CHAPTER I

SOCIOLOGY OF HEALTH
CARE DELIVERY SYSTEM
In this Chapter, the importance of mother and child health in the National context has been discussed. It also highlights the important MCH problems in India, and possible solutions to these problems in the form of simple MCH and Family Planning interventions which are available through the Governmental health care delivery system in the rural areas. The Governmental obligations to ensure MCH though constitutional commitment and being a signatory to the Alma Ata declaration have been given. The sociological concept of disease and sickness, sick role, Doctor-patient relationship and communication, sickness behaviour and models are also presented. The various concepts like social equilibrium, work ethic, organisational climate, organisation behaviour system, motivation, and health care delivery system as a social system have been discussed. The concept of modoernity, health modoernity, and changing of health beliefs are also presented in this chapter.
2.1 Mothers and Children - A Priority Group

In any community, mothers and children constitute a priority group. In India women of the child bearing age (15-44 years) and children (under 15 years of age) together constitute nearly 65 percent of the total population. Mothers and children not only constitute a large group, but they are also a "Vulnerable" or special-risk group the risk is connected with child bearing in case of women, and growth, development and survival in the case of infants and children. Whereas 50 percent of all deaths in the developed countries are occurring among people over 70 years of age, the same proportion of deaths are occurring among children below 5 years in the developing countries. The maternal mortality rate in India varies from 2-4 per thousand live births. From commonly accepted indices, it is evident that child and maternal mortality rates are high and deserve attention. Further much of the sickness and deaths among mothers and children is largely preventable. By improving the health of mothers and children we contribute to the health of general population. These considerations have lead to the formulation of special health services for mothers and children. Since the problems affecting the

1. Preliminary Census Reports, Census Commissioner, Govt. of India, 1991.
2. Sample Registration Scheme, Registrar General of India, 1986.
health of mother and child are multifactorial in origin, the present strategy is to provide the MCH care services as an integrated "package" in order to achieve the greater impact.

2.2 Mother and Child as One Unit

Mother and child must be considered as one unit. It is because during the antenatal period, the foetus is a part of mother and the child's health is closely related to maternal health. After birth, the child is dependent upon the mother for at least up to 6-9 months of age. The mental and social development of child are also dependent upon mother. Moreover, mother is also the first teacher of child. It is for these reasons that the mother and child are treated as one unit.

2.3 Maternal and Child Health (MCH) Problems in India

The report of the World Conference of the UN Decade for Women (Copenhagen, July 1980), has a sentence, which states:

"While women represent nearly 50 percent of the world adult population, and one third of the official labour force, they perform nearly two third of all working hours, receive one tenth of world's income, and own less than 1 percent of world's property."

Women are the principal provider of care and support for infants and children. The role of women in the economy and their status in society, thus becomes crucial for children and for development. The trends in relation to females in the demographic evolution as well as in the
health, nutrition and education are intimately inter-linked. These trends have almost always been adverse to women. This phenomenon cannot be explained as distortions arising from poverty, but rather understood against a common denominator of in-built social prejudice, and discrimination against women. Even if poverty were reduced, the situation of women in unlikely to improve unless social attitudes towards them change and their essential dependent status gives way to equality with men.

**Demographic Imbalance**: The declining proportion of females to males in India, is exceptional to the general pattern in other parts of the world. The sex ratio has gradually declined from 972 in 1901 to 929 in 1991. If female infants die at a rate faster than male infants despite their biologically superior strength, the inference is that social neglect of female health is deeply entrenched. In the common pattern of life expectancy, women outlive men in the developed countries. On an average they live longer than men by nearly 10 years. In India the life expectancy at birth in males in 1901 was 22.6 years which increased to 55.1 years in 1981, whereas for females, the figure shows a slower progress from 23.3 years in 1901 to 54.3 years in 1981. Social scientists attribute social factors to this unusual trend. The mortality among females is greater than among males at all ages, more so in 15-35 years age group. Although an improvement of health services has helped to
bring down the death rates of both males and females, yet men appear to have benefited more than women.

Unequal Access to Health and Nutrition: The number of hospital beds reserved for women is much less than that for men. Because of social barriers, women do not usually go to male doctors, and there are not enough women doctors in villages. On the basis of records of indoor and outdoor patients of medical institutions, it has been observed that for every three men who avail of health services, only one woman does so, although the percentage of sick women appears to be higher than that of sick men at any given time. Moreover, normal working hours of the clinics are often not convenient for women to attend and generally a woman is not inclined to seek treatment unless she is severely ill. The nutritional status of women is very poor. It is estimated that on an average, an Indian rural woman during her life time becomes pregnant 8 times, gives birth to 6-7 children of whom 4-6 survive. Out of the 30 years of reproductive life span she spends 16 years in pregnancy and lactation. The theory that women need less calories than men is based on the assumption that she expends less calories. However, the results of various surveys undertaken in rural areas have shown contribution of men, women and children to the labour force as 31 percent, 53 percent, 16 percent respectively.

Educational Neglect: Education determines aspirations, technology, productivity and social mobility. It also changes perception of values of human beings and their contribution to the economy of the household and of the nation. Illiteracy is the greatest barrier to improvement in the position of women in the field of employment, health, exercise of legal and constitutional rights, attaining equality of status and equal opportunities in education itself. A negative correlation has been demonstrated between IMR (Infant Mortality Rate) and education of women. An inverse relationship between fertility on the one hand and female literacy and relatively higher age at marriage has also been demonstrated. Female literacy, education alongwith employment and income, are devices for improvement in quality of family life and steady reduction in fertility. A woman's ability to control the size of family is closely related to her educational status.

Infant Mortality: The proportion of infant deaths to total deaths varies from State to State. It is 35.1 percent in UP and 16.9 percent in Kerala. General mortality rate has declined in India due to public health measures and control of communicable diseases. However, infant mortality is linked to factors like antenatal care (Periodic check-up

during pregnancy, detection and treatment of iron and iodine
deficiency, and common complications of pregnancy, immunity
against tetanus); Institutional care during delivery; Infant
care after birth; and Socio-economic support for family. The
pre-dominance of domiciliary child birth in rural areas
is a critical factor in post partum complications leading to
maternal and perinatal mortality. The main causes of child
deaths in first year of life have been Tetanus, Prematurity,
Acute Respiratory Tract Infections (ARI), Diarrhoea, Febrile
illness (Malaria etc.) birth injuries and Asphyxias. The
current level of IMR is 90. The annual death toll is about
2.5 million infants. The historical rate of progress during
the past decade shows an average annual reduction of IMR by
2 to 3 points in India. In order to achieve the target of
bringing down to 60 by 2000 A.D., efforts have to be
concentrated on the under privileged groups in rural areas
and on diseases like Diarrhoea, Acute Respiratory Tract
Infections, Vaccine Preventable Diseases and Malnutrition.

Maternal Mortality Rate (MMR): There are 1.25 lakhs
estimated maternal deaths every year in India. The main
causes being puerperal sepsis, abortion, anaemia, eclampsia
and bleeding. Anaemia continues to be the most serious
hazard to maternal survival. Anaemia aggravates the
complications of pregnancy such as eclampsia, antepartum
haemorrhage, sepsis and genito-urinary infections. Puerperal
morbidity has been found to be 3-4 times higher in
women with hemoglobin levels below 6-5 gms. as compared to
women with normal levels. Anaemia contributes significantly to premature births, low birth weight babies and to perinatal mortality. Maternal ill health is a complex interplay between malnutrition and frequent child bearing. Pregnancies below 18 years and above 35 years have been found to be hazardous for maternal health and survival, especially of malnourished mothers. Studies suggest that if a woman gave birth between the age of 20-34, the maternal mortality would be reduced for that reason alone by 19-25 percent. The factors considered to be associated with maternal health are: Mother's excess to health care services, before, during and after child birth; human settlement pattern in relation to health related education, safe water supply and basic sanitation; and Income and consumption levels, especially in relation to food. A comparative analysis of the mortality situations in the State of Kerala and West Bengal lead to the inescapable inference that the lower mortality level in Kerala can be attributed mainly to its better developed social services (Education, Health facilities and Communication) and partly to its better environmental and hygienic conditions as against the higher level of economic development in West Bengal.

**Childhood Disability:** A disabled child is one who is unable to ensure by himself, individual or social life including work, as a result of deficiency in his physical or mental capabilities. The National Sample Survey Data (1981),
reveals 2.5 lakhs blind, 2.5 lakhs deaf, 2-3 million mentally retarded and 5 lakhs children with severe orthopaedic disability in our country. Disability prevention, detection and intervention is a multi-disciplinary and multi-sectoral endeavour involving the sectors of nutrition, health education, employment, social and child welfare.

**Mortality of Children under 5 years:** The number of annual deaths is around 4 million (including infant deaths). The average annual rate of reduction during 1980s has been 2.8 percent. The mortality rate has to be reduced from 150-160 to 70 per thousand live births. The main causes to be controlled are infections and malnutrition.

**Malnutrition of Children under 5 years:** An estimated 45-50 million children below the age of five years subsist on a caloric deficient diet, the average deficit is about 350 calories per day. Extensive deficiencies exist in respect of protein, iron, iodine, vitamin 'A' and others. The widespread malnutrition is due to a combination of inadequate diet, inappropriate feeding practices and repeated infectious diseases.
2.4 Solutions to the Common MCH Problems

The majority of the MCH problems can be managed with simple MCH interventions: The risk to mothers and children can be decreased by having pregnancy after 18 years, having 2 years of spacing in between the births, by limiting the number of births to 2; and having children before the age of 35 years. Nearly 5 lakh maternal deaths and 5 million deaths among infants in the developing countries can be avoided if during pregnancy women take more food and rest, have at least 3 antenatal checkups, consume iron folic acid tablets, get immunisation against tetanus toxoid and know of "warning signs" in pregnancy. The deaths and infections are 2-3 times higher among the bottle-fed children. Therefore the newborn children should be breast fed for 4-6 months and thereafter other foods may be added alongwith breast milk. Under nutrition is underlying factor in 33 percent of child deaths. The nutrition of young children can be improved by introducing semi-solid foods around 4-6 months of age. The young children should be fed twice as often as adult. Extra foods should be given to children during recovery from illnesses especially measles, whooping cough and diarrhoea. In the developing world nearly 8 lakh childrens die of neonatal tetanus; 3 lakh of whooping cough and 20 lakh due to measles every year. Timely immunisation of

Children can save these lives. Children (below the age of 5 years) suffer 5-6 episodes of diarrhoea per year in the developing countries. Dehydration due to diarrhoea kills 3 million children every year. Giving fluids and foods to child during diarrhoea can prevent diarrhoeal dehydration. Nearly 2-3 million children die every year due to Acute Respiratory Tract Infections (ARI) in developing countries. Adequate care of child like keeping him warm, and well fed, giving him plenty of fluid, and seeking prompt medical advice if child develops rapid breathing (more than 50 per minute) can save deaths due to ARI.

2.5 Global Goals for Maternal and Child Health - for 1990s

Major goals are: Reduction of infant and under-5 child mortality rate in all countries by one third or to 50 and 70 per 1000 live births respectively, whichever is less; Reduction in maternal mortality rate by one third; Reduction in malnutrition among under-5 children by half; Universal access to safe drinking water and to sanitary means of excreta disposal; Universal access to basic education and completion of primary education by at least 80 percent of primary school age children; and Reduction in adult illiteracy rate to at least half of 1990 level with emphasis on female literacy.

Supporting Goals

Women's Health and Education: Special attention to the health and nutrition of female child, pregnant and lactating women; Access by all couples, especially women, to knowledge on child spacing; and Achievement of universal primary education with special emphasis for girls, and accelerated literacy programme for women.

Nutrition: Reduction in severe as well as moderate malnutrition among children under-5 by half of 1990 levels; Reduction of the incidence of low birth weight (2.5 kg. or less) by half of 1990 levels; Reduction of iron deficiency Anaemia in women by half of 1990 levels; Virtual elimination of iodine deficiency disorders; Virtual elimination of blindness and other consequences of Vitamin 'A' deficiency; Enable virtually all women to exclusively breast-feed their child for 4-6 months and to continue breast feeding with complementary foods; Growth promotion and its regular monitoring to be institutionalised in all countries by end of 1990s; and Dissemination of knowledge and supporting services to increase food production to ensure household food security.

Child Health: Global eradication of Polio by the year 2000 A.D.; Elimination of neonatal tetanus by 1995; Reduction by 95 percent in measles deaths and reduction by 90 percent of
measles cases by 1995, compared to pre-immunisation levels; Maintenance of high level of immunisation coverage (at least 85 percent of children under 1 year of age) against DPT, BCG, Measles, Polio and for pregnant women against T.T.; Reduction by 50 percent in the deaths due to diarrhoea in children under the age of five years; and 25 percent reduction in diarrhoea incidence; and Reduction by 50 percent in the deaths due to Acute Respiratory Tract Infections in children under age of 5 years.

2.6 Governmental Commitments to MCH

**Constitutional Commitment:** The constitution of India envisages the establishment of a new social order based on equality, justice and the dignity of the individual. Under Article 15(3) of the Constitution of India - the State can make special provisions for Children and Women. Article 39, b, e and f, provide that children are to be given opportunities and facilities to develop in a healthy manner and in conditions of freedom and dignity and childhood and youth are to be protected against exploitation, moral and material abandonment. Again Article 42 enjoins the State to make provision for securing just and humane conditions of work and for maternity relief. This is followed by Article 45, which states that the State shall endeavour to provide for free and compulsory education of all children until they
complete the age of 14 years. Article 47 of the Constitution makes it the duty of the State to raise the level of nutrition and standard of living and to improve public health. The Central and State Governments have enacted laws to cover specific aspects relevant to child life, marriage, legitimacy, adoption, social defence, health, education and employment. To protect the rights of women and to ensure their equality several changes have been made in personal laws, criminal law and labour laws.

**Alma Ata Declaration:** India is a signatory of the Alma Ata declaration and is committed to attaining the goal of "Health for All by 2000 A.D." through the universal provision of comprehensive Primary Health Care Services. To be effective, the Primary Health Care approach would involve transfer of knowledge, simple skills and technologies to health volunteers and communities. The success of the decentralised primary health care system would depend vitally on the effective community participation, and on the provision of organised back up support of the secondary and tertiary levels of health care services. The approach involves reorganisation of health infrastructure and reorientation of health functionaries at different levels. The MCH is one of the important and priority areas, identified in the Primary Health Care approach. Out of the eight components of the Primary Health Care approach

the components related to MCH, are: MCH Care and family planning; immunisation against major infectious diseases; promotion of food supply and nutrition; health education and appropriate treatment of common diseases.

**National Health Policy:** The National Health Policy (1983) document reviews the progress made after the independence in the promotion of health status. It states that Smallpox has been eliminated, plague is no longer a problem, mortality from cholera and related diseases has decreased, a fairly extensive network of health infrastructure at various levels has been developed. Inspite of such impressive progress, the policy document states that the demographic and health picture of the country still constitutes a cause for serious and urgent concern. The mortality rates for women and children are still distressingly high. And the high rate of population growth continues to have an adverse effect on health of people and the quality of their lives. The policy emphasises to provide high priorities to programme for improvement of maternal and child health, such as immunisation programmes, training programmes for Traditional Birth Attendants to ensure that deliveries are conducted by trained persons and a comprehensive programme providing ante-natal, intra-natal and post-natal care. The provision of safe drinking water and the sanitary disposal of waste

waters, in the form of an integrated package has been suggested in the health policy. The policy says that the basic objective of medical research should be to translate the available know how into simple, low cost, easily applicable, appropriate technologies and interventions suitng local conditions. Therefore, higher priority should be given to applied, operational research for continuously improving the costeffectiveness of health delivery systems.

Child Survival and Safe Motherhood Programme: The Government of India launched the programme in March 1992, in 100 Districts in the country which had poor performance in MCH and family planning. The programme is directed to meet the total health needs of both mother and child. The entire mother and child health programmes including immunisation, Anaemia prophylaxis, prophylaxis against Vitamin A deficiency, oral rehydration therapy, Acute Respiratory Infection Control, birth timing and spacing have been integrated to be delivered through health workers, Anganwadi workers and Trained Dais to rural mothers and children both during health and disease. The overall objectives of the programme are i) to reduce Infant Mortality Rate (IMR) from 80 to 50; child (14 years) mortality rate to 10; maternal mortality rate to 2 by 2000 A.D.; ii) the

programme also envisages Polio eradication by 2000 A.D. and Neonatal tetanus elimination by 1995; and iii) to prevent 95 percent of deaths due to diarrhoea and 40 percent of deaths due to Acute Respiratory Tract Infections. These objectives are to be achieved through the activities like: Newborn care at home; Primary Immunisation by 12 months of age (100 percent coverage); Vitamin A prophylaxis (9 months to 3 years) (100 percent coverage); Pneumonia correct case management at home or health facilities; Diarrhoea ORT at home or health facility and availability of ORS in every village; Anaemia prophylaxis and therapy to pregnant women (100 percent coverage); Antenatal checkups at least 3 checkups in 100 percent cases; Care of women at time of child birth and promotion of clean delivery; and Birth timing and spacing (pregnancy after 20 years of age).
Being sick is fundamentally, a social state of affairs rather than being a narrowly defined bio-chemical malfunction of the organism. Sociology is concerned to explain the social causes of sickness, the character of sickness as a social role and the human response to sickness in terms of feeling, language and social action. The notion of sickness as a social role is very closely associated with the sociology of Parson (1951) who first conceptualised the notion of sick role. Parson's approach is functionalist i.e. analysis of the social activities in terms of their contribution to the maintenance of a social system or institution.

**Sick Role:** The sick role can be defined in terms of four components: The sick role legitimates social withdrawal from a number of obligations, such as those relating to work and family duties. The idea is that a sick person ought to stay at home and take rest in order to facilitate recovery. The second feature of the sick role is that a sick person is exempted from responsibility for his medical condition; the assumption is that he cannot get better without professional help and support.

The third component is that the person has a social obligation to improve and get better; the legitimation of sickness as a basis for social withdrawal from roles is conditional on the patient's full acceptance of the obligation to get better by cooperating with the professional recommendations of a competent Doctor. The fourth element within the sick role is therefore, an expectation that the person will seek out competent health care from a trained physician.

**Doctor-Patient Relationship:** In terms of Parson's pattern variables, the doctor-patient relationship is characterised by its affective neutrality, universalism, functional specificity and orientation to collective norms.

**Abnormal Sickness Behaviour:** Abnormal sickness behaviour occurs when the Doctor does not believe that the sick role is appropriate, given the objective pathology i.e. there is a conflict between the patient's presentation and claims to the sick role and the Doctor's diagnosis of the condition. More technically this may be defined as:

"the persistence of an inappropriate or mal-adoptive mode of perceiving, evaluating and acting in relation to one's own state of health, despite the fact that a

# Sickness Behaviour

## Doctor's Perception of Illness

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### Person's Perception of Illness

- **+**
  - Normal Sick Role
  - Munchausen's Syndrome
- **-**
  - Fight into Health
  - Normal Health Role
Doctor or other appropriate social agent, has offered a reasonably lucid explanation of the nature of illness based on a thorough examination and assessment of all parameters of functioning and individual's age, socio-cultural and educational background" (Pilowsky, 1978).

3.2 Models of Illness

Health and illness are relative concepts, determined in part by culture and historical periods and in part by the health professionals. Certain kinds of phenomena may be considered as illness in one culture and health in another. Each culture also has customs and rituals that are related to the individual's perceptions and values regarding health and illness and the maintenance of a "healthy body" image. The definition of illness varies not only among societies and groups, but also within the society. Illness is constantly being redefined as the new knowledge is gathered and assimilated and with the change in different social institutions.

Models of Illness: Social Scientists have defined two models of illness.

I. The pathological Model

The model has been generated to comprehend organic malfunction, because medical concern is ordinarily initiated by the appearance of physiological conditions which

interfere with the biological functioning of the organism, the focus of the medical perspective is upon pathology and the symptoms of pathology. It is a pathological model in which disease syndromes are defined by the biological symptoms that characterise them. The pathological model concentrates on defining the nature of "abnormal" functioning.

Limitations of Pathological Model

Beliefs that the pathological model describes illness lead to certain actions based on assumptions hidden in the model, such as - 'What is wrong with the person rather than what is right' is emphasised in the model. Thus members of the health profession approach the person, believed to be ill from a negative perspective. The idea, that each illness has specific cause is found in the model, and negative consequences may arise from this assumption. The acute illnesses are explained on this but chronic ailments require a more complex model. The pathological perspective is heavily biased towards biological explanations. This bias may prevent one from recognising those explanations of illnesses that may require an understanding of culture and social structures.

II. The Statistical Model

The statistical model defines abnormality in terms of an individual's position on an assumed normal distribution, relative to others in the population being studied. The
normal is defined by making measurement of the characteristic in total or representative sample of the population i.e. the manner in which a majority act or the scores that a majority make on an examination is defined as "normal", the persons who differ from the majority come to be considered as "less normal" or "abnormal" and possibly "sick".

Limitations of the Statistical Model: It over-emphasises the larger groups in the population and defines their members as normal, whereas it under-emphasises the smaller groups and defines their members as ill. A definition of illness derived from the statistical model may be valid only in the group of people from which it was defined. From this perspective, there is no limit on the proportion of persons who may be labelled "ill", other than what the society will accept. With the pathological model some physiological malfunctioning had to be demonstrated in order for illness to be verified. The statistical model is not so limited.

Models of Illness Behaviour: Mechanic and Volkart have provided a working definition of illness behaviour as "the way in which symptoms are perceived, evaluated and acted upon by a person who recognises some pain, discomfort or other signs of organic malfunction". Two persons having much the same symptoms, may behave quite differently. The various factors which influence the behaviour are social, cultural and psychological. The group pressures to conform
and to perform according to group standards are exerted on every individual, whether sick or not. These pressures may lead one to deny feeling ill and to attempt to carry out roles in a normal fashion. They may, on the other hand, lead one to define seeking immediate care for perceived feelings of sickness as appropriate behaviour. Concern for financial cost of care and for being absent from work may also influence sick person's behaviour. There are also culturally embedded anxieties which may alter the meaning of illness. Beliefs about disability, disfigurement and death are all cultural components which may motivate patients to seek care or to delay seeking care. Cultural differences also have a bearing on the extent of one's knowledge about disease, the beliefs about causation and care. Fear or anxiety, frequently accompanies the onset of undefined symptoms. The degree of fear or anxiety seems to be inversely related to the knowledge about symptoms. It appears also to be related directly to unknown outcomes, fear of disability, and to the personal knowledge of the suffering of a victim. In addition to fear, there is another psychological factor called "secondary gain", which refers to the possibility that illness may represent a welcome relief from arduous role performance and a way of obtaining personal attention from others.

Models of Illness Behaviour

I. Suchman describes the following stages in his illness behaviour Model.

1. **Symptom experience state** - The whole medical care process begins with the individual's perception that "something is wrong". This perception may include awareness of physical change, such as pain, rash, etc.; an evaluation of the change as to its degree of severity; and some kind of emotional response attached to the evaluation. During this phase the sick person may also attempt self treatment by a variety of means to achieve relief from the symptoms.

2. **Assumption of the sick role** - When symptoms are severe and persist, the individual decides to adopt the sick role and seeks to obtain "provisional validation" for that claim. The illness now becomes a social phenomenon because the sick person seeks agreement with significant others that he is sick and should be excused from regular duties. Initial contacts are made with whom he has close ties like spouse, family members, friends. Many seek medical help, others may continue self-treatment and try various remedies suggested by others.

3. **Medical care contact stage** - At this phase the sick person leaves the lay care system and enters the professional care system. Essentially the
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<td>MEDICAL CARE CONTACT</td>
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<td>RELINQUISH NORMAL ROLES</td>
<td>SEEK PROFESSIONAL ADVICE</td>
<td>ACCEPT PROFESSIONAL TREATMENT</td>
<td>RELINQUISH SICK ROLE</td>
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<td>REQUEST VALIDATION FOR SICK ROLE FROM MEMBERS OF LAY REFERRAL SYSTEM</td>
<td>SEEK AUTHORITY LEGITIMATION FOR SICK ROLE NEGOTIATE TREATMENT PROCEDURES</td>
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<td>RESUME NORMAL ROLE</td>
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Stages of Illness Experience
individual is seeking authoritative validation for the claim to the sick role as well as treatment. In addition he is also seeking an explanation of symptoms. On the one hand the physicians may judge the person to be well i.e., with-hold authoritative validation of the sick role claim. The individual may thus reject the physician judgement and may consult another or resumes his normal roles. If the doctor agrees that the person is ill, thus providing the legitimation for the sick role claim and entry into next stage.

4. Dependent-patient role: Upon reaching a decision to undergo treatment for the illness, the sick person becomes a patient.

5. Recovery and rehabilitation: In acute ailments, recovery may be quick and the patient resumes normal activities temporarily until strength returns.

II. Fabrega Model of Illness Behaviour

Fabrega has made an effort to extend the scope of Suchman's stages of illness behaviour by extending the stages of nine; but the focus is on decision making which takes into account judgments by the individual as to the degree of "danger" implied by symptoms, weighing costs against anticipated benefits and choice and behaviour based on previous experiences with illness.
I Stage - Identification and labelling of a problem as illness.

II Stage - Evaluation of the presumed danger or degree of disability.

III Stage - What action to take? Assessing the potential outcomes based on previous experiences, and making a judgment of expected benefits against potential costs.

VIII Stage - The patient selects a treatment plan and evaluates the outcome.

IX Stage - The information of evaluation becomes a part of the memory system for subsequent experiences.

III. Health-belief Model

Originally formulated in 1950s the model was based on concepts derived from Psychology and Social Psychology and was concerned only with explaining preventive health behaviour i.e. behaviour in the absence of symptoms of illness. Later the model was expanded to include socio-cultural and environmental variables in predicting illness behaviour as well as the health behaviour. The dependent variable i.e. the probability that an individual would take appropriate action either to prevent illness or to recover health depends upon individual's perceptions of threat. The perception of threat includes a measure of susceptibility ("Can I be affected"?) and severity ("How much could I be affected"?). These perceptions are modified by factors like - Demographic variables (Age, Sex, Race, Ethnicity), Social Psychological variables (Peer and Reference Groups, Personality Previous Experiences) and Structural variables (Social Class, Access to health services etc.).
3.3 Doctor-Patient Communication

Friedson (1961, 70) has discussed the importance of "lay referral system" in the social process by which lay people consult the physician. Friedson has argued that the lay person only consults the Doctor after a series of consultations with significant "lay groups". It is the lay culture, not the professional values of the physicians, which defines the meaning of illness in a social contest. If a person perceives himself to be sick and in need of a specialised help, he is likely to find support within his own cultural context only if "he shows evidence of symptoms the others perceive to be illness and if he interprets them the way the other find plausible" (Friedson 1970). Once the requirement for specialised health care is acknowledged by the 'lay culture', then help seeking behaviour is organised in terms of the lay referral system. The lay referral system has two components; the lay culture and a network of personal influence which is the lay referral structure. A variety of sociological studies (McKinlay, 1973; Suchman 64;)

Scambler et al. (1981) have found that the majority of patients reporting to a Doctor had already consulted extensively with lay colleagues and discussed the various symptoms which were subsequently presented to the Doctor.

**Doctor-Patient Mis-communication:** The research (Enlow & Swisher, 1979) suggests that not only do Doctors and patients employ entirely different languages of disease, but often have a conflicting interests. While the patient may be seeking general reassurance, the Doctor may be attempting to communicate specific technical information with respect to specific symptoms. This "Competence-Gap", is at least partly a consequence of the fact that the professional doctor has social monopoly of expertise and knowledge, which is the very basis of the professional claim to be a privileged status in society. The Doctor's authority in the consultation, depends to a considerable extent on his monopoly of knowledge. It would be expected, at least initially, the Doctors would not be inclined to transform this prestige by sharing technical knowledge with patient. On the other hand it is clear that sharing of information brings about reassurance and understanding and is an important part of the actual process of therapy. There is some empirical evidence that the sharing of information as an aspect of surgical treatment improves recovery rates and

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enhances the outcome of medical interventions (Skipper and Leonard 1968). Sharing information with patient is also important as the basis of achieving the patient's cooperation with the therapeutic process. In fact research suggests that approximately 50 percent of the patients will not follow the Doctor's advice and do not comply with medical regimen. One estimate suggests that wasted drugs as a result of non-compliance may well cost in excess of $300 millions per year (Walton et al 1980). Successful communication with the patient is an important part of therapeutic process in so far as the successful interaction may well restore the confidence and sense of well being of the patient. There is a sociological argument, therefore that the medical consultation should be regarded as a meeting of experts, since the patient is often well informed of his or her illness and may, over a long period of time, become technically competent in the analysis of his problems (Tuckett et al 1985). The research has shown that medical consultations were successful in situations where they


simply confirmed the patients existing view of the character of their illness. However, where there were differences between Doctors and the patients' views of the illness or where the patients' knowledge was inappropriate medically, then consultations with Doctors tended to be unsuccessful in the sense that the information was not successfully communicated, not remembered or not acted upon. A major practical proposal for resolving the "competence gap" has been to encourage Doctors to treat seriously the lay knowledge of their patients and to listen more carefully to what is said and expressed by lay persons during the consultation. In addition, it has been argued that patients should be more systematically encouraged to present their views or their problems so that the consultation can be genuine sharing of information by "experts".
3.4 Sex Differential in Society - Women's Bodies - Between Nature and Culture.

Throughout human history women's bodies have been treated of especially threatening to the moral and social stability as society (Suleiman 1986). In particular, female sexuality has been the target of religious and magical practices which have been mobilised to restrain women and to provide a surveillance of female reproductive capacity. Magical systems, mythology and 'Shamanism' were typically pre-occupied with the problems of taboo and pollution surrounding the female menstrual cycle. The polar Eskimos, relied upon their 'Shamans' to regulate the dangerous forces of nature, the dead and women. Shamanism was thus an important Institution for the regulation of women and the maintenance of social order (Eliade 1964; Lewis 1971). The literature on witchcraft and demonology in European societies has drawn attention to the special relationship between witchcraft crazes and the status of women in traditional societies (Thomas 1971; Trevor-Roper 1967).


Women were seen to be irrational, emotional and lacking in self-restraint; they were especially vulnerable to 'Satanic' temptations. The women's bodies and female sexuality have been seen as threatening to the moral and social fabric of human societies. Social anxiety about sexuality was directed against women and this anxiety has been expressed historically through a variety of medical categories which pinpoint and articulate the subordination of women to patriarchal authority. The implications of this was that women could only lead healthy lives in so far as they were sexually connected to a man in a lawful marriage which had the aim of reproduction. The social and psychological values of pregnancy inside marriage finally acted as an argument against further education for women on health grounds. A protracted period of education would delay the necessary functions of reproduction and satisfaction inside marriage. The social roles of women within the private space of domestic reproduction come to be seen as socially inferior to the productive performance of men within the public domain. Whereas women are allocated and trained into a psychological structure of emotions, which sharply distinguishes them from the neutral rationality of the public sphere, men are socialised into a life style emphasizing the importance of reason and restraint. This cultural dichotomy between cognitive reason and emotional desire is closely related to the dichotomy between private and public space so that women occupy the world of private
emotion and affection, whereas men are allocated to social roles emphasizing reason, instrumentality and public responsibility. In traditional societies, patriarchy characteristically involved the exercise of power by adult males over women, children, relatives and other dependent persons. The analysis of female subordination can be made coherent when it is combined with an analysis of the role of property in human societies, especially when we take into account the important historical continuity of arguments about primogeniture, private property, population regulation and political power. All human societies have to find some relationship between the reproduction of persons and the management of property which will produce stability in social and political relations.

Sex Differentials in Illness and Medical Care

The observed sex differences may be the outcome of - Real disease process; Behaviour of the individual in response to real or perceived illness; and Diagnostic and treatment practices of health care providers. The following four explanatory frameworks may be employed to account for observed sex differences in health status.

1. Biological Differences Between Males and Females: The crucial biological differences between males and females are genetic in origin. The female possesses two large 'X'-chromosomes, the male one 'X' and a very much smaller 'Y'. The 'X'-chromosome carries many

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genes, as addition to those responsible for sex determination, giving the female "options for variability not open to the male". This genetic difference has been held responsible for sex differences in infant mortality as well as for greater susceptibility of male to disease in general. In addition to genetic make up, males and females also differ in hormonal balance.

2. The Differences in Social and or Psychological Stress Levels: Differences in levels of conflicts and ambiguity associated with male as compared with female sex role expectations have been hypothesized and advanced as possible explanations of certain sex differences in diseases.

3. Differences in the Characteristic Behaviour Patterns or Life Styles of Men and Women: Not only is sex universally employed as a basis for the ascription of social status, but "all societies prescribe different attitudes and activities to men and to women". Gove (1973) has listed three behavioural factors creating different life chances for men and women, which are: Social norms regulating appropriate behaviour for men and women; life style differences, creating different risks of exposure to death and disease; and model personality differences.

MODEL FOR INDIVIDUAL'S DECISION MAKING PROCESS

Concept of Modernity, Modernisation

For over about two centuries the economists, in their study on development have emphasised the economic dimension. The development of a nation has been made synonymous with its wealth or poverty. Only an economically affluent nation was considered modern. The economic model of development has been blind to the role of social factors in economic growth. The economic model of development has two main inadequacies: (i) It is devoid of ideals and goals for the society and does not show any concern for developmental direction of a society towards a humanitarian and human socio-political order; and (ii) the values of social and economic equality, tolerance of ethnic and religious differences, sex discrimination, equal opportunities for social mobility by ensuring equal access to human resource development inputs. The economic model of development has not fully appreciated the importance of non-economic and human factors in development. Recently Myrdal (1968) has identified six broad inter-related categories of social system, influencing economic development. These are - Output and Income; Conditions of production; Level of living; Attitudes towards life and work; Institutions; Policies. He labels the first three as economic factors and the rest as social factors. The concept of modernity has emerged in social science literature as an important socio-

Inkels conceives modern man as innovative, capable of understanding complex issues, democratic, time-oriented particularly to the present and future, planning for future, free from fatalism, being cognizant of others' dignity, having faith in science and technology, and achievement oriented, rather than ascriptive. Open-mindedness, adaptation to change in social life, healthy self-image and non-hierarchic attitudes towards other family members and community are other characteristics of modern man.

Black defines Modernisation as "the process by which historically evolved institutions are adapted to the rapidly changing functions that reflect the unprecedented increase in man's knowledge, permitting control over his environment, that accompanied the scientific revolution. This process of adaptation had its origins and initial influences in the societies of Western Europe, but in 19th and 20th centuries these changes have extended to all the societies.....".

Moore states - "Industrial development involves a tremendous complimentarity of structures and functions, and depends on social and psychological characteristics that are not

entirely associated with industrial work in an immediate and
direct way community organisation, relations with the family
and personal behaviour may be fairly modified with the onset
of industrialisation. Industry radiates changes in
structures and activities of the community.

Hoselitz sought a description of the process of
industrialisation in terms of pattern variables suggested by
Talcott Pearsons. The pattern variables suggested for the
analysis of the implications of industrialisation are the
dichotomies: achievement - ascription; universalism-
particularism; specificity-diffusiveness.

Smelser has employed the concept of structural
differentiation to analyse the structural changes that
accompany industrialisation. He defines structural
differentiation as "a process whereby one social role or
organisation differentiates into two or more roles or
organisations which function more effectively in the new
historical circumstances. The new social units are
structurally different from each other, but taken together
are functionally equivalent to the original unit...." He
observed that differentiation occurs in family activities,
religious systems, and in systems of stratification.
However, differentiation by itself is not sufficient for
development. The differentiated structures need to be

1. Hoselitz, B.F. Industrialisation and Society, Mouton,

2. Smelser. Social Change in the Industrial Revolution,
integrated on a new basis. According to Smelser, the process of industrialisation envisages changes in relations of work, family community and kinship.

**Characteristics of Modernity** - Modernity is a Psychological Concept. It is a part of the personality system. Modernity is not external and it is not related to one's dress, appearance and maternal possessions. Modernity is not synonym with certain indices of development like income, education, urbanisation and industrialisation. Modernity is not Westernised urban life style of the rich upper strata of the society. Modernity consists of a syndrome of personality-cum-attitudinal traits. The personality traits include rationality, internal locus of control, openness to change, work commitments and aspirations. The important socio-cultural and political attitudes include social equality, women's rights, civic rights, democracy, secularism and political participation. Two important themes underlie the various components of Modernity, Rationality and Humanism. Rationality covers such issues as internal locus of control, openness to change and family planning. Humanism covers the issues of social equality, women's rights, civics rights, democracy and secularism. Modernity facilitates personal growth and development as well as social responsibility. The traits of rationality help the individual in his personal growth and the traits of humanism make him socially responsible. Modernity makes the individual an effective agent of socio-economic and
Health Belief Model and Personal Health Behaviour

INDIVIDUAL PERCEPTIONS

MODIFYING FACTORS

PROBABILITY OF ACTION

DEMOGRAPHIC VARIABLES
SOCIAL VARIABLES
PSYCHOLOGICAL VARIABLES
STRUCTURAL VARIABLES

PERCEIVED SUSCEPTIBILITY
SEVERITY OF DISEASE
SYMPTOMS

PERCEIVED THREAT OF
DISEASE SYMPTOMS

CUES OF ACTION
(MASS MEDIA, MAGAZINES,
NEWSPAPER ETC.)

PERCEIVED BENEFITS
OF ACTIONS MINUS
PERCEIVED COST OF
ACTIONS

LIKELIHOOD OF TAKING ACTION
FOR HEALTH

SOURCE - COE R.M. 1978
political change and development. Modernity is a Multifaceted Concept. It has many dimensions and views the individual in totality and embraces his entire personality. Modernity enriches the quality of life by enabling a person to live more meaningfully, intelligently and effectively. Modernity helps the individual in adjustment to a plural democratic and scientific society. Hence, modernity is an aggregate of certain personality-cum-attitudinal traits which facilitate individual growth and development with social responsibility and make the individual an effective agent of socio-economic and political development.

3.6 The Changing of Health Beliefs

Beliefs that certain symptoms are important and the trust in health care professional, affect the perception of illness and the seeking of care. Thus changing health actions and practices among members of a group may come only with belief changes. Given the link between actions and beliefs, when change in actions is desired, manipulation of beliefs may be required. Ideas about belief change can be drawn from the research on "adoption of innovation". Based on an analysis of 500 studies of innovation adoption, Everett Rogers has defined a model that can be used to evaluate any situation and the belief changes within it. The variables considered under the heading "Antecedents",

ADOPTION OF AN INNOVATION

ANTECEDENTS
- STATUS
- LEADERSHIP
- ANXIETY

ACTOR'S
- IDENTITY
- VALUES
- ABILITIES

CHARACTER
- OF SOCIAL
- UNIT

SOCIAL
- NORMS
- ECONOMIC
- CONSTRAINTS

PERCEPTION OF SITUATION

ADOPTION PROCESS

I. AWARENESS
II. INTEREST
III. EVALUATION
IV. TRIAL
V. ADOPTION

PERCEPTION OF INNOVATION

RESULTS

ADOPTION

REJECTION

RESULTS

ADOPTION

REJECTION

CONTINUANCE

DISCONTINUANCE

NONADOPTION

LATE ADOPTION
describe those aspects of the individual and the individual's situation that may influence the extent to which adoption or change of beliefs will occur. For instance, an individual ("actor") who is more "cosmopolitan", (i.e. more oriented to persons and places outside the local community) is more likely to change his or her beliefs. Further, a "situation" in which the community's norms - (i.e. its "Social Systems") stress change and innovativeness will be a situation in which individuals are more likely to change their beliefs.

It should be noted that adoption is a process occurring over time rather than something that occurs instantaneously. During separate time periods, the individual becomes aware of alternatives, develops an interest in the alternatives and eventually, after evaluation and perhaps trials, adopts the change. Thus a complete change in belief requires motivational, educational and reward systems to keep the individual progressing through the change process. Among the critical factors affecting one's progression through the change process is the source of information available to him or her. The type of information source relevant at different stages of the adoption process varies. To make a population aware of alternatives, and perhaps to create an interest in change, "Cosmopolitan" and "Impersonal" sources of information appears to be particularly useful. These sources come from outside the local community and are persons not known personally by those who are in the process
INTERACTION OF SOCIAL, TECHNICAL AND ADMINISTRATIVE SYSTEMS

INTERNAL SOCIAL SYSTEM

EXTERNAL SOCIAL SYSTEM

SOCIAL SYSTEM

TECHNICAL SYSTEM

STRUCTURE

TECHNOLOGY

ADMINISTRATIVE SYSTEM

PEOPLE ORGANISATION RELATIONS
of change. Thus mass media efforts may create an awareness of alternatives and an interest in them, although they may have minimal effect at the evaluation, trial and adoption stages of the adoption process. At these later stages the "local" and "personal" sources of information become critical for convincing the person to change, and without them change may not be complete. Sources of information from persons close to home and from those known by individual in the adoption process seen to be particularly relevant for completing the change process. A second major factor affecting one's progress through the change process is the way in which one perceives characteristics of the innovation. If the people can see no relative advantage in changing, they may not feel that change is needed. The greater degree of incompatibility of the change with the existing beliefs, the less likelihood of change. The degree to which a suggested change can be divided into less complex parts to make it more compatible and easier to commute to the persons concerned, will affect the degree of change. To introduce the concept of "Sanitation" a complex idea that suggests an entire way of life - all at once might be too drastic to change and might be resisted. However, the residents may be taught how to wash a baby, build the latrine, away from well etc. Other complex health concepts like "nutrition", would similarly have to be broken down into simpler ideas in order to gain change and adoption.
4.1 Health Organisation as a Social System

A social system may be conceptualised as a complex set of human values and relationships mutually interacting in an infinite number of ways. The interactions in a system is such that a change in one part of the system affects all other parts.

Social Equilibrium: A system is said to be in social equilibrium when there is a dynamic working harmony among the interdependent parts of the system. Movement is taking place all the time in a social organisation, but the movement is done in a way that retains working harmony and balance in the system. When minor changes occur in a social system, they are absorbed by adjustments within the system, and equilibrium is retained.

Psychological Contract: When employees join an organisation they make an unwritten psychological contract with it. This contract is in addition to the economic contract for wages and working conditions. The psychological contract defines the conditions of each employee’s psychological involvement with the system. Employees agree to give a certain amount of work and loyalty, but in return they demand more than.

economic rewards from the system. They seek security, treatment as human beings, rewarding relationships with people, and support in fulfilling expectations. If the organisation honors only the economic contract and not the unwritten psychological contract, employees will tend to lose interest in their jobs. Essentially the psychological contract is governed by Exchange Theory, which states that in order for people to join and remain with an organisation, the benefits they receive must be more than their costs. Unless they feel that the exchange relationship is rewarding, they will tend to withdraw from it. The more rewarding it is, other things being equal, the more they will be attached to the organisation and support it. Exchange theory relates to Equity Theory, which is concerned with each person's feelings of fairness about the rewards received from an organisation. The theory holds that employees tend to determine equity by considering their inputs and outcomes of the job, compared with the inputs and outcomes of selected comparison people. If the ratios of the two people are unequal, this condition creates a tension of inequity in the employee that motivates corrective action. When outcomes are low in relation to employee perceptions of equity, employees will be dis-satisfied and will tend to reduce inputs, to more nearly-match outcomes. Many people want to feel that in return for their rewards they are giving an appropriate contribution to their organisation. They want to merit what they receive, because in this way their self-esteem is preserved.
ROLE PERCEPTIONS OF MANAGER AND EMPLOYEE

MANAGER'S PERCEPTION OF HIS OWN ROLE

MANAGER'S PERCEPTION OF EMPLOYEE'S ROLE

MANAGER'S PERCEPTION OF HIS ROLE AS SEEN BY EMPLOYEE

EMPLOYEE'S PERCEPTION OF HIS OWN ROLE

EMPLOYEE'S PERCEPTION OF MANAGER'S ROLE

EMPLOYEE'S PERCEPTION OF HIS ROLE AS SEEN BY MANAGER

MANAGER  ------

EMPLOYEE  ------
Culture Affecting Work: Many aspects of life have a significant influence upon behaviour. People interact with each other and develop a set of basic values. These basic values are so well ingrained that they are very difficult to change. These influence, how hard one works on job, and the way in which one cooperates with fellow workers and managers. The basic relationship is that culture off the job affects on-the-job performance.

Motivational Patterns: All parts of culture interact to develop in each person certain motivational patterns, which determine the way individuals approach their jobs and even life in general. Motivational patterns develop from a person's family background, education, and culture. Four motivational patterns that are especially significant are:

i) Achievement Motivation is a design to overcome challenges, advance, and grow. Achievement motivation leads to higher levels of aspirations, so the people work harder and make more progress. Such persons are best source of competent leadership.

ii) Affiliation Motivation is a drive to relate to people. The persons with affiliation motive work best when they are complimented for their favourable attitude and cooperation.

iii) Competence Motivation is a drive to do quality work. Competence motivated employees are often interested in
the technical part of their job, and seek job mastery and professional growth.

iv) **Power Motivation** is a drive to be in control. Power motivated persons tend to be higher risk takers. They may use power constructively in building or destructively in destroying Institutions and people.

**The Work Ethic:** The work ethic has its origin in both religious and secular values. Research has shown that work ethic may be deeply embedded in the drive to control one's environment. The important thing appears to be not that human beings get food, water and shelter, but that they get these things in ways that convey to the individual the sense that he is important, that he does control what happens to him. People have deep seated drives to control their environment and to test and affirm their competence. Work is an important means to these ends.

**Role:** Role is the pattern of actions expected of a person in activities involving others. It includes both rights and obligations, both power and responsibility. It arises as a result of the way each person's position is viewed in the social system. In order to be able to interact with each other, people need some way to anticipate other's behaviour. Role performs this function in the social system. A person has roles both on the job and away from it. Each role calls for different types of behaviour. When there is a wide variance between a manager's role perception of the job and the employee's role expectations of that job, there tends to
be poor motivation and inefficiency. They may have
difficulty even in communicating, when expectations of a
role are materially different or opposite, a person tends to
be in 'role conflict' because there is no way to meet one
expectation without rejecting the other. When role
expectations are inadequately defined or are substantially
unknown, role ambiguity exists, because people are not sure
how they should act in situations of this type. Research
shows that where 'role conflict' and 'role ambiguity' exist,
dysfunctional results occur. There is particularly a
decline in job satisfaction and need fulfilment.

**Status - The Social Rank of a Person in Comparison with Others in a Social System is Referred to as Status:** Status
may be either formal or informal. Individuals are bound
together in status systems, or status hierarchies, which
define their rank relative to others in the system. There
is a tendency to achieve slightly more status. When people
become seriously upset over their status and their inability
to change it, they are said to have status anxiety. Loss of
status is a serious event for a typical person.

**Symbols of Status:** These are visible external trappings
that attach to a person or work place, and serve as evidence
of social rank. These may serve as a disruptive-force or as
positive motivation, depending upon the skill with which the
management handles them.
AN ORGANISATION BEHAVIOUR SYSTEM

PHILOSOPHY AND GOALS

LEADERSHIP

FORMAL ORGANISATION

INFORMAL ORGANISATION

COMMUNICATION

SYSTEM OF CONTROL

EMPLOYEES' ATTITUDES

SOCIAL SYSTEM EQUILIBRIUM

SITUATION

MOTIVATION

ACHIEVEMENT OF GOALS
Organisation Climate: Each organisation has its own culture, traditions, and methods of action which in their totality constitute its climate for people. As the new employees make their psychological contracts with their organisation they hope that it will have a supportive climate to help them meet their economic, social and psychological wants. An organisation tends to attract and keep people who fit its climate, so that its patterns are to some extent perpetuated. Organisational climate can have a major influence on motivation, productivity and job satisfaction. It does this by creating certain kinds of expectancies about what consequences will follow from different actions. Employees expect certain rewards, satisfactions, and frustrations, based upon their perception of the organisation's climate. These expectations tend to lead to motivation. Organisational climate represents the entire social system of a work group. It is clearly a system-concept. Employees feel that the climate is favourable when they are doing something useful that provides a sense of personal worth. Many employees also want responsibility. They want to be treated as if the organisation really cared about their needs and problems.

4.2 An Organisational Behaviour System: The climate of each organisation is achieved through an organisational behaviour system. Elements of the system are usually derived from the philosophy and goals of those who join together to create it. Persons bring their own
psychological, social and economic wants, which they express in both individual and group ways. All these different interests come together in a working social system. The philosophy and goals of people are implemented by leadership, working through formal and informal organisation. These formal and informal organisations provide the structure to find the institution together into a working team. Each institution is affected by other institutions with which it comes in contact. These constitute its social environment. All organisations influence their members by means of a control system, that reflects the intermingling of formal organisation, informal organisation, and social environment. This is made possible by communication and group processes.

Social System at Work: The system of controls in an organisation interacts with a person's attitudes and with situational factors to produce a particular motivation for a designated person at a certain time. If any one of the three-controls, attitudes or situations is changed, the motivation will be different. Motivation is determined by the interaction of controls, attitudes and the situation all operating in equilibrium within the social system. The result of an effective organisational behaviour system is productive motivation. This kind of motivation should get above-average performance out of average people. It develops problem solvers out of problem makers. It builds
LEADERSHIP STYLES

AUTOCRATIC

LEADER

EMPLOYEES

PARTICIPATIVE

LEADER

EMPLOYEES

FREE-REIN

LEADER

EMPLOYEES

EMPHASIS IS ON

LEADER

WHOLE GROUP

EMPLOYEES
two way relationships, meaning that manager and employee are jointly influencing each other and jointly benefitting.

**Models of Organisation Behaviour:**

Organisations differ in the quality of organisation behaviour that they develop. These differences are substantially caused by different models of organisational behaviour that predominate in management thought in each organisation. There are three models - the autocratic model; the custodial model and the supportive model. These three represent a historical evolution in management practice. The autocratic model dominated a century ago. In 1920s and 1930s it yielded ground to the more successful custodial model. In the present generation the supportive model tends to dominate.

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<thead>
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<th>Models of Organisation Behaviour</th>
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<tr>
<td><strong>Autocratic</strong></td>
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<tr>
<td>1. Depends on:</td>
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<td>2. Managerial: Authority</td>
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<tr>
<td>4. Employee: Dependence on 'Boss'</td>
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<td>5. Employee: Subsistence Needs Met</td>
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<td>6. Performance: Minimum Result</td>
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<td>7. Motivational: Extrinsic Environment</td>
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<td>8. Motivational: Negative Style</td>
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<td>9. Need Priority: Physiological Security</td>
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Job Satisfaction: One of the signs of deteriorating conditions in an organisation is low job satisfaction. It may be reflected in the form of low productivity, disciplinary problems and other organisational difficulties. On the other hand, high job satisfaction is the hall mark of a well managed organisation. Wanous (1972) defines job satisfaction as the favourableness or unfavourableness with which employee view their work. Job satisfaction results when there is a fit between the job characteristics and the wants of the employee. Job satisfaction is the amount of congruence between one's expectations of the job and the rewards that the job provides.

4.3 Motivation

Some of the commonly used definitions of motivation are: Motivation is a pre-disposition to act in a specific goal directed way. Motivation includes the immediate influences on the direction, vigor and persistence of action. Steering one's actions toward certain goals and committing a certain part of one's energies to reach them is motivation.

Motivation tells how behaviour gets started, is energised, is sustained, is directed, is stopped and what kind of subjective reactions present in the organism while all this is going on. All these definitions contain certain common aspects of the motivation process: What energises human behaviour? What directs or channelise such behaviour? How this behaviour is maintained or sustained?

The process of motivation is characterised by the following:

a) **Motivation is an Internal Feeling** - Motivation points to energetic forces within individuals that drive them to behave in certain ways and to environment of forces that trigger these drives.

b) **Motivation Produces Goal-Directed Behaviour** - Motivation has got a profound influence on human behaviour, it harnesses human energy towards the goal oriented behaviour.

c) **Motivation Contains Systems Orientation** - It considers those forces in the individual and in their surrounding environments that feedback to the individuals, either to reinforce the intensity of their drive and the direction of this energy or to dissuade them from their cause of action and redirect their efforts.

d) **Motivation can be either Positive or Negative** - Positive motivation offers something precious to the person in the form of additional pay, incentives, praise etc. Negative motivation emphasises penalties.

e) **Motivation Means Bargaining** - Behaviour is what people do; motivation is why they do it.

f) **Motivation is a Complete Process** - Motive is a hypothetical concept. Individuals may have a host of needs that are continuously changing. As a result it
becomes difficult to measure motivation with certainty. People satisfy their needs in different ways. Gratification of a particular need may gradually lead to an increase in its intensity. Goal directed behaviour does not always lead to need satisfaction.

g) Motivation and satisfaction are related but are not synonymous concepts.

4.4 Utilisation of Health Care Services

Although there is a mass of literature, one is nonetheless unable to make definitive statements about why some use health services and others do not. However, one can draw ideas from literature about factors that may be important and to understand differences in utilisation. McKinlay (1972) has defined six sets of such factors:

1. Economic Causes - The researchers have examined economic causes of difference in utilisation, in order to whether cost of health care influences its usage. Although some differences in utilisation have been noted based on income of families and individuals and on methods of payment; it has also been found that removal of cost as a factor has not altered differences in utilisation found among social classes. Thus,

although cost is important, it is not the only nor
necessarily the most important variable affecting
health care utilisation.

2. **Socio-demographic Variables** - (Including age, sex,
education, religion, ethnicity and socio-economic
status) have been found to be related to utilisation of
health services.

3. **Geographical Location of the Services** - It has been
argued that the closer proximity of services, the
higher the usage will be.

4. **Social-Psychological Variables** - Certain social-
psychological variables have been related to
differences in utilisation. These include various
fears (of medical findings, treatment, getting worse)
beliefs that legitimate health care can help the
situation, knowledge of the illness, recognition of
need, sense of urgency, and alienation from health care
organisations.

5. **Socio-cultural Variables** - Certain writers have looked
at socio-cultural variable in utilisation. This
approach is based on the idea that within certain
groupings, one will find beliefs about when action
should be taken, including the action of seeking health
care.
Organisational Variables - Some writers consider primarily organisation variables. Specially examined from this perspective have been conflicts between, the values and beliefs of the health care personnel and the persons using the services. A major orientation of this approach has been with those organisational impediments and client dissatisfactions that may affect health care utilisation.

Although all six variables may be important in understanding differences in health care usage, but perhaps a small number of them are important. What is needed is research examining the relationships among the six variables and determining their relative importance in utilisation. The fact that certain variables affect utilisation in two or more contradictory ways may account for some of the inconsistencies in findings. For example, income may act to both increase and decrease the seeking of care. On the one hand, those with higher income may have a life-style that is compatible with good health; thus they do not become ill and do not require a high level of health care usage. On the other hand, those with higher incomes can afford to seek care more often than those of lower incomes, and thus income overrides any negative effect of the cost of care on utilisation. Income can be both positively and negatively related to health care utilisation. Only through examining the interactions and inter-relationships among the various variables can knowledge reach a level that permits us to
offer conclusive answers to the question who seek care? The most widely known effort to develop a multivariate model of utilisation, has been that of Edward, A. Suchman (1965). Suchman related health, social structure, attitudes toward modern medicine, and socio-demographic characteristics to health care usage. However, the relationships among variables pointed in this model have not been verified in subsequent researches. His own data have been found not to support his model completely, and other research has indicated that the model is population specific (that is, it can be verified only in certain groups).

Model of Incompatibility between the Providers and Receivers of Health Services: One of the important factors which stands out to explain low or no-utilisation of modern health services, is the problem of lack of compatibility between the providers and users of the health services.

I. Users System - Diseases are caused by evil spirits and offenses to dead ancestors. The cure is based on performance of propitiating rituals. There is delayed perception of disease (when unable to work or take food). They cannot afford to play sick role long and therefore, late detection and early cure is desired.

They use the medicine man who specialises in calling and communicating with spirits. The minor ailments are ignored. The symptoms of sickness are stopping of work or not taking of food. As the economic compulsions do not allow to remain sick for long, preference is for sure and quick treatment through potent medicines like injections. In some cases, free treatment is considered less effective and, therefore, there is disbelief in Govt. System. The preventive and promotive aspects of health are considered unnecessary. The negative personal hygiene is a means to fight away evil spirits. Therefore personal hygiene is usually neglected. Because of problems of poverty and distances, one time treatment service is preferred. The treatment is largely participatory. Generally the whole man is treated. There is holistic basis of treatment. The local medicine man share the diagnosis with the client. The local medicine man speaks the same language, puts on similar dress, and is integrated part of their community. The local medicine man is a part of the community and enjoys the negative and positive aspects of the local life. In local indigenous treatment, most of the medicines are locally grown or made. The health needs are peculiar and specific to their environment.

II. Provider System - It has Scientific basis of disease causation. The treatment is based on scientific investigation and removal of causes. There is early perception of disease. The Sick role is legitimised role and social and economic systems provide for it. There is no economic compulsion to delay the detections and quickers the cure process. The modern medicine man has his diagnosis and treatment based on systematically developed science of medicine. Treatment is required even for minor ailments. There are several physical symptoms declaring sickness and need for treatment. The treatment is gradual and sick role is prolonged. Free treatment is considered as a human right. The preventive and promotive aspects are highly valued. In all situations personal hygiene is desirable and respected. The repeated visits are made. There is very little scope for participatory treatment. Only disease is considered in treatment. There is specialist basis of treatment. The diagnosis is reduced in the form of a coded prescription and the client is discouraged to know about the diagnosis. The modern medicine man of PHC is outsider, speaking different language and dressing different way. The Govt. Doctors and workers suffer from a sense of frustration and the posting is considered punishment posting. The service centres depend on the medicine supply from outside and usually have poor supplies.
Providers provide the services in the general pattern without caring for the local needs. There is high incompatibility between the providers and receivers of health services. This ultimately results in very low utilisation of health services.

4.5 Factors Responsible for Low Performance of Health Programmes

I. Programme Factors

1. Organisational Set Up - The poor State level leadership due to - Short tenures of health Secretaries, Directors and vacancies in key positions; Political pressures; Various factors leading to malpractices. The weak PHC and District level leadership - due to the appointment of subject-specialist as the head of the district for health services; Medical Officers strongly oriented towards clinical practices with very limited training in Public Health; Ad hocism in posting of Medical Officers; Inadequate powers of the District Head and Block Medical Officers; Vacancies at various levels; and Political interference in transfers.

2. Development and Management of Infrastructure Facilities. These include - Poor maintenance of buildings; Inadequate and poor maintenance of equipment; Inadequacy of vehicles, inadequate POL
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and complicated lengthy procedures for getting sanctions for repair of vehicles; Supplies not on the basis of demands; and Lack of supervision and poor monitoring system.

3. **Utilisation of Facilities** - The factors affecting are - Accessibility of facility; Administrative structure and arrangements; Motivation and morals of service personnel; Current strategies; Home visits by health workers; Quality of services; Inadequate knowledge and training of services personnel; IEC component; Management interventions; and State Budgetary resources.

II. **Non-Programme Factors** - These include-
Operationalisation of developmental programmes; and Frequency of occurrence of floods, draughts and other scarcity.

III. **Socio-economic and Demographic Factors** - These comprise of Status and role of women; Socio-economic factors; Religious and cultural factors; and Psychological factors.
Following are the main conclusions, which emerge from the discussions in the Chapter:

1. The mothers and children are a priority group in our context, because they constitute nearly two-third of the population; are more vulnerable than the other segment of the population and suffer from diseases which can be easily prevented by simple technological interventions.

2. The Government of India has committed itself to ensure better status of maternal and child health, through constitutional obligations, Alma Ata Declaration and in the statement of National Health Policy. The Government document has already initiated the programmes like Child Survival and Safe Motherhood Programme, Universal Immunisation Programme, Diarrhoeal Disease Control Programme etc. in that direction. The success and acceptance of these programmes by the potential beneficiaries in the community depends to a large extent on the perceptions of the programme services by the masses, their socio-cultural mileu, and certain socio-demographic factors and operationalisation of health care delivery system.

4. The social aspects of illness, illness behaviour and doctor-patient communication, affect utilisation of services.
5. The Health organisation functions as dynamic social system. The work culture, motivational level of its functionaries, leadership styles, work ethic, job-satisfaction all affect its functioning.

6. There have been incompatibility between the providers and receivers of health services in terms of disease etiology, spread, prevention and treatment, which could result in poor utilisation of governmental health care delivery system in rural areas.

7. The socio-demographic variables like education, socio-economic status, head of family, exposure to mass media, perception of beneficiaries, social norms, values, beliefs, leadership, affect the adoption process.