumulated which indicates that there is an association between health and lifestyle of individuals (Park, 2002).

Many current-day health problems especially in the developed countries (e.g. coronary heart disease, obesity, lung cancer, drug addiction) are associated with lifestyle changes. In developing countries such as India where traditional lifestyles still persist, risks of illness and death are connected with lack of sanitation, poor nutrition, personal hygiene, elementary human habits, customs and cultural patterns. WHO's World Health Report 1995 (WHO, 1995) corroborates these findings, stating that lifestyle-related diseases and conditions are responsible for 70-80% of deaths in developed countries and about 40% in the developing world. Even in developing countries, the situation is expected to worsen in the future with a growing number of lifestyle related diseases, attributed to the rapid emergence in the middle class of unhealthy dietary and behavioral changes. The development process brings about changes in lifestyle which increases the risk of developing those so called "diseases of modern civilization" common in industrialized countries such as cardiovascular diseases, certain type of cancer and obesity (Pinet, 1998).

All the lifestyle factors are not harmful, but there are many that can actually promote health, such as adequate nutrition, enough sleep, sufficient physical activity etc. Thus the
achievement of optimum health demands adoption of health lifestyles because health is both a consequence of an individual's lifestyle and a factor of determining it. That is why WHO has adopted some priority areas for international action. WHO's World Health Report 1997 (WHO, 1997), indicates six priority areas for international action, including: a major intensified but sustained global campaign to encourage healthy lifestyles, with emphasis on the healthy development of children and adolescents in relation to risk factors, such as diet, exercise and smoking; and the adoption of healthy public policies and their legislative support (Pinet, 1998).

(C) Environmental Determinant:

The environment is usually defined as the aggregate of all the external conditions and influences affecting the life and the development of an organism. It consists of those things to which man is exposed after conception. It is defined as "all that which is external to the individual human host". It can be divided into physical, biological and psycho-social components, any or all of which can affect the health of man and his susceptibility to illness. It is an established fact that environment has a direct impact on the physical, mental and social well being of those living in it. Some studies carried out in North America in the 1980's, aimed at calculating the respective influences on health of each main group of factors, show that right after the "lifestyle" group of factors, the environment ranks second, far ahead of the other determinants of health. Another interesting aspect is the close-relationship between these two determinants; the way that people live has a continuous effect on the physical environment. As lifestyle changes, some health hazards are controlled or eliminated, while new ones are generated. Some epidemiologists have used the term "microenvironment" (or domestic environment) to personal environment which includes the individual's way of living and lifestyle e.g. eating habits, other personal habits (e.g. smoking or drinking), use of drugs etc.

In the poor and least developed countries, the domestic environment remains a major factor of ill health, linked with lack of access to safe water supplies and adequate basic sanitation, upon which the control of many infectious diseases largely depend. If the environment is favorable to the individual, he can make full use of his physical and
mental capabilities. But in the industrialized countries, there is considerable concern about the adverse health effects of continuing environmental degradation: notably, pollution, the uncontrolled dumping of chemical wastes, and the transport and storage of potentially dangerous substances, especially nuclear wastes. Another environmental threat is the depletion of the ozone layer, predicted to result in global climate changes. Changes in climatic conditions may have an impact on public health (Park, 2002), increasing the potential for transmission of infectious diseases through the extension of breeding areas for mosquitoes and other insect vectors of disease. Together with the WHO and UNEP, WHO has studied the impact of the depletion of the ozone layer on health and analyzed the potential impact of global climate change on health.

In the 21st century, developing countries will still be coping, possibly even more intensively, with the environmental health consequences of the lack of basic sanitation, unsafe water, uncontrolled industrial developments and haphazard urbanization. In June 1992, the Earth Summit held in Rio de Janeiro, Brazil, heralded a new approach to development and environmental planning. By adopting the principles of the Rio Declaration and Agenda 21 (U.N., 1993) as the route to sustainable development in the 21st century, the world's leaders stressed that development is about meeting the needs of people, their health, their well being, their lives, and the environment upon which they depend. Sustainable development was defined by the Brundtland Commission (www.sustainablemeasures.com/training/indicators/Def-Br1.html) as "development that meets the needs of the present without compromising the ability of future generations to meet their own needs". The reduction or elimination of environmental hazards to human health depends largely on legislations and regulations to be adopted both by national or regional authorities and at international level. But the health standards that are aimed at limiting pollution are often compromise between the requirements of health protection and economic and political interests. In environmental policies, the protection of health occupies an important place but is not necessarily a predominant concern. (Pinet, 1998). So there is a need to strike a balance between the protection of environment and the public health.
(D) Health System as Determinant:

The term, health and family welfare services covers a wide spectrum of personal and community services for treatment of disease, prevention of illness and promotion of health. The purpose of health services is to improve the health status of population. Health care system in the 21st century will continue to be confronted with a wide variety of challenges, such as demographic evolution, new patterns of diseases, escalating environmental degradation, changing economic and social structures and status, further developments in health technology and growing expectations of health care consumers. To be effective, the health services must reach the social periphery, equitably distributed, accessible at a cost the country and community can afford and socially acceptable. Health services can also be seen as essential for social and economic development. In fact health care does not produce good health, but the most we can expect from an effective health service is good care. The epidemiological perspective emphasizes that health services, no matter how technically elegant or cost effective, are ultimately pertinent only if they improve health (Park, 2002).

Since the concept of primary health care was defined and given international recognition at the International Conference on Primary Health Care, held in Alma-Ata in 1978. Primary health care has marked the dawn of a new strategy to improve the health of peoples of the world. The Alma-Ata conference defined primary health care both as a "level of care" and as an "approach" to health services development, which has major implications for the entire health system and for its interactions with the broader economic and social development structures. Most countries, many NGO's and health institutions have made formal commitments to 'Health for All'. This global movement has had considerable influence in promoting a more equitable distribution of health resources, in reorienting health services and in training new types of health workers in many countries. However, less effort has been made to define clear primary health care objectives and targets. Little progress has been made in introducing necessary changes in resource allocation based on primary health care principles. Many of the health reforms that have been introduced have been concerned with improving efficiency, with inadequate attention to equity issue. Special efforts are needed to reach the
underprivileged in the pursuit of equity. For the successful implementation of primary health care in countries is legislation to support the various strategies. There is a need for a legal framework to support primary health care. The starting point of such a legal framework is the recognition by individual countries and the global community that "access to essential health care is a human right" (Pinet, 1998). Legislation can support primary health care both as an approach to health development and through the implementation of the content of primary health care programmes according to the eight essential elements of comprehensive care: health education; food and nutrition; water and sanitation; maternal and child care and family planning; immunization; prevention and control of locally endemic diseases; treatment of diseases and injuries; and the provision of essential drugs (Park, 2002). Improving health care in today's world calls not only for new medical techniques but also for new human relations. Modern health care system can only function when physicians and patients behave as partners. Indeed, experience and research have shown that patients who are informed and involved, and whose rights are respected, recover more quickly and have shorter stays in hospital. Awareness of patients' rights is evolving rapidly.

(E) Socio-Economic Determinant:

The socio-economic situation of a country, closely dependent on its sustainable development, has a definite influence on the health of its population. A large body of evidence supports the view that the lower the socio-economic status, the higher the prevalence of disease. For the majority of the world's people, health status is determined primarily by their level of socio-economic development, e.g. per capita GNP, education, nutrition, employment, housing, the political system of the country etc.

In many developing countries, it is the economic progress that has been the major factor in reducing morbidity, increasing life expectancy and improving the quality of life. The economic status determines the purchasing power, standard of living, quality of life, family size and the pattern of disease and deviant behavior in the community. It is also an important factor in seeking health care." In developing and developed countries, the number of poor people has increased substantially. Poverty is the major single
determinant of individual, family and community health" and a major challenge of present times. Director General of WHO, Dr. H. Nakajima, in his message, presenting the 1995 World Health Report, cited poverty as the world's deadliest disease, stressing its role in contributing to the suffering and burden of illness, disability and death affecting many people worldwide. Extreme poverty - the world's most ruthless killer - is listed in WHO's "International Classification of Diseases". Reduction of poverty is one of the four key priorities identified for future international health action in achieving the goals and targets defined in WHO's 'Ninth General Programme of Work' (1996-2001). In renewing its "Health For All" policy for the 21st century. WHO has chosen to combat against poverty as its first strategic line of action. Often the main obstacle to the implementation of health technologies is not technical, but rather political. Decisions concerning resource allocation, manpower policy, choice of technology and the degree to which health services are made available and accessible to different segments of the society are examples of the manner in which the political system can shape community health services. The GNP spent on health is a quantitative indicator of political commitment. To achieve the goal of 'Health For All', WHO has set the target of at least 5% expenditure of each country's GNP on health care. Political commitment and leadership is needed which is oriented towards social development, and not merely economic development. If poor health patterns are to be changed, then changes must be made in the entire socio-political system in any given community. Social, economic and political action is required to eliminate health hazards in people's working and living environments.

(F) Aging of Population as Determinant:

A regular increase in life expectancy, ensuring an increasingly larger population of elderly people of 65 years and over, has created in industrialized countries a new and most important societal phenomenon in the second half of the 20th century: the aging of the population. Since the longevity revolution is also expanding in developing countries, the increase in the number of elderly persons in the world will have profound consequences for humanity and will represent a strong force affecting health and social services far into the next millennium (Park, 2002).
Although the elderly in many countries enjoy better health than hitherto, a major concern of rapid population aging is the increased prevalence of chronic diseases and disabilities, both being conditions that tend to accompany the aging process, in particular in the older part of the population where there exists a definite concentration of chronic health care problems. The long term consequences of chronic diseases are said to affect 7-10% of the world’s population. In 1996, these diseases caused more than 24 million deaths a year (WHO, 1997), equal to almost half of all deaths worldwide. WHO’s World Health Report 1997 was devoted to the theme of chronic conditions, disability and ill health caused by non-communicable diseases. Chronic diseases have often been regarded mainly as problems of the industrialized world but they are emerging at an alarming rate in developing countries for several reasons. Firstly, all populations are aging, but the rate of increase in the number of people over the age of 65 is occurring faster in middle and low income countries than in industrialized ones. Secondly, life expectancy is also increasing in developing countries, thus making people increasingly prone to diseases that are more common amongst old age groups. Thirdly, behavioral patterns of living are changing and poor countries inherit the prevailing health problems of the rich-chronic ailments.

(G) Science & Technological Advances as Determinant:

An advance in science and technology, medical sciences, engineering and communications in the last decade of the 20th century has offered untold opportunities to influence health. There is a need to consider the benefits as well as the potential risks of these new technologies in terms of health, integrity and dignity of the individual. Advances in fields such as genetic screening, assisted reproduction, organ transplantation and intensive care units have reaped considerable advantages. They also produce potentially adverse consequences for the health of the individual and for HR., thus raising difficult ethical problems (Pinet, 1998). Because of their rapid pace of development, medicine finds itself in possession of outstanding and efficient, yet more and more threatening tools. These refined instruments give man more and more power to manipulate life and come to question our values. This inevitable technological evolution necessitates ongoing ethical reflection in order to prevent deviations or excesses and
ensure the respect of the identity, dignity and autonomy of the human being. In fact ethics and law complement each other. Moving from ethics into law also depends on the capacity of the legislator to respond to a felt social need. This requires precise identification of the need to be satisfied, the determination of feasible and desirable solutions, and the choice of the most relevant legal tool.

(H) Exploding population

The world population is said to be exploding from 500000 years ago to around 10000 BC, the global population is thought to have remained below 10 million (Borrinmi-Feyeraband, 1995). A large increase occurred with the development of agriculture and 2000 years ago the world population was about 300 million and doubling every 1240 years. Then a massive acceleration occurred from around 1 billion in 1800 to 6.3 billion in 2004 and is predictive to reach 9 billion in 2050 and plateau at around 11 billion in 2100 (U.S. Census, Bureau, 2005). It has been speculated that about 5.8% of all people ever born are alive today (Haub, 2002).

The US Census Bureau (2005) publishes an estimate of world’s population on its website daily (www.census.gov/cgi-bin/popolockw). Over the one year period 1 July 2004 – 1 July 2005, the world population was predicted to increase from 6372797742 to 6446131400, an increase of 73.5 million. This is a daily increase of around 200000 people, equivalent to the population of the English city of Southampton sufficient to replace all those killed by Asian Tsunami in December 2004.

While population numbers have been increasing, life expectancy has also been increasing almost everywhere and there has been a dramatic decrease in both infant and adult mortality. These improvements have resulted largely from a decline in the occurrence of fetal infections diseases. Several implications arise from the increase life expectancy and increasing population. Life expectancy in Britain is currently around 75 years for men and 80 years for women. The retirement age is 65 years for men and 60 for women. A working man can expect 10 years of pensioned retirement on average and a working woman about 20 years. Research carried out by Deppen and Vaupel (2002) suggests that life expectancy increases of three months every year are occurring in developed countries. If life expectancy increases in the twenty-first century to 85, 90 or
even 100, thus will place our social security, health and pension system in a perilous position.

(I) Poverty

Of the 64.4 billion people living in 2005, approximately 5 billion (81%) are living in developing countries. World poverty is on a massive scale. One billion people are living on less than one dollar per day – that is, one on every six people worldwide. For them, health services and modern medicine are out of reach. Many initiatives that have attempted to improve the health of people in extreme poverty have failed (World Bank, 2004).

The United Nations as ‘a level of income below that people cannot afford minimum, nutritionally adequate diet and essential non-food requirements (United Nations Development Programme, 1995). Half of the world’s population lacks regular access to treatment of common diseases and most essential drugs.

Poverty is the greatest cause of ill-health and early mortality. The health effects of poverty are tangible everywhere and the biological and socio-economic mechanism are everywhere the same. The major impacts of poverty on health are caused by the absence of: Safe water, Environmental sanitation, Adequate diet, Secure housing, Basic education, Income generating opportunities, Access to health care etc.

The most common health outcomes are infectious diseases, malnutrition and reproductive hazards (Anand and Chen, 1996). A major killer disease is acquired immune deficiency syndrome (AIDS). In 2004, 6 million people living with HIV/AIDS in developing countries urgently needed access to antiretroviral treatment (ART).

(J) Gender

Major differences occur across place and time in health prospects of men and women. Recent researches have focused on the political, psychosocial and economic implications of gender. A medical text book from the nineteenth century stated: “Child bearing is essentially necessary to physical health and long life, the mental happiness, the development of women. Woman exists for the sake of womb (Holbrooks, 1871, pp. 13-14, cited in Gallant et al, 1997).

In industrialized societies today men die earlier than women but women have poorer health than men (Macintyre and Hunt, 1997). The evidence suggests that from the
paleolithic period to the industrial revolution men lived longer than women, 40 years as compared to 35. Also in less developed countries (e.g. India, Bangladesh, Nepal and Afghanistan) men still live longer than women. (WHO, 1989). Thus there are significant historical and regional differences in gender related health. To complicate the picture further the SES – mortality gradients appears to be steeper for men than women, while illness rate, treatment rate, absenteeism and prescription drug use are generally higher for women (Macintyre and Hunt, 1997).

Women have higher morbidity rate but lower mortality rates. Women suffer more non-fetal chronic illness and more acute illness. They also make more visits to their family physician and spend more time in hospital. Women suffer more from hypertension, kidney disease and autoimmune disease such as rheumatoid arthritis and lupus (Litt, 1993). They also suffer twice the rate of depression. Men, on the other hand have a shorter life expectancy, suffer more injuries, suicides, homicides and heart disease.

In addition to biological factors, the political and economic causes of gender related health differences, including policy issues, SES, psychosocial factors, life style differences, life cycle changes and violence.

Psychosocial and life style differences are likely to play a major role in mediating gender related health differences. In industrialized societies women suffer more poverty, stress from relationships, rape, childbirth, domestic violence, sexual discrimination, lower status work, concern about weight and the strain of dividing attention between competing roles of parent and worker. Financial barriers may prevent women, more than men, from engaging in healthier lifestyles and desirable behaviour change (O’heary & Helgeson, 1977).

Social support derived from relationships, intimate relationships and marriage, although significant, appears to be less positive value women than to men. Although physical and mental well-being generally benefit from social support, women often provide more emotional support to their families than they receive. Thus, the loss of a spouse has a longer and more devastating effect on the health of men than on that of women (Stroebe & Stroebe, 1983). The burden of caring for an elderly, infirm or dementing family member also tend to be greater for females in the family than for males, especially daughters (Grafstrom, 1994). Gallant et al. (1997) have made a useful
review of the literature on the psychological, social and behaviourla influences on health and health care in women. While the health of women is a focus for renewed efforts in health care, the health of men cannot be taken for granted. Men are more likely to suffer diseases of the cardiovascular system, more often suffer a violent death and die younger. More research is needed on the health of men, why they suffer more from alcoholism and drug dependancy and why they are reluctant to seek health from professionals.

(K) Ethnicity

Empirical evidences suggest that the health of minority ethnic groups is generally poorer than that of the majority of the population. This pattern has been consistently observed in the USA between the African – Americans (or black) and whites for at least 150 years (Krieger, 1987). Under the age of 70, cardiovascular disease, cancer and problems resulting in infant mortality account for 50% of the excess deaths for black males and 63% of the excess deaths for black females (Williams & Collins, 1995). Analyses of three censuses from 1971 to 1991 have shown that people born in South Asia are more likely to die from ischaemic heart disease than the majority of the UK population (Balarajan and Soni Raleigh, 1993).

There are many possible explanations for these persistant health differences between people of different races who live in the same country and are served by the same education, social welfare and health care systems (Williams and Collins, 1995; Williams et al, 1997).

First, the social practice of racism means that minority ethnic groups are the subject of discrimination at a number of different levels. Such discrimination could lead directly or indirectly to health problems additional to any effects related to SES, poverty unemployment and education. Discrimination in health-care system exacerbates the impacts of social discrimination through reduced access to the system and poorer levels of communication resulting from language differences.

Second, ethnocentrism in health services and health promotion favours the needs of majority over minority groups. The health needs of majority over minority groups. The health needs of members of minority ethnic group are less likely to be appropriately addressed in health promotion that in turn leads to lower adherence and response rate in
comparision to the majority population. These problems are compounded by cultural lifestyle and language differences.

Third health status differences related to race and culture are to a large extent mediated by differences in socio-economic status (SES). Studies of race and health generally control for SES and race-related differences frequently disappear after adjustment for SES. Race is strongly correlated with SES and even sometimes used as an indicator of SES (Williams & Collins, 1995; Modood et al., 1997).

Fourth, differences in health-protective behaviour may occur because of different cultural and social norms and expectations. Fifth, differences in readiness to recognize symptoms may occur also as a result of different cultural norms and expectations.

Sixth, differences could occur in access to services. There is evidence that differential access to optimal treatment may cause poorer survival outcomes in African-Americans who have cancer in comparison to other ethnic groups (Meycrowitz et al., 1998). Seventh, members of minority ethnic groups are more likely to inhibit and work in unhealthy environments because of their lower SES.

Eighth, there could be genetic differences between groups that lead to differing incidence of disease and some diseases are inherited. There are several well-recognized examples, including sickle cell disorder affecting people of African-Caribbean descent, thalassaemia, another blood disorder that affects people of the Mediterranean, Middle Eastern and Asian descent, and Tay-Sachs disease that affects Jewish people.

Other possible mechanisms underlying ethnicity differences in health are differences in personality, early life conditions, power and control, and stress (Williams & Collins, 1995; Taylor et al., 1997).

(L) Disability

Current estimates suggest that global population of people with disabilities is between 235 million and 549 million individuals (Metts, 2000). However, its accurate measurement is beset with problems. The theoretical and methodological issues surrounding the measurement of disability are covered in depth within the disability literature (Albreent et al., 2001; D. Marks, 1999a, b), but they include: variations in definition and measurement system (e.g. functional limitation versus disease/impairment presence); lack of data and inadequate analysis of available data, blurring of the concepts
of illness and disability; and an over-reliance on self-report measures leading to underreporting (e.g. chronic conditions individuals have adapted to or perceive as commitments of old age and mental health conditions tend not be reported as disabilities). Despite these and many other issues relating to the availability of data on disability and health, it is generally thought that people with disabilities make up around 10% of the population.

The experiences of disabled people are in many ways similar to the experiences of other disadvantaged groups. As with racism experienced by ethnic minorities and gender discrimination experienced by women, the social practice of ‘disablism’ results in discrimination against people with disabilities at many levels.

In an influential paper Verbrugge and Jette (1994) discuss the “disablement process” that (i) describes how chronic and acute conditions affect functioning in specific body system, generic physical and mental actions, and activities of daily life, and (ii) describes the personal and environmental factors that speed or slow disablement, namely, risk factors, interventions and exacerbators. Disability is defined as “difficulty doing activities in any domain of life (from hygiene to hobbies, errands to sleep) due to health or physical problem”. Verbrugge and Jette distinguish between ‘intrinsic disability’ (without personal or equipment assistance) and actual disability (with such assistance). Disability should therefore not be viewed as a personal characteristic, but as a gap between personal capability and environmental demand. Researchers and clinicians previously tended to overlook the efforts people make to reduce demand by activity accommodation, environmental modifications, psychological coping and external supports. Verbrugge and Jette compared the disablement experiences of people who acquired chronic conditions early in life (lifelong disability) and those who acquired them in mid or late life (late-life disability).

The psychological effects of discrimination, prejudice and physical and social exclusion affect health outcome negatively, over and above the effects of the disability itself or SES and poverty-related factors. The link between disability and SES factors is well established.

People with disabilities are two or three times more likely to be unemployed and to stay unemployed for long than non-disable people. They are more likely to suffer
poverty, debt, exclusion from or restriction to lower status work, and poorer education (Metts, 2000).

These factors are consistently associated with poorer health outcomes, although these relationships are not unidirectional. The link between disability and poverty appears to be two way: people with disabilities are at increased risk of poverty (mediated by employment status) but poverty also increases the risk of disability (mediated by factors such as diet, housing quality etc.). Marginalization and exclusion from services, and from social and community activities, can also make people with disabilities and their families worse off. Many people with disabilities also incur additional costs related to their disability (e.g. medicines, equipment, travel, services and care costs). The consequences of disability do not affect people with disability alone, it also impacts upon their families economically, socially, psychologically and health-wise.

Disability may not be the only source of disadvantage negatively impacting on the health of a person with a disability. Berthoud (2003) argues that there are six sources of disadvantage relating directly to employment, family structure, skill development, age, labour demand and ethnic group and that they have additive effects. These sources of disadvantage also relate directly to disability, and gender is a seventh interacting factor. The impact of multiple illness/disability conditions must also be considered.

(M) Inequity and Growth

Economic growth is the rate of increase in total production of goods and services within an economy. Such growth increases the capacity of an economy to produce new goods and services allowing more needs and wants to be satisfied. A growing economy increases employment, stimulate business enterprise and innovation. Sustained growth is fundamental to the rising of living standards and to providing greater quality of life. Gross national income (GNI) is defined as the monetary value of all goods and services produced in a country over a year. GNI is a useful indicator for measuring growth.

It might be expected that economic growth should lead to increase prosperity for all and even to a reduction of inequalities. A World Bank study of 21 developing countries over the period 1950-85 by Lal and Myint (1996) made a distinction between "mass structural poverty", "destitution", and "conjunctural poverty". Lal and Myint found
is all countries studied, growth in income per capita led to the alleviation of mass poverty. They found that growth does “trickle down” and that when growth collapse there is increasing poverty.

This economic research means that, while the level of man poverty tends to be reduced by economic growth, disparities in wealth across a society are not reduced by growth. World Bank data also suggests that, over two decades, growth-oriented structural adjustment programmes have worsen inequalities in many cases (Shakow and Irwin, 1999). This is a hard fact of life that can be difficult to accept from a social justice perspective and it has many knock on effects on human health.

GNI and income distribution, therefore appear to operate independently of each other. It has been established for many years that health and GNI are highly related. Recently some interest was generated by the hypothesis that income distribution also played a role in the health of a society (Wilkinson, 1996). Income distribution can be measured by computing the percentage share of income or consumption taken by lowest and highest income groups in a society.

It was argued by Wilkinson (1996) that the average life expectancy is higher when income differences are relatively small and societies are more socially cohesive. It has also been suggested that the same basic principles determine the health of populations in both rich and poor countries (Rodgers, 1979). Recent evidences suggest that such a relationship does exist for infant mortality in many wealthy countries (Lynch et. al, 2000) and for all mortalities in USA (Ross et al. 2000). Further, the focus on income inequalities in research may have led to a lack of emphasis on other measures of social inequality. As Lynch and Davey, Smith (2002) stress: social inequality is multidimensional – it is not limited to income differences – and is expressed in education, occupations, housing access to services and discrimination across to ethnicity, gender and age.

## WELL-BEING

General Well Being (GWB) may be termed as the subjective feeling of contentment, happiness, satisfaction with life experiences and of one’s role in the world of work, sense of achievement, utility, belongingness, and no distress, dissatisfaction or
worry etc. These things are difficult to evaluate objectively, hence the emphasis is on the term “Subjective” Well Being. It may well be maintained in adverse circumstances and controversy may be lost in favourable situation. It is related to but not dependent upon the physical conditions. Physical WB generally concerned with an individual’s feelings about his / her daily life experiences. These feelings extend from extreme negative state such as stress, worry or unhappiness to more positive states which are not simply states of absence of worry or unhappiness but are states which are related to sound mental health and include favourable self-esteem and success (Herzberg, 1966). Studies of positive & negative affect of psy. WB have been undertaken by Bradburn (1969) who found that positive affect corresponded with greater social relationship and more new experiences whereas negative affect was closely related to fear of a nervous breakdown, ill heath, anxiety & stress. Similar conclusions have been recorded by Warr (1976) who used three measures:- positive, negative affect, anxiety level and feelings about present life as measures of WB.

In 1967, Warner Wilson presented a broad review of SWB research entitled, “Correlated of Avowed Happiness”, Based on the limited data present at the time. Wilson concluded that the happy person is a “young, healthy, well-educated, well-paid, extrovert, optimistic, worry free, religious, married person with high self-esteem job morale modest aspirations of either sex and of a wide range of intelligence (p. 294). In the 3 decades since Wilson review, investigations into SWB have evolved. Although researcher now know a great deal more about the correlates of SWB, they are less interested in simply describing the demographic characteristics that correlated with it, instead they focus their effort on understanding the processes that underlie happiness. This trend represents a greater recognition of the central role played by people’s goals, coping efforts and dispositions.

In a review of the research conducted in the area of SWB, Dienes, Suh, Lucas & Smith (1999) have reported that early research on SWB was limited to cataloging the various resources and demographic factors that are correlated with SWB. Although the most recent 30 years of research have increased our knowledge in this area, the most important contribution is in the understanding that these external bottom-up factors are responsible for only a small part of the variance in SWB. One’s temperament &
cognitions, goals, culture and adaptation coping efforts moderate the influence of the life circumstances and even on SWB. Theoretical models have been developed in each of these areas to explain how internal factors, within the person, moderate and mediate the impact of the environment on people's SWB.

In considering Wilson's (1967) conclusions about who is happy, one must first recognize that the studies on which he/she based his/her judgments were really about who is most happy. In fact, the majority of people avow positive levels of happiness (Diener & Diener, 1996; Jeadu & Wearing, 1988; Hartlin & Stang, 1988). Most individuals report that their WB varies between slightly satisfied and very satisfied and between slightly happy and very happy. There is a truncated range of SWB that some have conjectured might be of genetic origin (Pienor & Diener, 1996; Lykken & Tellegen, 1996). What causes the variation in SWB between people who score at varying places in the positive range may differ considerably from what causes a few people to experience depression and other severe negative states.

The area of WB has three hallmarks (Oienus, 1984). First it is subjective. According to Campbell (1976) it resides within the experience of the individual. Notably absent from the definitions of SWB are necessary objective conditions such as, health, comfort, virtue or wealth. Although such conditions are seen as potential influences on SWB, they are not such as an inherent and necessary part of it.

Second, SWB includes the measures. It is not just the absence of negative factors as is true of most measures of mental health. However, the relationship between positive and negative indices is not completely understood.

Third, SWB measures typically include a global assessment of all aspects of a person's life. Although affect or satisfaction within a certain domain may be assessed, the emphasis placed on any integrated judgment of the person's life. Nonetheless, measures may cover a period ranging from a week to one's entire life. There is no priori way to decide what time period is best. Rather, researcher must uncover the correlates of SWB within varying fine frames.

Wilson (1967) reported that health is strongly correlated with SWB. This association, however holds only for self-reported health measures (George & Lenderman, 1984, Larson, 1948, Okun, Stock).
The correlation weaken's considerably when objective health ratings by physicians are examined (Watten, Vessend, Higher & Syversen, 1997). In health may negatively influence SWB because it interferes with attainment of important goals.

Within countries increases in income are not inevitably associated with increases in WB. Brickman et al. (1978) found that lottery winner were happier than control but no significantly so. Wealth may contribute to SWB by providing the means to meet certain basic need such as food, shelter, clean water and health care. The poverty should affect SWB if it affects basic needs. People who value money more highly than other goals are less satisfied with their standard of living and with their lives (Richins & Dawson, 1992, Crawford, 1998).

Religion may provide both physical & social benefits. Religious experiences can provide a sense of meaning in daily life (Pollner, 1968) as well as during major life crises. The positive relation between marriage & SWB noted by Wilson (1967) has been consistently replicated in national and regional surveys conducted in the United States (Glenn, 1975, Gov & Shin, 1989), Canada Chhite, 1992 & Norway as well as in international studies. The large scale survey reveals that married people reported greater happiness those who were never married and or divorced seperated or widowed. Life satisfaction does not decline with the age (Butt & Beiser, 1987. Inglehart. 1990, Voerrhoven, 1984).

Correlates of WB

The General WB may show positively related with quality of life, job satisfaction/general satisfaction level, sense of achievement etc. & negatively related with neuroticism, psychoticism & other such variables. It should show relative stability overtime (reasonable time gap without any significant intervening life events). It is believed that old age is period of cumulative stress, deprivations & loss and therefore, old people must be the unhappy of all groups.

It is very important to identify the relationship between age & Well Being because most of the studies have shown that older person do not appear unhappier than middle aged or younger persons, despite the decline in physical health, death of peers & spouse, and other objective rigours (Staudinger, Fleeson & Battes, 1987. Fillipp, 1996.
Brandtstadter & Greve, 1994, Battes & Bites, 1990) & other adverse conditions (Sehultz, 1985, Haug & Beik Grave & Gratton, 1984, Herzog, Rodgers & Wood worth, 1982. Larsen & Ketelaar, 1991, Cameron, 1975) that accompany aging. Some theorist have suggested improvement in WB with advancement in age (Cartersen & Tusk, 1994; Carstensen, 1991, 1995; Lawton, 1989, 1996; Labouvie & Bulachard, 1982). Lawton (1996), Carstersen (1991,1995) & Labouvie & Balanchard (1982) have investigated that shifts in social contexts and changing inner states provide the underpinning for the eruption and regulation of changes that leads to greater happiness in old age. These theories are different from the social indicator movement, which predict worse WB in older adulthood and focus not on social context or personality but in membership in particular demographic categories. These are related to culture as well as life style of individuals and need to be cultivated to ensure a livelier old age.

Survey research from the West has shown that the old people are not particularly unhappy. McCrea (1984) held that their answers depend on an understudying of the relation between environment and cognition, cognition and affect and personality. Bader & Hoffman (1996) have remarked that older people were more in disease group than their younger counter parts, because of differences in social, cultural and economic experiences extending over long period of time and these differences tend to increase with age. Taruis (1982) could not find much evidences of mid-life rise and proposed that it could be accounted due to socially desirable response. Herzog et al. (1982) also raised this as a possible explanation for the reported high life satisfaction or happiness or high well-being of the elderly.

Hence, there is a lack of systematic efforts to examine the state of SWB and quality of life in the elderly (Rathore, 1991, 1992, 1995) and emotional problems. (Rawa Murthi, 1990) It is also opinioned that there a lack of Indian data based on longitudinal studies depicting the influence of factors at younger age on the quality of life in later years. (Venkoba, 1991)

Gender and WB:

Several studies have suggested that the relation between age and WB may differ between men and women. Glenn (1975) observed that women in their 50’s were less happy than women in their 40’s. Women appear to be less happy and this seems to
persist across different age groups. One exception to this is increased rate of suicide among older men (Daniel & Christian, 1998) which may indicate great unhappiness. Inglihart (1990) Shmotkin (1990) have reported that women have better SWB, but the differences disappear when other demographic variables are controlled. Women are twice prove to depression as men (Comer, 1992, Eaton & Kessler, 1981). On an average, both positive and negative emotions are experienced more strongly and frequently by women than men. Wood et al. (1989) and Lee, Seccombe & Shehan (1991) found that women reported higher levels of positive affect on average and more often report extremely high level of SWB. This is the general perception that, women’s more intense positive emotions seem to balance their higher negative affect. Because women are more open to intense emotional experiences on average, and therefore, this may make them more vulnerable to depression if they encounter uncontrollable events. If their lives are good, women may experience more intense level of happiness. Diener et al. (1999) provided a possible explanation of extreme emotionality in women by saying that the difference carries mainly low socially prescribed gender roles. The traditional female gender role includes greater care giving responsibilities that may encourage more emotional responsiveness in women than in men. As a result, women may be more willing to experience and express emotions (Diener, 1996).

A number of studies have shown that subject’s role involvement affect their psychological WB but the source of this relationship is unclear. Some researchers have reported that multiple role occupancy is beneficial (Thoits, 1983, Epstein, 1980) while others found that conflicts among roles are detrimental to women’s sense of WB. Still other agent that it is not the number of roles occupied per se but the quality of experience associated with each role that is the key to WB (Barnett & Baruch, 1987 & Helson, (1947). Moreover, there is a lack of consensus over the relationship between gender and WB.

Spirituality and WB:

Spiritual awareness is to reach out and touch that area of “self” which is linked to the universe. Philosophers and modern scientists acknowledge the existence of different dimensions. The physical dimension refers to the gross body and its function. The vital energy indicates the life energy, which sustain the body and the mind. The mental or
psychic dimension is characterized by all the psychological processes such as understanding, stored experiences, thoughts etc.

Throughout the history of mankind in the civilizations, there has been an attempt to reach this stage of awareness. The spiritual dimension of an individual's life has been focus of interest not only for philosophers, theologists, academicians or psychologists but to all health care professionals. The role of spirituality and religiosity as a factor in the health outcome has diverted the attention to harness this resource to enhance the WB. The holistic model of health emphasizes that spiritual health is an important ingredient in individuals' WB, as well as overall health of the community.

According to the consensus document of National Institute of Health Care Research (Hill, et al. 1998), spirituality is defined as “feeling, thought, experience and behaviours that arise from a search for the sacred”. Spirituality refers to set of beliefs and practices, which directs and influences the behaviour of a person. The spiritual attitudes, behaviour and an awareness of spiritual core in oneself forms the important component of this dimension. The spiritual beliefs constitute an orientation to a power greater than self, or awareness of cosmic consciousness, a belief in God and interconnectedness to self to everything in the world. It also constitutes specific beliefs about life and death. The need to seek support and strength from superordinate self are the issues related to the spiritual orientation. There are certain practices which can constitute the spiritual behaviour. Religious commitments, ability to give and receive, forgive contemplation, community services, meditation etc. It is also characterized by behaviors to search for meaning and purpose to life and also the truth.

Bulk of research in spirituality focus on the evaluation of its role in health and health outcomes. The studies have focused on spiritual belief and prayers, health outcomes. King, Speck and Thomas (1999) studied the spiritual belief in 250 clinical patients and found that strong spiritual belief was an independent predictor of poor outcomes in a month and the authors consider it as vulnerability factor, and make patients believe in a life after death thus struggle less to recover.

A major study conducted by Piedmont (2001) involves development of spiritual transcendence scale. According to him, spiritual transcendence is, “the capacity of individuals to stand outside their immediate sense of time and place and view life from
a larger and more objective perspective. This transcendence perspective is one in which a person sees a fundamental unity underlying the diverse striving of nature”. He conceptualizes spirituality as a trait construct similar to personality dimension accounting for individual differences. Using confirmatory factor analytic study and incremental validity, he demonstrated that spirituality as measured by his 24 item spiritual transcendence scale is a separate dimension of individual traits from that of 5 factor model of personality by Costa & McCrea (1992). This questionnaire showed a significant positive correlation between spiritual transcendence and other psychological outcome variable such as positive affect, happiness etc. The three factors of spirituality were prayer fulfillment, universality and connectedness, and a global score of transcendence.

Studies on spirituality as an important resource in rehabilitation process is emphasized by researchers, such as disability rehabilitation (Bosewell, et al. 2001) and coronary patients rehabilitation. In empowering persons and making appropriate health choices, spirituality is considered as valuable internal resource.

**Happiness:**

Happiness is a multidimensional construct comprising of emotional and cognitive elements (Hill & Argyle, 2001a). Argyle (2001) presents a triplicate conceptualization of happiness consisting of the average level of satisfaction over a specific time period, frequency and degree of positive affect and the relative absence of negative affect. Researchers have identified three distinct routes to happiness: positive emotion and pleasure, engagement and meaning (Saligman, 2002).

Researchers over the past three decades have shown that peoples' psychological and physical health get profoundly affected by their life events. Empirical studies by Holmes and Rahe (1967) generated a hierarchical list of event changes likely to require significant alteration in the ongoing pattern of the individual. The events themselves need not be traumatic or of negative character to provoke disease. The essential factor is the new demand in the usual adaptive pattern of the person. The greater the strain on coping mechanism, the more likely that an inadequate or inappropriate response will be utilized thus eliciting idiosyncratic life events can act as a moderator
variable which can help a person to be happy if new demands are put on the usual
adaptive pattern.

Meaningful living has been directly equated with authentic living (Kenyon, 2000). Failure to achieve meaning result in psychological distress (Frankl, 1963). Having more meaning has been related to life-satisfaction (Chamberlain and Zika, 1988) and happiness.

Theoretical Synthesis and Perspective:

A detailed description of health and well being along with there determinants in
the forgoing pages help to reach the following zeist to take on the problem at hand:

1. There seems to be overlap in health and well being concepts at theoretical
level. Both have been explained time to time to be inclusive of each other in
theory, research and practice of medical, paramedical and related disciplines
e.g., sociology and psychology.
2. Popular measures of well being and subsurving concepts, such as life
satisfaction, happiness, positive affect and negative affect, self esteem,
depression, organized psyche, cognitive interference (facilitation) and
subjective well being are oftenly used selectively from a few to all.
3. It is not clear whether presence of positively toned feelings and absence of
negative affect, psychological distress constitute well being together or both
have separate axis.
4. Although well being seems to have proper cognitive functioning, organized
psyche and transcendence of self as their correlates, could these be structural
component of the construct or the outcome is a matter of empirically settele.
5. There happens to be common determinants and their similar impact on health
as well as on well being. So, there is no stoachistic independence which
further suggest common dimensions among measures of health(disease) and
well being.