CHAPTER I
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CHAPTER I

INTRODUCTION

Welfare of human life has been the ultimate motive of every human endeavour. Health is the first of all welfares a human being seeks. Human beings have the most advanced social system in the universe. Thus society and health are always interlinked. The Introductory chapter aims to define the principles of interaction between the society and healthy living of its members. Health is seen outside the triangle of patient, doctor and drugs.

1.1 The Concept of Social Medicine

Hippocrates, the father of Medicine was the first to point out that people and their physical environment were the causes of common and frequent epidemics. He recognised that factors such as age, sex, climate, economic position, geographic location in the community etc. affected susceptibility to illnesses. While he was not able to gain specific insights into the causal factors of diseases, his linking together of people, their life styles and environmental elements still provides the foundations of public health knowledge and practice.¹
Two and a half millennia ago, the Hippocrates, author of the monograph *On the sacred disease* (written to prove epilepsy was not "sacred" but natural) asserted:

"Men ought to know that from the brain and the brain alone arise our pleasures, joys, laughter and jests, as well as our sorrows, pains, grieves, and tears. Through it ... we think, we see, we hear, and we distinguish the ugly from the beautiful, the bad from the good, the pleasant from the unpleasant. By the same organ, we become mad or delirious, and fears and terrors assail us ... and dreams and untimely wanderings ... All these things we endure from the brain when it is not healthy, but it becomes abnormally hot, cold, moist, or dry, or suffers any other unnatural affection."

When that paragraph was written, it was a testimony of faith; today, scientific evidence strongly supports its assertions. The brain is the organ of the mind. But our current understanding includes the recognition that the very structure of the brain is moulded by inputs from the biological and social environments to which the individual is exposed.²
The idea that medicine is a social science was put forth for the first time by Neuman of Berlin in 1847, who stated that medicine is fundamentally a social science. It was the time of the Industrial Revolution and it was impossible to ignore the extent to which the factory system impoverished the workers, thus creating poverty and disease. The most famous representative of early social medicine is Rudolf Virchow, the distinguished German pathologist who developed the theory of cellular pathology. Virchow was also a social reformer who remarked that "politics is nothing more than medicine on a grand scale." But these ideas were too far ahead of their times. In the 20th century George Rosen would distill the Virchow's principles into the following:

1. Social and economic conditions profoundly impact health, disease and the practice of medicine.

2. The health of the population is a matter of social concern.

3. Society should promote health through both individual and social means.

When Virchow described medicine as "a social science and politics as medicine on a large scale", he anticipated the political (social) control of medicine. In 1911, Grotjahn published his famous
book 'Soziale Pathologie' in which he advocated a systematic study of human disease with special reference to social factors. He also emphasized the need for sociological analysis of health problems making use of the methods of statistics, demography, anthropology, economics and sociology.

Towards the twentieth century, John Ryle and a group of medical men started discussing about the need for changes in attitudes. It seemed to them that the practice of medicine had become too focused on treatment and cure of diseased organs and on the effects on the individual alone. They thought that the science was not rendering the greatest possible service. The goals of public health and social medicine gradually became identical with disease prevention, health promotion and the study of man as a social being in relation to the total environment. The realization grew that not only man was a biological animal, but also a social being and that diseases have not only social origins but social consequences as well.4

It is possible to argue that all medicine by its very nature is social. The way we define diseases and health, the methods we use for diagnosis and treatment, how we finance health care, all these cannot help but reflect the social environment in which medicine operates.
Social medicine, however, looks at these interactions in a systematic way and seeks to understand how health, disease and social conditions are interrelated. As might be gathered from these ideas, social medicine was not simply an academic pursuit. Its practitioners were political reformers, radicals, activists. Virchow believed that the "physician was the natural advocate for the poor." And this defense of social justice would stamp future generations of physicians and health care workers.

Social medicine has grown and developed in many different ways in the past two centuries. At times it has seemed as if the "biomedical paradigm" would make social issues in medicine irrelevant. Yet we cannot escape the reality that we are social animals and our diseases occur in "social animals" and not in test-tubes. The current debate over emergic epidemics illustrates both the astounding success and spectacular failure of modern biomedicine. Once looked upon as a healing art, medicine is looked upon today as the sum total of all activities of a society and individual that tend to promote, restore and maintain the health of the people of current as well as subsequent generations.
Health services throughout the world are now confronted with new challenges. (a) First they are not considered as a complex of solely medical measures. Today it is well known that it is not possible to raise the level of people's health without making changes in their economic, social and cultural environments. This has given rise to the concept of intersectoral approach to the problems of health and disease, also known as the concept of health development. (b) A second challenge is the growing realization that the existing health services are over sophisticated and not within the reach of majority of the population. This has been termed as social injustice (c) Community participation is a keyword in modern day health philosophy as it is in many areas of human life. Communities are encouraged to take the initiative in identifying their own health problems and in finding solutions to them. This will ensure social control of health services. The community participation as envisaged by the World Health Organisation (WHO) and United Nations Children’s Educational Fund (UNICEF) is the process by which individuals or families assume responsibility or health. It also implies community participation in health, what was once called as “health by the people, for the people and of the people”15.
The social and physical environment in which the individual lives can also contribute to illness. Many diseases could be prevented by alterations in environment. A rather extensive range of socio cultural responses to the signs and symptoms of illness have been recognised by social workers. There can be varying patterns of response by different groups to the same illness. When the disease is considered as legitimised, the individual may be considered as patient. On the other hand, when the disease is a result of a misdeed from the individual, the 'sick role' may not be very comfortable for the patient. The patient's obligations to others and their obligations to the patient are bound to change most often. The situation becomes very complex when the 'misdeed' is just another deed of the person's past life. For the affected individual to cooperate, the patient should perceive the illness as serious enough to require a definite, changed role. Economic and social class, cultural, psychological and institutional environments all have an impact on people's response to illness. The fact that none of these factors act independently argues strongly for an understanding of illness behaviour from an ecological perspective.
1.2. Health for All.

As we approached the end of the twentieth century, there was growing recognition of the special responsibility devolving on us to protect and promote the health and well being of not only the current but also the future generations. The resolution adopted in 1977 on the attainment of the social goal of “Health for All by the year 2000, the Alma-Ata declaration of 1978, and subsequent developments have provided not only a new direction but also a value system of health development. The World Health Assembly referred to it as an attainment by all people of the world, of a level of health that will permit them to lead not only a disease free life, but also a socially and economically productive life. Right kind of food, essential drugs for all, safe drinking water for all, basic sanitation, complete immunization coverage were major milestones. The cardinal features also included ensuring access to essential health care for populations that have suffered poverty and neglect for years, community involvement and even national and international resource mobilization. To bring about these changes, reforms are needed not only in health sector, but also in political, social and economic fields. The enjoyment of the highest attainable standard of health has been
declared a fundamental right of every human being, irrespective of race, religion, political belief, economic and social conditions.  

The targets -- medical as well as social -- were becoming nearer and nearer, when as a bolt from the blue the disease AIDS (Acquired Immuno Deficiency Syndrome) was recognised in a group of homosexual men in the United States.

1.3 Gandhian perspectives on Health:

So long as man can live in harmony with nature and all living beings, the human body can maintain itself and can resist many diseases. If man becomes completely alienated from nature, the result will be disastrous. Gandhiji has repeatedly thought and written about man’s problems. A major portion of Gandhi’s thoughts were devoted to health of human beings. Even before publishing “Hindu Swaraj”, Gandhiji published a book entitled “Guide to Health”. After returning to India, he published a book entitled “Key to Health” for the sake of his African friends. The fight for freedom and good health was his life-long passion. Gandhi remarked that proper knowledge of our own body would help us to understand the very universe itself. He leads us to believe that human body is a wonderful phenomenon coordinating the five perceptions of nature, the five
senses and five moral principles of life. In our efforts to settle the obligations to God, it is also our duty to keep our body clean and healthy. From his personal experiments, Gandhiji had explained in simple terms the fundamental requirements of man. He asserted that self control was absolutely essential for a healthy human life. The concept of ‘brahmacharya’ was well explained and practiced by him. To him life itself was an experiment. The principles he recommended for health was based not only on faith but also on his observations across the globe.

The passage of time does not reduce, but rather enhances the conditions where we can keep him alive in our minds. Then we can look forward confidently to a new dawn for Gandhiji’s ideals. This is probably the best time we have to make use of such an opportunity in India. 8

1.4. The Kerala Model of Health— a review

What is the Kerala model? It generally refers to the high achievements of Kerala’s people on statistical indicators of health. These indicators have been achieved despite continuing low incomes 9.
Kerala’s 1991 birth rate was 20 per 1,000 females compared with India’s rate of 31 and a world poor country average of 38. Kerala’s infant mortality was 17 per 1,000 live births versus 85 for India and 91 for other poor countries. Kerala’s adult literacy rate was 91% while India’s was 52% and other poor countries had 55%. Yet Kerala’s per capita income in 1991 was $298 compared to the all-India average of $330 and a world poor country average of $350. By comparison, the USA in 1991 had a per capita GNP of $22,240. Yet Kerala’s material quality of life indicators were far closer to those of the USA than to those of the rest of India or those countries with similar income levels. Kerala proves empirically that literacy, low infant mortality, and the like can be achieved even before industrial world income levels. Some aspects of development do not have to wait for economic growth. The Kerala model has become an inspiration partly for two reasons. As the rich countries have become increasingly unwilling to extend meaningful foreign aid and as the threats of violence and anarchy have seemed to spread in the Third World, Kerala has become increasingly more of a model.

What is the economics behind this? One study by Richard W. Franke and Barbara H. Chasin showed that positive changes had
occurred in long term period. They achieved these through a combination of educational opportunities, special programs for the disadvantaged castes, and access to education and information. Overall, people improved their houses, their wells, and made small gains in the ownership of good and healthy qualities. The introduction and sustenance of the footwear usage amongst the poorer of the poor in Kerala is one typical example. Even though this is a well forgotten step now, the benefits it has transferred to the people is unthinkable.

Despite the progress clearly evident at the village level, most people remained very poor by international developed country standards. Their diet is just barely adequate, their homes are almost bare of furniture, and many have lives full of intense periods of very hard labor alternating with anxious periods without work. The study found that the 42% of households dependent on agricultural work found only an average of 90 days work in the year. Across Kerala more generally, we also see severe limits to the Kerala model.

So now we have the challenge. After decades of achievements, Kerala still faces daunting obstacles in bringing a better life to its people and in maintaining the resources for that life for future
generations. In the face of such obstacles, Kerala is fortunate, however, because of another element of the Kerala model that needs mention.

The key word is participation. In Kerala, more than in most parts of the underdeveloped world, large numbers of people participate in activities to better their lives. Malayalees are not just literate. More people in Kerala read the newspapers and discuss them. They also write letters to complain about problems and demand solutions. Malayalees do not just have the right to vote. In Kerala people vote in far higher percentages than in most of the rest of India -- and more so than in the United States also. Malayalees do not just benefit from the advances of modern science. While science movements exist in other parts of India, none is as highly developed as in Kerala.

Kerala's people thus face the seemingly overwhelming problems with a large dose of the one element that makes solutions possible: a strong capacity to organize on their own behalf. After decades of practice, the idea of organizing movements to solve problems is well established in Kerala.
Development economists use income as a key indicator to track well-being. Crudely put, higher a person's income over time, the more developed she is. According to Amartya Sen, we are developed only when we have the freedom to lead the kind of lives we have reason to value. A person with the ability/freedom to choose between alternative lifestyles (and not just earn more) is more developed than a person without that freedom.

"Do you have the choice to be educated, to be healthy, to freely participate in politics? Does one have the freedom to spend the money one earns? Different people value different things, but some of these may be common to all (example: desire to lead a healthy life). The important thing is to ask whether we have the ability to choose, and to overcome un-freedoms. This is the spirit of Sen.

Amartya Sen's perspective of 'development as freedom' is not criticism-free. But its popular version (human development) is the most influential strand in contemporary international Development thinking. Today, it is acknowledged that governments should seek to not just increase income, but also provide conditions for enhancing people's freedoms in political, economic, social, and household spheres (including access to education, health, employment, politics).
Sen invariably uses Kerala to illustrate (1) the existence of Development in terms of non-income freedoms like education and health, though incomes of people are low - highlighting the government's role (2) the importance of education - for example, how literacy helps women gain more control over family planning (3) the importance of political freedom - for example, how the freedom to protest can be used to monitor and ensure good medical services.  

Thus the Kerala model happens to give us a very good idea of how health of a society can be influenced by the social aspects in development, but also gives us ample chances to explore how better this can be utilized for the welfare of the next generation as well.

1.5 Risk Perception as a pertinent social tool for health

Both risks and benefits have to be considered when seeking to understand what drives some behaviours and why some interventions are more acceptable and successful than others. Social, cultural and economic factors are central to how individuals perceive health risks. Similarly, societal and structural factors can influence which risk control policies are adopted and the impact that interventions can achieve. Preventing risk factors has to be planned within the context of local society, bearing in mind that the success of preventive
interventions is only partly a matter of individual circumstances and education. In designing intervention strategies, it cannot automatically be assumed that the diverse groups which make up the general public think in the same way as public health professionals and other risk experts. In addition, estimates of risk and its consequences, presented in scientific terms based on a risk assessment, have to be communicated with particular caution and care. The best way is for well respected professionals, who are seen to be independent and credible, to make the communications. An atmosphere of trust between the government and all interested parties, in both the public and private sectors, is essential if interventions are to be adopted and successfully implemented.¹³

Risk perceptions all over the world are increasingly being influenced by three other trends. First, by the power and influence of special interest groups connected to corporate business interests and the opposition being organized by many advocacy and public health groups. Second, by the increasing influence of the global mass media. And third, by the increase in risk factors within many middle and low income countries as a consequence of the effects of globalization.
Until recently, risks to health were defined largely from the scientific perspective, even though it has been recognized for some time that risks are commonly understood and interpreted very differently by different groups in society, such as scientists, professionals, managers, the general public and politicians. Assessment and management of risks to health is a relatively new area of study that has been expanding steadily since the early 1970s. It began by focusing on developing scientific methods for identifying and describing hazards and for assessing the probability of associated adverse outcome events and their consequences. Particular attention has been given to the type and scale of the adverse consequences, including any likely mortality. In the early years, risk analysis, as it was then called, was seen mainly as a new scientific activity concerned with environmental and other external threats to health, such as chemical exposures, road traffic accidents, and radiation and nuclear power disasters. The early study of risk developed mainly in the USA and Europe. During the early 1980s, risk analysis evolved into the two main phases of risk assessment and risk management, as more attention was given to how hazards or risk factors could be controlled at both the individual level and by society as a whole. The
emphasis moved from determining the probability of adverse events for different risk factors to assessing the scale. A greater understanding of men’s perceptions of sexual risk and their risk-taking behaviour is necessary if interventions are to be more successful in improving the reproductive health of both men and women.

Risks to health, as an area for further study, have only recently begun to receive attention in developing countries. The need to view such risks in their local context is obvious when analysing perceptions of risk in these countries, especially when risk factors are considered alongside life-threatening diseases such as tuberculosis, malaria and HIV/AIDS. There are also other daily threats, such as poverty, food insecurity and lack of income. In addition, families may face many other important “external” risks, such as political instability, violence, natural disasters and wars. Thus every day there is a whole array of risks that have to be considered by individuals and families.

Models of individual risk perception and behaviour were, however, mainly developed in industrialized countries where people have considerably higher personal autonomy and freedom to act, better access to health information, and more scope for making
choices for better health. These models may be less appropriate in low and middle income countries, where illnesses and deaths are closely associated with poverty and infectious and communicable diseases. In industrialized countries, studies of HIV/AIDS and, to a lesser extent, noncommunicable diseases such as cancer and coronary heart disease have been carried out using the perspectives of applied medical anthropology and sociology. However, in developing countries where communicable diseases still cause a high proportion of the avoidable mortality, these disciplines have most frequently been co-opted to help evaluate the effectiveness of disease control programmes. Perceptions of disease, use of health services and reasons for non-compliance are some areas often studied.

For communicable diseases, it is important to differentiate perceptions of the risk of a disease from those concerned with the risk of acquiring the infection, particularly as not all infections, such as sexually transmitted infections and tuberculosis, will develop into symptomatic disease. Interrupting transmission of infections, for example through the use of measles vaccine or bed nets in malaria control, is the main way in which control programmes reduce risk. In such situations, risks are often determined from the point of view of
whether an effective response exists in practice. Thus effectiveness evaluation is based on such indicators as early recognition of signs for severe illness (for example, acute respiratory infections), symptoms requiring self-referral for treatment (for example, leprosy and schistosomiasis), or use of impregnated bed nets to prevent malaria transmission. Because of the effects of the demographic and epidemiological transitions, many middle and low income developing country populations face existing risks from communicable diseases, as well as rapid increases in risks to health from many risk factors and noncommunicable diseases. Although avoidance of risks of infection, often perceived as risk of disease, are implicit in most biomedical and public health models of disease control in developing countries, more research from the anthropological point of view is clearly needed to place these risks in perspective among a whole array of other risks to life. Given competing risks, it cannot be assumed that if people are better informed on their exposures to risk factors they will necessarily act to change their health behaviours. Discussions of risk perceptions are often still bedevilled by a number of simplistic and polarized views, such as between expert (scientific) understanding and general public (lay) perceptions; between quantitative (objective) and
qualitative (subjective) assessment of risks; and between rational analytical and "irrational" emotive responses. Such stereotyping, reflected in the debates about nuclear power in the 1970s and 1980s, is unhelpful today in considering risks to health and how risk factors can be prevented. In addition, policy recommendations are likely to be resisted if they attempt to define the "correct" definitions of risk and support only the so-called "true" and objective measures of risk factors. Risk acceptability depends upon many different aspects of perceived risks of technologies and interventions, as well as any perceived benefits. Both risks and benefits have to be considered when seeking to understand what drives some risk behaviours and why some interventions are more acceptable and successful than others. Moreover, social, cultural and economic factors are central to how individuals perceive and understand health risks. Similarly, structural factors can influence which risk control policies are adopted and what impact interventions for risk factor prevention can finally achieve. A focus on individual perceptions, particularly when considering communicable diseases in the developing world, essentially considers the risk from the point of view of personal health services and individual people. This approach ignores,
however, the constraints on the autonomy or control that individuals have to act in their societies. Preventing risk factors thus has to be planned within the context of the local society, and prevention through interventions is only partly a matter of the individuals' circumstances and education. In addition, because of the great lack of risk research in developing country populations, the transferability of research findings on risk perceptions from developed nations should also be treated with caution. This suggests a need for a concerted agenda for international research.14

It is widely agreed that before interpreting risks and planning any communications or health interventions, people's basic perceptions and frames of reference for interpreting risks must be well understood. It cannot be assumed that the general public thinks in the same terms and categories that are routinely used by public health professionals and other risk experts. Although obvious, this is a common mistake in designing intervention strategies.

The boundary between "experts" and "public" is not as straightforward as it might at first seem. The general public in fact consists of many different "publics", such as young and old, women and men, and poor and vulnerable. Each group can hold valid and
different risk perceptions and frames of reference for similar risks factors. Estimates of numerical risk and its consequences, presented in scientific terms based on a risk assessment, therefore have to be communicated with particular caution and care. Communicating information on risk frames and perceptions, and risk prevention, is best done by independent and credible senior professionals. They can help create the atmosphere of trust between the government and all interested parties, in both the public and private sectors, that is essential if interventions are to be adopted and successfully implemented. 15

1.6. The role of Advocacy in promoting health

A growing number of disciplines have recognised the centrality of “empowerment” to the health and wellbeing of communities. For health promoters, this concept emphasizes greater community control over health determinants, ultimately implicating health promotion practice that strengthens communities’ participatory capacities in preparation for engagement in public policy advocacy. In recent years health promotion literature has somewhat unpacked the notion of community empowerment recognizing the multi-levels of power relations inherent in this construct. Calls for community action
to improve health determinants, and in particular the engagement of
disenfranchised communities in these activities, require a more
nuanced understanding of the power relations (and their changing
nature) that must be negotiated within community empowerment
projects.

The decisions of the communities and individuals in relation to
health are shaped by the environments and circumstances in which
decisions are being made. It is of major concern as we enter the
twenty first century that health promotion is able to contribute
actively to action that addresses these social determinants— at global,
national and local levels. The demands are great and the stakes are
high. One of the first issues is to understand why and how to
contribute actively to the policy decisions that influence
environments, social norms and behaviours. The legitimacy of the
role of health promotion is well established and the challenges are
greater.\textsuperscript{16}

If we accept that physical, economic and social environments
determine people's access to healthy choices and that these
environments are created by decisions made by individuals,
organizations and governments, then it is essential that people
concerned to promote health and well-being of populations be engaged in making these decisions: either directly as participants or indirectly by providing information and building constituencies to support the preferred courses of action.¹⁷

Chapman and Luton (1994)¹⁸ identified barriers to achieving public health goals:

a. political philosophies that devalue health and quality of life at the expense of economic outcomes;

b. political and bureaucratic opposition or inertia to health promoting regulatory provisions and policies, and to the participation of consumers in planning for health;

c. the marketing of unsafe and unhealthy products, increasingly by transnational corporations of immense political power and wealth;

d. the pervasiveness of cultural values such as racism, ideas on sex etc. which find expression in values and personal attitudes.¹⁸

Plainly such barriers can be overcome only by engaging in the processes used by our own organizations and governments to set goals and to make and implement policies and programs. As a health
promotion strategy, advocacy is a process for bringing about change in society. It is process to overcome structural (as opposed to individual or behavioural) barriers to achieving public health goals. Public health advocacy employs the methods of political advocates to bring about changes in the system that influence the health and well being of populations. It aims to change the legislative, fiscal, physical and social environments in which individuals’ knowledge and attitudes are developed and expressed, and in which behaviour changes take place. But in itself, public health advocacy is essentially, a political process that aims to influence political decisions about the distribution of society’s resources.

There are some differences between advocacy, public education and social marketing. Wallack (1998) points out that traditional methods of mass media intervention in health promotion, often emphasize the 'information gap', which suggests that health problems are caused by lack of information on the part of the individuals with the problem or at risk. Public education programs are then designed to fill the information gap. Here the problem is presented as an individual’s problem and the solution is for the individual to take action (on their own). On the other hand, media
advocacy focuses on the 'power gap' where health problems are viewed as a lack of power to define the problem and create a social change. The target of media advocacy is to close the power gap by attempting to motivate broad social and political involvement rather than changes in personal health behaviour.

What are then the major components of an effective public health advocacy campaign? This is neither the domain of a single person nor organization. Rather, multiple actions are required by multiple people and organizations. An effective public health advocacy campaign requires

(a) information about public health problems, their causes and determinants and about effective solutions or responses.

(b) involvement and important participation of health professionals in establishing an agenda or proposing courses of action. [They usually have high levels of credibility among the public, the media and politicians.]

(c) skilled professionals and administrators (bureaucrats) who play a crucial role in translating the agenda of public health into the language and thinking of government of the day.
(d) partnerships or coalitions with key stakeholders. This may be individuals / organizations among the government or private sectors.

(e) community educators and organizers to build wide spread community support for action to address an issue, for generating solutions and for supporting proposed changes in policy or for programming or resource allocation.

(f) research and evaluation, to identify problems, test solutions, and to assess the readiness of communities to take action on a health issue and to assess the effects of different components of the activity and to measure the impact and outcomes.

Of the three major strategies for promoting health, advocacy tends to be the least well used. Becoming effective masters in public health advocacy means mastery of the methods and tools of advocacy, particularly the successful use of mass media. It also requires understanding of the advocates on their roles in relation to the values and goals of the community or society on whose behalf they are advocating. This has to based on the understanding that determinants of health are socially constructed - not random- by the decisions of the governments, organizations (public and private), communities and individuals.²⁰
References


