Chapter 1
INTRODUCTION

1.1 Introduction

‘Health For All by 2000’ the very renowned maxim of the famous Alma Ata declaration of World Health Assembly as goal of health care systems of all nations, was resolved in the 30th Conference in May 1977. The new ideas and concepts like social justice and equity, crucial role of community participation, human rights etc are calling for new approaches in order to make the health services at the service of humanity more effectively. The fundamental principle of HFA strategy is equity, which is an equal health status for people and countries, ensured by an equitable distribution of health resources. The Member countries of WHO defined ‘Health for All’ as ‘attainment of a level of health that will enable every individual to lead a socially and economically productive life’ (WHO 1986).

From a historical perspective the concept of health has undergone a lot of change. The focus is shifted from ‘Biomedical concept’ as absence of diseases to:

- ‘Ecological concept’ as equilibrium between man and his environment and disease as maladjustment of human organism to environment;
- ‘Psychosocial concept’ as health is influenced by social, psychological, cultural, economic and political factors of the people concerned;
- ‘Holistic concept’ as a synthesis of all concepts where it recognises the strength of social, economic, political and environmental influences on health.

1.2 Definitions of Health

Although confident of the meaning of the word ‘health’ but people and scholars always find it difficult to define. Among the definitions still used, probably the oldest is ‘health is the absence of diseases’. Another author Webster defines ‘health is the condition of being sound in body, mind or spirit especially freedom from physical diseases or pain’. The Oxford English Dictionary defines ‘health as soundness of body or mind; that condition in which its functions are duly and efficiently discharged’. Perkins’ definition of health ‘it is a state of
relative equilibrium of body form and function which results from its successful dynamic adjustment to forces tending to disturb it. It is not passive interplay between body substance and forces impinging upon it but an active response to body forces working toward readjustment’ (cited in Park K 2005, p.13).

The widely accepted definition of health is of WHO’s (1948) in the preamble of its Constitution as ‘a state of complete physical, mental and social well being and not merely absence of disease or infirmity’. Though there are many criticisms and limitations related to this definition as an ideal goal than a realistic proposition, new philosophical trends are added to this understanding of health as it is a fundamental human right, it is the essence of productive life, intersectoral, an integral part of development, a worldwide social goal etc (Prakasham C.P.2010).

1.3 The Dimensions of Health

The above WHO definition envisages three specific dimensions namely physical, mental and social. Many more may be cited viz. spiritual, emotional, vocational and political dimensions to health(Park K. 2005). As the knowledge base grows, the list may be expanding. Although these dimensions function and interact with one another and each has its own nature. The conceptual descriptions are given:

**Physical Dimension** conceptualizes health biologically as a state in which every cell and every organ is functioning at optimum capacity and in perfect harmony with the rest of the body. At the community level, the state health may be assessed by such indicators as death rate, infant mortality rate and expectation of life.

**Mental Dimension** would mean that good mental health is the ability to respond to the many varied experiences of life with flexibility and a sense of purpose. More recently, mental health has been defined as “a state of balance between oneself and other, coexistence between the realities of the self and that of other people and that of the environment.”

**Social dimension** implies harmony and integration within the individual, between each individual and other member of society and between individuals and the world in which they live. The social dimension of health includes the levels of social skills one possesses, social
functioning and the ability to see oneself as a member of a larger society. In general, social health takes into account that every individual is part of a family and of wider community and focuses on social and economic conditions and well – being of the “whole person” in the context of his social network.

**Spiritual dimension** refers to that part of the individual which reaches out and strives for meaning and purpose in life. It is the intangible “something” that transcends physiology and psychology.

**Emotional dimension** has more close relation with mental health dimension. Mental health can be seen as “knowing” or “cognition” while emotional health relates to “feeling”.

**Vocational dimension** or aspect of life is a new dimension. It is part of human existence. When work is fully adapted to human goals, capacities and limitations, work often plays a role in promoting both physical and mental health.

Since health is a very broad concept and there are few other dimensions have also been suggested such as philosophical dimension, cultural dimension, socio –economic dimension, environmental dimension, educational dimension, nutritional dimension, curative dimension, preventive dimension etc.

### 1.4 Determinants of Health

Health is multifactorial. The factors which influence health lie both within the individual and externally in the society in which he or she lives. It is a truism to say that what man is and to what diseases he may fall victim depends on a combination of two sets of factors – his or her genetic factors and the environmental factors to which he or she is exposed. These factors interact and these interactions may be health promoting or deteriorating. Thus, conceptually the health of individuals and whole communities may be considered to be the result of many interactions. Park K (2005) enumerates the determinants of health and the details are given in the fourth chapter. These determinants are biological determinants, behavioural and socio-cultural conditions, environment, socio-economic conditions like economic status, education, occupation, political system, health care services, ageing of the population and gender.
1.5 Primary Health care as an approach to achieve HFA 2000

In 1977 the Alma-Ata International Conference on Primary Health Care reaffirmed ‘Health for All’ as the major social goal of governments, and stated that the best approach to achieve the goal of HFA is by providing primary health care, especially to the vast majority of underserved rural people and urban poor. It was envisaged that by the year 2000, at least essential health care should be accessible to all individuals and families in an acceptable and affordable way, with their full participation. This Conference called on all governments to formulate national policies, strategies and plans of action to launch and sustain primary health care as part of a national health system. It is for providing primary health care according to its own circumstances (WHO 1977).

The proposed new strategy of HFA made the nations to achieve or strive to attain tremendous growth in their overall performance. Many nations could eradicate epidemics, communicable diseases etc to a great extent. The WHO report describes how the past few decades, the period following the Declaration of AlmaAta had witnessed revolutionary gains in life expectancy. These gains build on progress that began for some countries in the late 19th century. Among today’s high income countries, life expectancy increased by 30 to 40 years in this century. Most of today’s low and middle income countries have experienced even more dramatic gains, although remaining inequalities needlessly burden disadvantaged populations and prolong their poverty. Under WHO’s leadership almost all countries eradicated smallpox, one of the most devastating diseases of history, and today a substantial majority of the world’s population faces relatively low risk from infectious diseases of any sort. These health gains have transformed quality of life and created conditions favouring sustained fertility reductions and consequent demographic changes. In many developing countries, for example the total fertility rate – the expected number of children a woman will bear over her lifetime – declined from over six in the late 1950s to about three at present. These health and demographic changes have contributed directly to the global diffusion of rapid economic growth that, like the health revolution, constitutes an extraordinary accomplishment of the 20th century. In an important sense, then, the world has made great progress towards better Health for All (WHO Report 2000).
Even after 2000, the nations are facing challenges that are very unique and specific. The people are now facing the problems of high morbidity both from re-emergence of communicable diseases, new life style diseases (non communicable diseases) like cancer, HIV, diabetics, blood pressure, cardiac vascular diseases and the second generation problems like the ageing population. Moreover there remains the challenge of sustaining the privileged health status.

India gives prime place to safeguard the health of the people and Article 246 of the Constitution of India covers all the health subjects. These have been enumerated in the seventh schedule under three lists-Union List, Concurrent List and State List. Article 47 of the Constitution under the Directive Principles of States Policy states ‘That the state shall regard the raising of level of nutrition and the standard of living of its people and the improvement of public health as among its primary duties’ (Indian Constitution). There are many health intervention programmes implemented to raise the health status of the citizens. The directives of WHO are carried out to its best and primary health care approach are the one of the remarkable contributions of India in promotion of health. In the very beginning of the new millennium 2000, in order to address contemporary health requirements, the Central government too adopted two developmental health programme interventions, viz-a-viz Millennium Development Goals (MDGs) and National Rural Health Mission (NRHM).

A. The Millennium Development Goals:

MDGs is an internationally agreed development aspirations for the world’s population to be met by 2015. The representatives of 189 countries met at Millennium Summit in New York in 2000 to adopt United Nations Millennium Declarations. The MDGs place health at the heart of development and represent commitments by Government throughout the world to do more to reduce poverty and hunger and to tackle ill health, gender inequality, lack of education, access to clean water, and environmental degradation (WHO 2003; UNDP 2003). There are eight Millennium Development Goals:

- Eradicate extreme poverty and hunger
- Achieve universal primary education
- Promote gender equality
• Reduce child mortality
• Improve maternal health
• Combat HIV / AIDS, malaria and other communicable diseases
• Ensure environmental sustainability
• Develop global partnership for development

These goals have underlined the importance of improving health, and particularly the health of mothers and children, as an integral part of poverty reduction. The health of mothers and children is a priority which emerged long before and it builds upon a hundreds of programmes, activities and experiences. What is new in the last decade, however, is the global focus of the MDGs and their insistence on tracking progress in every part of the world. Moreover, the nature of the priority status of maternal and child health (MCH) has changed over time. Mothers and children were previously thought of as targets for well-intentioned programmes, they now increasingly claim the right to access quality care as an entitlement guaranteed by the State. In doing so, they have transformed maternal and child health from a technical concern into a moral and political imperative (UNICEF 2004).

B. National Rural Health Mission

With the objective of providing more effective, accessible, affordable, accountable and reliable health care, NRHM was launched in India in 2005. The Mission aims at achieving health indicators like reduction in Infant Mortality Rate (IMR), Maternal Mortality Ratio (MMR) and Total Fertility Rate (TFR) within 7 years (2005-2012). These initiatives correspond to the Key performance areas outlined by NRHM:

• Institutional strengthening
• Improving access to better health care and quality services
• Accessibility of health care to the under privileged and marginalised
• Reduction in Infant Mortality Rate (IMR) and Maternal Mortality Ratio
• Universal access to public health services such as women’s health, child health, water, sanitation & hygiene, immunization, and nutrition.
• Prevention and control of communicable and non-communicable diseases, including locally endemic diseases
• Access to integrated comprehensive primary health care
Population stabilization, gender and demographic balance
Revitalize local health traditions and mainstream AYUSH
Promotion of healthy life styles

The above analysis shows that all health interventions either universally accepted or of the nations are aimed at the very unique status and dignity of the every individual person. He or she is entitled to have a healthy life and the resources essential for satisfying health needs should be available within the reach of everyone. WHO’s Director General Dr. Gro Harlem Brundtland holds the view that ‘the main message from WHO’s report is that the health and well being of people around the world depend critically on the performance of the health systems that serve them. Yet there is wide variation in performance, even among countries with similar levels of income and health expenditure. It is essential for decision makers to understand the underlying reasons so that system performance and hence the health of populations can be improved’. Dr. Christopher Murray, Director of WHO’s Global Programme on Evidence for Health Policy affirms that ‘although significant progress has been achieved in past decades, virtually all countries are under utilizing the resources that are available to them. This leads to large numbers of preventable deaths and disabilities, unnecessary suffering, injustice, inequality and denial of an individual's basic rights to health. The impact of failures in health systems is most severe on the poor everywhere, who are driven deeper into poverty by lack of financial protection against ill health.’ The WHO report reads ‘The poor are treated with less respect, given less choice of service providers and offered lower quality amenities. In trying to buy health from their own pockets, they pay and become poorer.’(WHO 2005; Puthenkalam J,2010).In short, the goal of WHO remains a distant dream in most of the developing nations and especially of marginalized groups like fisherfolk at large.

1.6 Context of the Study

India’s National Health Policy 2002 devotes an entire section on equity and concludes ‘It is the principal objective of the NHP 2002 to evolve a policy structure which reduces these inequities and allows the disadvantaged sections of the society a fair access to public health services’ (NHP 2002). The question of inequity and inequality are used as synonymous terms in the NHP and understood as unfair and unacceptable (GOI, 2002). Equality is found in the social status and dignity of an individual but equity is giving certain reservations to the
disadvantaged sections of population to keep pace with others. This context of equity and equality in the health provisions of the State and its reflections in the health status of population is an area of interest of study. This is relevant to look into the health indicators of the Nation, State and the marginalised fisherfolk of Kerala in particular.

Kerala had received worldwide attention for its unique achievements in social sector developments especially in the health indicators with low per capita income (Kannan, 2005). Kerala’s achievements are very high when compared to other major Indian States in areas like birth rate, death rate, IMR, MMR average life at birth and immunization. For instance, birth rate in Kerala is 17.3, death rate is 6.6 and infant mortality is 11. But all India birth rate is 25.4, death rate is 8.4 and IMR is 66. Average life at birth in Kerala is 73 years whereas it is 63 years for the Country. Kerala achieved good health status even with low growth in income and high unemployment rate (Economic Review 2009).

Even though the achievements in health status have been good, State now faces problems like high morbidity, low maintenance of health infrastructure, underutilized health care facilities and shortage of health man power. Emergences of new diseases like malaria, diarrhoea, dengue fever etc. create problems. This is a great challenge before the State to sustain the achievements and at the same time to reach the desired goals.

Ever since the dictum of Kerala model arose, there were critiques that pointed out that Kerala’s attainments in health and education were only based on averages and therefore have outliers. The marine fisherfolk of Kerala had been acknowledged as one of the marginalised communities, an outlier community in the central tendency of Kerala’s development experience (Kurien, 2000). A prominent issue that emerges, at present, is whether the process of development in contemporary Kerala could impart its effects on the marginalised communities such as the marine fisherfolk or the turnaround phase is also based on certain averages, leaving them unaffected.

Kerala the Southern tip of the Indian sub-continent has always an area of interest for academicians, social scientists, health activists and policy makers. Their interest proliferate all realms of life – economical, political, cultural, social and religion. Kerala remains as a riddle for development thinkers thatit’s paradoxical ‘higher level of morbidity and low mortality rate’ an area worth investigating. With respect to the health development indictors-
life expectancy, sex ratio, infant mortality and literacy, Kerala achieved favourable and positive achievements which are even comparable with the developed countries. Table 1.1 shows the performance of India and Kerala in the health indicators (Census 2001, Government of India).

Table 1.1 Basic Health Indicators of Kerala and India (2001)

<table>
<thead>
<tr>
<th>Health Indicators</th>
<th>Kerala</th>
<th>India</th>
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<tbody>
<tr>
<td>1. Birth rate (1000 population)</td>
<td>14.7</td>
<td>23.1</td>
</tr>
<tr>
<td>2. Death rate (1000 population)</td>
<td>6.8</td>
<td>7.4</td>
</tr>
<tr>
<td>3. Infant Mortality rate (1000 population)</td>
<td>13</td>
<td>55</td>
</tr>
<tr>
<td>4. Child Mortality rate (1000 population)</td>
<td>3</td>
<td>17</td>
</tr>
<tr>
<td>5. Maternal Mortality rate (1000 population)</td>
<td>110</td>
<td>301</td>
</tr>
<tr>
<td>6. Life expectancy Total</td>
<td>73.8</td>
<td>63.1</td>
</tr>
<tr>
<td>Male</td>
<td>71.3</td>
<td>62.3</td>
</tr>
<tr>
<td>Female</td>
<td>76.3</td>
<td>63.1</td>
</tr>
<tr>
<td>7. Sex Ratio</td>
<td>1058</td>
<td>933</td>
</tr>
<tr>
<td>8. Literacy rate</td>
<td>90.9</td>
<td>65.4</td>
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This is a rosy picture of the State but it is not found in all sections of population of the State especially of marginalised people like fisherfolk and other backward communities. There are many academicians, social activists and policy makers prefer the coastal people as their area of interest of study. From the very formation of the State, many social interventions were done in the coastal area and ‘the famous Marianadu Indo-Norwegian Project’ launching fishermen cooperatives of its first kind and planting new habitat for fishermen etc. in Thiruvananthapuram.

The Kerala Coastal Health Project was launched during the year 1994 with a view to improve the health care delivery system available at present in the coastal region of Kerala which was lagging behind in the overall health status of the State. This is a time-bound project for 4 years from 1994 to 1997. The project was implemented in coastal panchayats of 9 districts viz. Kasargode, Kannur, Kozhikode, Malappuram, Thrissur, Ernakulam, Alappuzha, Kollam and Thiruvananthapuram. The major objective of the project is the qualitative improvement
of the health delivery system through systematic utilisation of additional resources provided and with the active participation of the local community. As on 31-3-1997 under this project 169 coastal health care institutions were included. Minor civil works, supply of machine and equipment, ventilators and cardiac monitor and operation theatre equipment for major hospitals in the coastal districts etc. come under the project. (EconomicReview 1998).

It is fact created through certain research studies and from observation of the very life of the fisher people that the coastal fishing community villages and people are very backward, leading poor quality of life, living in a marginalised sections etc. There are relevant figures to substantiate these facts. The survey conducted by Matsyafed, GOK, in 1996 and 1997 under the guidance of the Task Force on Livelihood Security of Fishing Communities among the Kerala fisherfolk amply reveals their plight of the deprivation of their social security.

According to this survey, the housing condition remains poor. The continued congested housing condition is evident from the fact that about 53 per cent of fishermen’s houses in the State are located within 200 metres of the tide line. Besides, about 19 per cent of the houses are still thatched (compared to 48 per cent in 1981). Of these, 12 per cent are prone to sea erosion, and 10 per cent have no title deeds. There are no toilet facilities in 93 per cent of the marine villages, and the beach is used as an open toilet. Though wells are the major source of drinking water in the coastal area, only 17 per cent of the villages have wells exclusively designed for drinking water. With regard to literacy, 70 per cent of the villages lag behind the State average (Socio- Economic Survey, GOK, 1997).

A recent sample survey conducted by K.Push pangadhan and K.Murugan (2000) of the two fishing villages of Pulluvila and Adimalathura of Thiruvananthapuram district in 1998 also revealed that the fisher folk remain much below the general standard of living of Kerala. While the per centage of illiteracy in Thiruvananthapuram district as a whole is 8 and 15.8 respectively for males and females in 1998, the corresponding figures for the sample fisher folk are 38.7 and 39.4. The morbidity rate among the fisher folk is higher than among the rest of population (7.0 compared to 2.6 in the case of males and 15.8 compared to 3.0 in the case of females in year 1998). It ia also argued by the authors that the poor health status coupled with socio-economic and environmental backwardness of fisher folk’ demand the need for ‘alternate health care model, in that way that embraces the participation of people, community and other local agencies and also by taking care of the local specificities’.
Besides the situation of deprivation among the fisher folk in general, the gender-bias is also apparent within the fishing community. Pushpangadhan and Murugan (2000) study also reveals that two communities, Fisher folk and Scheduled Tribes, have gender bias in their population unlike rest of Kerala. First part of the model is the measurement of well being arising from personal interests of the household members. Second part consists of the informational base related to well being of individuals if the bargaining process breaks down. They consider only four basic capabilities - escapable morbidity, avoidable mortality, educational attainments and nutrition status - among the fishing households. All four basic functioning - morbidity, longevity, education, nutrition- estimated from survey data using capability approach show female deprivation. This context enables the researcher to examine the deprivation of the fishing community in the field of health, within context of the overall health status in Kerala.

In the beginning of 1990s, the researcher himself had an experience of implementing Rural Health Education Programme of Trivandrum Social Service Society (TSSS) a voluntary religious organisation in the coastal villages – Vizhinjam, Pulluvila of Trivandrum district of Kerala. Though there was government machinery with all government programmes, could not reach out to people in the preventive and promotional levels of health. They are more institutions oriented and of curative in nature. The formation of health clubs and women’s forums could bring qualitative change in the life of the fisherfolk. They themselves could succeed in arresting water prone diseases during monsoons. The wide range of promoting kitchen garden and herbal medicine could change the conventional approach to treatment. The health clubs made certain paradigm shifts in their health practices. This revealed the fact that the health interventions of the State and personnel are not designed according to the health requirements of the target population. This experience made the researcher to enquire into the rationale of State sponsored public health programmes in order to address the health needs of such marginalised sections population like fisherfolk.

The literacy campaign in the beginnings of 1990s also taught lessons to the researcher that uniform pattern of intervention programmes will never attain the desired goals. The literacy campaign had taken a separate approach with regard to fisherfolk and tribals to promote literacy. The government changed the timing of classes; content of the course and literacy
campaign voluntary workers with special allowances. The campaign could make remarkable change in the entire programme and to certain extent it succeeded among the fisherfolk.

1.7 Conclusion

The understanding of the concept of health and new emerging trends in the health scenario are matters of great interest of study. The progressive understanding of health in relation to marginalised and subaltern groups like fisherfolk is also of great interest. But it is the fact that the better health achievements of the State are not truly reflected in all sections of population. WHO sets certain parameters to reach out to the outliers groups in the society is a promising attempt to make health care more accessible to the large public. Thus the question of equity and equitable distribution of health resources is of great concern across the country. This chapter made an attempt to give an introduction to the research work by stating the definitions of health, the various dimensions of health and the determinants of health status in general. The WHO’s basic approach and introduction of primary health care to make available health services to the general population is explained in the introductory part. The Government of India’s concern for the health and two new interventions were briefly narrated to focus the study’s objectives. The context which prompted the researcher to conduct such a study is also analysed. The success story of literacy campaign among the fisherfolk is also an example for unique programme implementation for the fisherfolk and other marginalised population. This motivated the researcher to review the concerned literature and books pertaining to health status and health care systems in India and Kerala in particular.