

Block

5

Socio-Economic Dimensions of Health Care

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UNIT 17 SOCIAL STATUS OF WOMEN AND HEALTH

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17.1 INTRODUCTION

This unit introduces you to the issues and determinants affecting the women's health in society. Here, we have examined various dimensions of women's health in contemporary Indian society. Women's health is looked not only physiological conditions but also social and cultural empowerment point of view. This unit in brief will provide how social factors, cultural milieu play significant role women's health and other limitations. You will also come to know about important measure that how to promote women's health which ultimately led a healthy society. Thus, the background for further discussion will emerge in further units of this block linking with developmental issues relating to health.

After studying this unit you should be able to:

- a) describe the status of women in contemporary India in terms of her health status,
- b) discuss the women's social empowerment and health,
- c) discuss the women's cultural empowerment and health,
- d) explain the measures to be taken to promote women's health.

17.2 WOMEN AND HEALTH CONCEPTS

The status of women and their health very much associated with their social role and status in any society, therefore, understanding of four basic concepts is essential. These are gender, health, culture and women empowerment.

Gender:

Gender refers to the social and cultural construction of female and male identity. It is not the same as sex (biological characteristics of women and men). Gender is determined by the conception of tasks, functions and roles attributed to women and men in society and in public and private life. Gender is a key factor in

structuring the types of opportunities and life chances faced by individuals and groups and strongly influences the roles they play within social institutions from the household to the state.

Health:

Health is in general capability enhancing. Good health is sought not only for pleasure, nor only for reducing pain, but also for expanding a person's significantly important capabilities and freedoms. Role is given to health and longevity in the concept of human development.

Culture:

Cultures and traditions are simply the forms of social interaction accepted by particular communities at particular times, and according to their world views and historical experiences, such that there are several alternatives and systems of values selected for their usefulness. Societies and cultures are not static. They change over time in accordance with the interpretive values, beliefs and practices of the group, whose members define and live by the ideals of those practices and values.

Women Empowerment:

Women empowerment refers to increasing and improving the social, economic, political and legal strength of the women, to ensure equal-right to women, and to make them confident to claim their choices and decisions. It also refers to creation of an environment so that they have complete control of their life, both within and outside of their home and workplace.

17.3 STATUS OF WOMEN'S HEALTH

The Millennium Developmental Goals (MDGs) were adopted in 2000 by India and other UN member states. Three of the eight MDGs are directly related to health. The three goals are- to reduce child mortality (goal-4), improve maternal health (goal-5), and combat HIV/AIDS, malaria and other diseases (Goal-6) (WHO:2005). Sex-ratio at birth is becoming increasingly favourable to males 914 (Census: 2011). It is the result of female foeticide, which shows the biasness against females. It is rampant in many states and how the state is aggressively campaigning for the balance of the sex ratio at birth. Women's health status is reflected in terms of certain indicators which are discussed below:

17.3.1 Infant and Young Child Mortality:

Although young child mortality has declined significantly over the past three decades, One in every 21 children being born in India are dying before reaching their fifth birthday as the country recorded the highest number of under five deaths in 2015 globally. Infant mortality under five in India is 69.7 whereas for female it is 79.2 (IIPS: 2007). Despite their innate biological advantages, more girls than boys die. During the past decades the gap between the mortality rates of young boys and girls even widened. A girl child aged 1-5 years is 75 percent more likely to die than a boy child (United Nations: 2000). High girl child mortality is explained by socio-cultural values. So strong is the biological advantage for girls in early childhood that higher mortality among girls should be seen as a powerful warning that differential treatment or access to resources is putting girls at a disadvantage.

17.3.2 Maternal Mortality:

Maternal mortality in India estimated at 178 maternal deaths per 100,000 live births, results primarily from infection, hemorrhage, eclampsia, obstructed labour, abortion and anaemia. The maternal mortality rate is 12.4 per cent and the Life Time Risk is 0.4 per cent (Sample Registration System: 2013). Lack of appropriate care during pregnancy and child birth, and especially the inadequacy of services for detecting and managing complications, explains most of the maternal deaths.

Among all, deaths due to communicable, maternal, perinatal and nutritional conditions in India between 2007-2009 shows that the percentage of female is 36.1 per cent as compared to 31 per cent for males. Within the female deaths rural women have high death rate i.e. 38.1 per cent as compared to urban i.e. 28.9 per cent (Sample Registration:2013).

17.3.3 Morbidity:

Morbidity refers to a diseases state, disability or poor health due to any cause. There is an absence of reliable data on morbidity particularly related to pregnancy. Although many sociological studies confirm that there is high morbidity and malnutrition among girls and women. Emerging evidence suggests that the prevalence of reproductive tract infections is considerably higher and is constantly on increasing trend. Spread of HIV/AIDS is also a concern among women. Iron deficiency anaemia is widespread among girls and women and affects 50 to 90 per cent of pregnant women. Morbidity rates due to diarrhoeal diseases in South East Asia in 2012 among 0-27 days female is 248 as compared to 195 among males. Again in 1-59 months age-group for females it is 112 as compared to male which is 85 (UN: 2000)

17.3.4 Fertility:

Female mortality and morbidity rates are linked to overall fertility levels- i.e. 2.45 (2016) children per woman. However, there is wide range of gap between the poor and rich, illiterate and literate and rural and urban women. Children closely follow marriage, which tends to occur at young ages: 12.8 per cent of females between 15 and 19 are married (Rapid Survey on Child Birth: 2013-14). Child bearing during adolescence poses significantly greater health risks than it does during the peak reproductive years and contributes to high rates of population growth. Women also tend to have closely spaced pregnancies. Thirty seven percent of births occur within two years of the previous birth, endangering both the health of the mother and the survival of the infant and older siblings (Sharma et al. :2008).

17.3.5 Occupational Hazards and Health:

Women, especially in agricultural areas, are expected to perform a variety of strenuous tasks within the household, on family lands, and, in some regions, for wages. These occupations often have serious consequences for undernourished females, including adolescents, whose bone structure is not yet fully developed and who may be required to carry heavy loads or to adopt unnatural postures for prolonged periods. Another problem is exposure to heavy smoke from kitchen fires, which causes a variety of respiratory difficulties. Women are also susceptible to usually high rates of physical assaults such as rape, burning, and beating.

17.3.6 Reproductive Health:

Despite the decline in fertility, the reproductive health situation in India remains poor. Although the rate of infant mortality declined from more than 200 infant deaths per 1,000 live births in the 1960s to approximately 74 per 1,000 live births in the 1990s, (Sample Registration Bulletin: 1996) maternal mortality ratios (178 deaths per 100,000 live births) remain among the highest in the world (Sample Registration System: 2013). Moreover, two-thirds of Indian women go through pregnancy and childbirth without seeing a trained birth attendant (Sample Registration System: 1997), and obstetric and gynaecologic disorders are widely prevalent and remain largely untreated silently (Visaria, Jejeebhoy and Merrick: 1999).

17.3.7 Nutrition and Health:

Ill health caused by deficiencies of calories, protein, vitamins, and minerals interacting with infections and other poor health and social conditions, saps the strength and well-being of millions of women and adolescent girls. Adequate nutrition, a fundamental cornerstone of any individual's health is especially critical for women because inadequate nutrition wreak havoc not only on women's own health but also the health of their children. Children of malnourished women are more likely to face cognitive impairments, short stature, lower resistance to infections, and a higher risk of disease and death throughout their lives.

Women are more likely to suffer from nutritional deficiencies than men are, for reasons including women's reproductive biology, low social status, poverty and lack of education. Socio-cultural traditions and disparities in household work patterns also increase women's chance of being malnourished.

After going through basic concepts related to social status of women and health including their fertility, morbidity, and issues related to reproduction and nutrition, now see your progress in Check Your Progress – 1.

Check Your Progress 1

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) Mention the extent of women's health in India.

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2) Define women empowerment.

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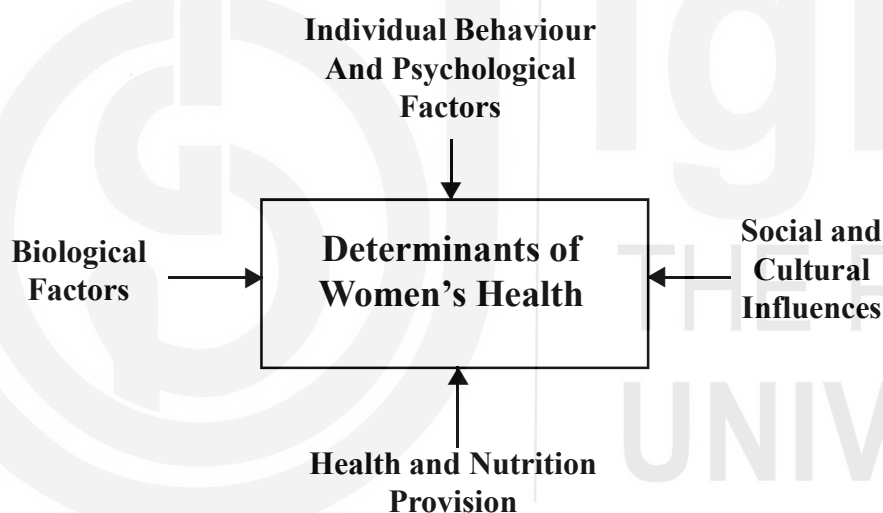
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17.4 DETERMINANTS OF WOMEN'S HEALTH

Health status is influenced by complex biological, social, psychological, intake of nutrition and cultural factors that are highly interrelated (Figure-1). These factors affect men and women differently. Women's reproductive biology, combined with their lower socio-economic status, result in women bearing the greater burden of unsafe sex- which includes both infections and the complications of unwanted pregnancy. Pregnancy and childbirth can be life threatening, women's exposure to risk associated with pregnancy and childbirth tend to equalize life expectancy between the sexes.

Biological and social factors affect women's health throughout their lives and have cumulative effects. Therefore, it is important to consider the entire life cycle when examining the causes and consequences of women's poor health. For example, girls who are fed inadequately and do not have sufficient nutrition in their diet during childhood may have stunted growth, leading to higher risks of complications during and following childbirth. At the psychological level abuse during childhood increases the likelihood of mental depression in later years, and repeated reproductive tract infections can lead to infertility.



17.5 WOMEN'S SOCIAL EMPOWERMENT AND HEALTH

Women's empowerment is hindered by limited autonomy in many areas that has a strong bearing on development. Their institutional capacity owing to low levels of literacy, limited access to money, restricted mobility, restriction on taking decisions, obstructs competence. Empowerment of women through work participation is fast emerged as a slogan for the 1990s. However, merely increasing work participation does not bring empowerment in a situation where not only does the labour market favour men over women, but the division of labour within occupations is sex-biased. Women regarding their health do not feel empowered because of their vulnerability, lack of autonomy, unequal social status and limited access to economic resources. It inhibits a woman's capacity to seek health care and even it limit her ability to recognize that she is in need of services.

17.5.1 Economy/Labour Participation, Women and Health:

Poverty underlies the poor health status of women. The socio-economic environment affects women's exposure to disease and injury, their diet, their access to and use of health services, and the manifestations and consequences of disease. Women's disadvantaged social position, which is often related to the economic value placed on familial roles, helps perpetuate poor health, inadequate diet, early and frequent pregnancy, and a continued cycle of poverty. For example, women in many parts of the country receive medical treatment less often when sick, and then only at a more advanced stage of disease.

The ability to withdraw women from outside work is one of the most important symbols of economic and social status in rural Indian society. In practice, however, only the richest landowning families can afford to do without the money their women earn outside the home. In more modest landowning households, women typically work on family lands during peak agricultural seasons and do other work outside, including caring for animals and gathering fodder and fuel. In landless families, the income provided by women who perform agricultural or domestic labour is often the household's chief support. The agricultural innovations too have not reduced the burden of women labour. The decreasing availability of firewood has forced women to go far off places to collect firewood.

The extensive and often strenuous physical labour women must perform, combined with men being given preference in the household allocation of food, accounts in good measure for malnutrition among women. One study estimated that when women's physical activity, including field and domestic labour, was taken into account, women had a higher daily expenditure of calories than men in the same households (Batliwala:1982).

Productive responsibilities are hardest on young women in their childbearing years. Many women work until late in their pregnancies; no special provisions are made for rest or additional food, and most women resume work before they have fully recovered from childbirth. A woman whose physical reserves are already exhausted by childbearing, lactation, anaemia, and heavy agricultural labour has no reserves to ensure that another pregnancy will be safe and healthy. Continued physical activity until late in pregnancy and a lack of adequate rest not only negatively affect women's health but also contribute to excessive rates of stillbirths, premature births, and intrauterine growth retardation (Khan, Ghosh, Dastidar and Singh: 1982; ICMR:1977).

17.5.2 Education, Women and Health:

Females are clearly at a disadvantaged in India with regard to education. There is high levels of female illiteracy in India and low rates of female school enrolment and retention. However, these rates now show a promising upward trend. Whether a girl will be enrolled in school- and, once she is enrolled, how long she will be allowed to continue- is linked to socio-economic status.

In rural India, girls from families with little or no land and with limited resources are less likely to be enrolled in school and more likely to be withdrawn early than girls from landed families. In urban areas, girls most at risk of not attending school are from slum areas whose parents are having poor income and low social status. The importance of the link between a woman's educational level and her health (and that of her female children) cannot be overemphasized. There is a

strong relationship between mother's education and her children survival- that is, the more educated the mother, the more likely it is that her child will survive. Education provides a sense of empowerment to deal with the health care services.

17.5.3 Social Practices, Women and Health:

The unfavourable status of women affects the health status of women and their female children both directly and indirectly. The effects include a strong preference for sons; early age at marriage, inequitable distribution of food etc.

a) Family Responsibilities:

Family rests socially on the shoulders of women in all areas. As spouses, parents and caregivers, they take on the primary responsibility for ensuring the proper functioning of families and the provision of everyday care and maintenance. Preparing family meals, maintaining hygiene, caring for the family members and myriad of other chores related to children consume a good part of the day for women. While men are increasingly getting involved in the daily functioning of families, it is still predominantly women's responsibility, thus no time left for her health care.

b) Preference for Sons:

According to UNICEF, 12 million girls are born in India every year. Out of which 25 per cent do not survive the 15th year. The fact is that as the mortality rate of 0-5 year age group is about 20 times greater than any other five years age group. At the national level the 'Child Sex Ratio in population aged 0-6 years decline in 1981 to 945 in 1991. In 2001 Census child sex ratio has declined further by 18 points from 945 in 1991 to 927 in 2001. The Child sex ratio has slightly increased to 13 points in 2011 (940). Adverse sex ratio is the result of strong preference for son, traditional inculcated attitude of self-effacement among women and religious sanctity of certain ritual. The drastic imbalance of sex ratio is the result of female foeticide. The government has banned the Sex determination test by bring the Antenatal Diagnostic Technique (Regulation and Prevention of Misuse) Act as a legal offence. However, it is still going on.

c) Early age at marriage:

Child marriage is still widespread in India, which is home to a third of the world's child brides. About half of Indian women were married before the age 18. Rapid survey on Children (2013-14) suggests that age at marriage for girls between the age group of 15-19 is 12.8 per cent which is significantly higher. Marrying girls at early age affects the health adversely. Marriage at a very young age has grave health consequences for the child brides and their children. Women married as minors are more likely than those married as adults to report early, frequent and unplanned pregnancies (typically as a consequences of non-contraceptive use), which have been consistently linked to increased risk for maternal and infant morbidity and mortality (UNICEF: 2008).

d) Food Distribution in the Family:

Food distribution in the family is not only a problem of scarce resources but also of social practices. Among Indian families, the largest share of food is usually given to the bread earner, the next to boys, to the old or sick and the last, to young girls and women in the household. Girls are often neglected in matters of feeding and health care. Discrimination in feeding may begin soon after birth as girls are

breast fed less frequently and for shorter duration than boys. Ethnographic literature suggests that females are not fed as well as males (Harriss: 1996; Miller:1981). The discrepancy of distribution of food within the family increases with age. Boys get more leafy vegetables, more of fruits and more of milk products. As children grow up and take up a sedentary or active job, the gap in the degrees of nutrition widens even more.

Women are often responsible for producing and preparing food for the household, so their knowledge- or lack thereof- about nutrition can affect the health and nutritional status of entire family. For increasing women's control over resources and their ability to make decisions, is crucial.

e) Life Time/Old age and Health:

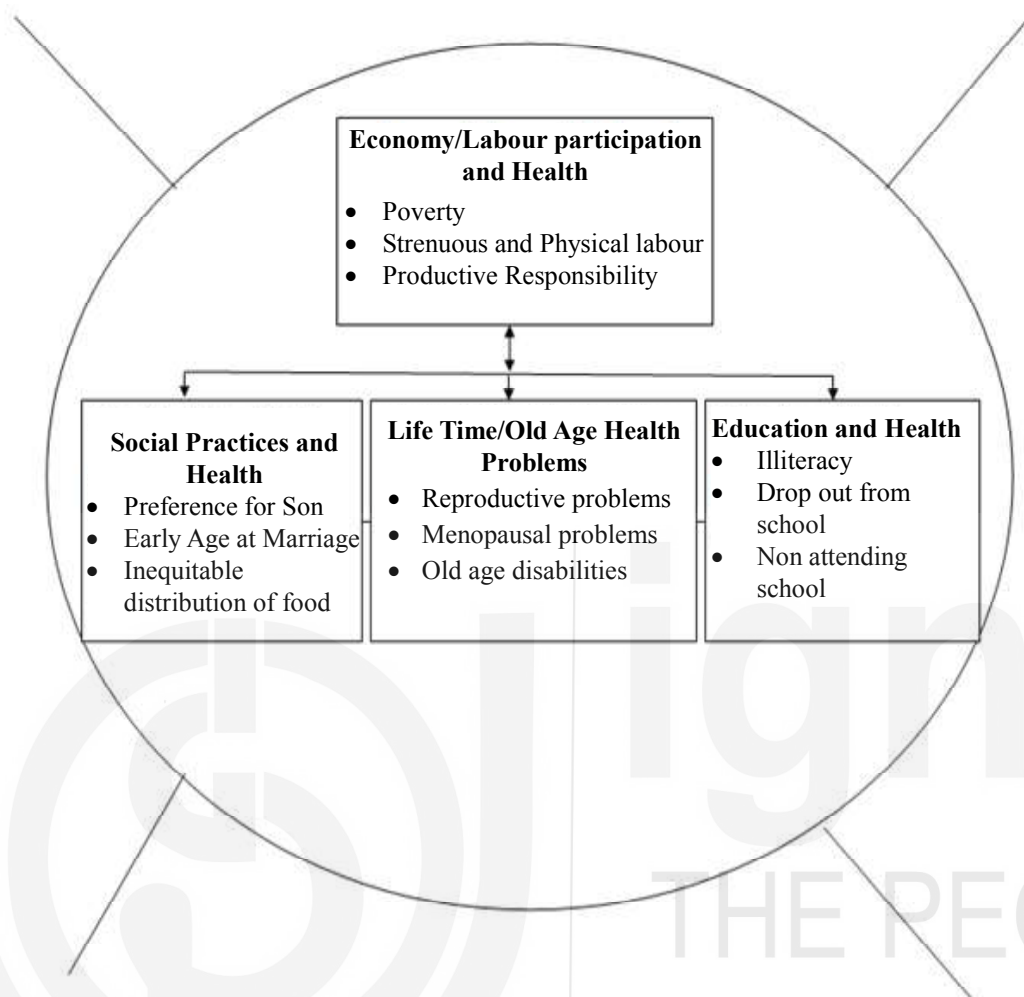
Ageing is often perceived as deterioration in health. Most research and services tend to concentrate on women of reproductive age ignoring those beyond these years. While the process of growing old may bring some improvements and benefits to a women in the post middle age period, these may diminish as she advances into old age or she is widowed (Rao and Townsend: 1999). A woman often derives power from authority from her association with the male head of family. If this association suffers erosion, her access to resources for care and sustenance is reduced, making her vulnerable. The risk increases for women who have no assets for survival such as education, possessions or social status. This vulnerability may be compounded by failing health and disability. Thus, an indigent and physically frail, elderly widow is the most defenseless in the Indian context (Chen and Dreze: 1995). It is important to note that the elderly women suffer not only from ailments specific to ageing, but also from ill-health accumulated over the life-cycle which may manifest in old age in an aggravated form. The proportion of women reporting problem of joints is higher than that of men. This is expected, as after menopause women are particularly prone to development of osteoarthritis, a painful degenerative joint disease (Tinker et al: 1994).

Disability also affects the health of elderly people. This is well-known fact that the prevalence of blindness also varies by gender. Disorders during pregnancy can cause cataract, while diabetes, glaucoma and metabolic disorders can increase the risk of cataract. Several health conditions affecting elderly women such as changes in the skeletal, cardiovascular, nervous, skin, genitourinary, and gastrointestinal systems are caused by declines in ovarian hormonal levels triggered by menopause. Gynaecological cancers, prolapsed and fistulae are some conditions afflicting the elderly women which are the result of child-bearing begin early and fertility is high. Elderly women may find it difficult to disclose to younger members the nature of their illness, especially if there are gynaecological problems. This is one reason why conditions such as prolapsed tend to be neglected.

The Health of women is determined by women's social status, social practices, educational and economic status (see figure-2).

Figure-2

Women's Empowerment and Health



In this section, After going through social determinants of women's health, their changing status, various social factors and preferences that effects their health conditions, now check your progress with following questions given in check your progress – 2.

Check Your Progress - 2

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) What are the determinants of women's health?

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2) How education and changes in social practice changes health of women.

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Activity

Visit your nearest *anganbadi kendra* and interact with functionaries to see the changes in women's health status in last five year.

17.6 WOMEN'S CULTURAL EMPOWERMENT AND HEALTH

Like most cultures across the world, Indian society has deeply entrenched patriarchal norms and values. Patriarchy manifests itself in both the public and private spheres of women's lives in the country, determining their 'life chances' and resulting in their qualitatively inferior status in the various socio-economic sphere. It permeates institutions and organisations and works in many insidious ways to undermine women's right to dignified lives. Culture is an important correlate of health behaviour. The absence of empowerment provided by institutions and organizations results into the health deprivation to women across the country.

Even when a problem has been indentified, women may not be able to obtain proper treatment because accessing the service is too difficult or because expense is deemed unnecessary. Constraints on women, and therefore on their health seeking behaviour, operate through social beliefs, norms and practices that are dismissive of women. Physical restrictions, faith and beliefs related to health, illness and treatment, belief related to pregnancy and child care, widowhood status are discussed below.

17.6.1 The Physical Restrictions:

The physical restrictions on women's movements, combined with limited access to financial resources within the household, severely constrain women's ability to seek health care for themselves and their children. Social mores regarding the seclusion of women result in reluctance to have women and girls examines by an outsider such as doctor, particularly if he is a male, as most doctors are males (Basu: 1990; Jeffery, Jeffery and Lyon:1989). Furthermore, a woman who wishes to obtain health care, whether from a local traditional practitioner, the district hospital, or some intermediate provider, is not free to do so on her own. She must obtain permission from her husband or in-laws, be escorted by male family member if she travels outside the village.

17.6.2 Belief Concerning the Health, Illness and Treatment:

The pluralistic characteristic of many aspects of Indian society and culture is evident in beliefs about health, illness and healing and extends to the ways in which the various types of treatment systems are used.

Indian dietary practices and the associated beliefs about their physiological implications have a significant impact on attitudes towards pregnancy in general and the care and diet of pregnant women and new mothers in particular. Traditional views about diet and behaviour are in many ways not inconsistent with modern medicine and can be accommodated by flexible practitioners concerned with the ultimate success of treatment rather than with the correctness of one or another belief system.

Women have faith in local deities for the treatment of certain group of diseases like smallpox, chicken pox, measles, typhoid fever and plague. Epidemics are understood as a sign of displeasure with the whole community for immoral behaviour or neglect of regular worship. The appropriate response involves propitiating the deities to persuade them to leave the afflicted individuals; medical treatment is specifically avoided, as a displeased goddess could react by killing those afflicted.

The possibility of committing transgressions against the supernatural world is considered much greater during pregnancy, at the time of child birth, and in the first year of life than at any other time in the life cycle. The belief that infants are particularly susceptible to invasion by bad or evil eye explains much about what appear to be low levels of care infants are accorded. Women's fear of stirring up evil influence for child is the major reason for not seeking antenatal or postnatal care.

17.6.3 Beliefs related to Pregnancy and Child Care:

There is growing evidence that appropriate social support during pregnancy, childbirth and the postpartum yields benefits in purely biomedical terms. For instance, appropriate emotional support can result in fewer interventions during the birth itself (Klaus et al: 1992). An Oakley's review of 38 published researches shows that social support during pregnancy can help reduce low birth weight as well as pregnancy complications. Maternal stress constitutes an etiological factor in pregnancy outcomes, as shown by studies in the sixties comparing married with unwed mothers (Oakley:1985). She says that social support does not include just material resources, but also having and feeling social connectedness with other people; giving and receiving support. Patel (2012) argues that voices and views about the body, its care and healing during birthing are not uniform within a given culture, let alone across cultures. Biomedicine itself works in the context of given cultures and modulates itself accordingly as it travels from one culture to another and within a culture from one or even a person to another.

Women are not considered the sole owner of the products of conception, their role being to nourish their husband's offspring. Just as women have little control over the ability to engage in productive work, so they have limited control over their own pregnancies. Nevertheless, it is generally recognized that a women's health can affect the outcome of her pregnancy and that some changes in her diet and work schedule may be beneficial. The nausea, vomiting, and indigestion characteristic of early pregnancy are believed to be the result of a "heated" condition. Women are advised to eat cold rather than hot foods during pregnancy, especially certain fruits, rice and milk products, which are considered strengthening. However, a pregnant woman in rural India usually has no way of obtaining food that is not normally available in the household. Her diet is conditional on what her mother-in-law and husband permit, and she normally hesitates to ask for anything extra or special for fear of being thought shameless. Moreover, the idea of making special dietary arrangements for a pregnant woman is unheard of, so that even if a husband brought his wife something special, it would have to be shared with the rest of the household.

There is also a belief that overeating during pregnancy will result in either a large baby, and consequently a difficult labor, or a small, weak baby that has not had enough space to develop because of overconsumption of food.

Childbirth is considered as polluting in large part of the country. Thus, old clothes, rags, bed linen, and cots are used during the delivery which results in the serious implications for hygiene. After delivery, the umbilical cord is cut with a sharp instrument that may not be sterile. The unsanitary circumstances of such deliveries, including the internal examination and the cutting of the cord, result in high rates of puerperal infections and neonatal tetanus. The dai performs an essential role for the household by cleaning up during and after delivery. She is responsible for delivering the placenta, for removing the waste and dirty linen from the place of delivery and for helping to bath the postpartum woman.

17.6.4 Widowhood and Health:

There have been improvements in women's life expectancy at birth for both men and women. In the beginning of the 1950's, life expectancy at birth of both men and women was around 32 years and in 2011 it had increased to 67.3 for women and for men it is 63.8. It is gain of almost four years for women. As a consequence of higher life expectancy and other cultural reasons, more women tend to be widowed than men; for e.g., in 1988 nearly two-thirds of elderly women were widowed compared to about the fifth of men (NSSO:1991). This happens due to several reasons in general, women tend to be younger than their husband; and cultural and social norms inhibit women from remarriage

17.7 MEASURES TO BE TAKE TO PROMOTE WOMEN'S HEALTH

17.7.1 Expanding Health Services:

Women remain one of the most underserved segments of the Indian population. The almost singular focus of the Indian Family Welfare Programme on female sterilization resulted in the neglect of many areas of women's reproductive health. An expanded reproductive programme must include access to safe, effective and affordable methods of family planning for both women and men, informed choice in contraception and high-quality supplies. It also must promote safe motherhood and the prevention of sexuality transmitted diseases, and make efforts to reduce violence against women. It must provide access to safe and affordable abortion services, as well as services for the infertile, and comprehensive and accurate information about reproductive health care, including the risks and benefits of different contraceptive methods.

An expanded programme also must offer services to a wide range of females, not just to married women of childbearing age. Unmarried women, adolescent girls and; postmenopausal women all have distinct needs for information and services. An expanded reproductive health programme must address men, both in terms of their role in ensuring reproductive health and choice for their wives.

17.7.2 Access to Quality Care:

Service delivery strategies have not addressed the serious constraints that women face in acquiring good health. In many public health facilities, there are no specialized services which women are in need for their health care. Rural areas are devoid of quality health services.

17.7.3 Informed Choice:

The women's should be informed about the process of treatment, for example women who accept sterilization, particularly those living in rural areas, often do so having only minimal information about the procedure, about the after-care and about the possible complications.

17.7.4 Empowerment of Women:

The empowerment of women to gain greater control over the circumstances of their own lives is a necessary condition to overcoming the barriers for seeking health. Women must be encouraged to recognize and articulate their health needs and concerns and to access services with confidence. At the same time, they must be prepared to challenge service providers and programme managers to make them more accountable. Full access to appropriate care for women requires the creation of an environment that supports women's efforts towards self-determination.

In this unit, you studied about women's cultural empowerment status, barriers and measures to promote women's health conditions, now check your progress with following questions given in check your progress – 3.

Check Your Progress - 3

Note: a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

- 1) Develop Action Plan for improving health status of women.

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- 2) How women's social empowerment promotes her health?

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- 3) Illustrate how cultural practices inhibits health of women?

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17.8 LET US SUM UP

Women's health is related to social status which depends on her social and cultural empowerment. Women's health status can be identified on the basis of mortality, morbidity status and also depends on intake of nutrition. Maternal mortality is still very high in India as compared to other nations in the world. A female mortality and morbidity rate is also very high among girls and women. Ill health is the result of deficiencies of calories because intake of nutrition not only depends on the economic status but also on socio-cultural factors. Women's empowerment is restricted by poverty, unpaid labour, extensive and strenuous physical labour conditions and extra baggage of productive responsibilities. High level of female illiteracy inhibits the good health. Females are also having low rates of school enrolment and retention.

Social practices like preference for sons results in imbalance of sex ratio. Female foeticide is rampant. Marrying girls at early age affects the health adversely. Women and girls are often neglected in matters of feeding. Elderly women suffer not only from ailments specific to old age, but also from ill health accumulated over the life-cycle which may manifest in old age. They also suffer from gynaecological and menopausal health problems.

In terms of cultural practices, the patriarchal norms and values are disadvantage to women's empowerment. Physical restriction to move out for health care, beliefs related to illness and treatment, beliefs regarding pregnancy and child care brings constraints on women for their health seeking behaviour. Widowhood status leaves women alone and further brings dependency on her children. Women have little control over their own pregnancies. What to eat, what to do during pregnancy all depends upon others in the family. Child birth is considered as polluting in large part of the country and at the same time unsanitary circumstances results in infections etc.

Looking to the poor health status of women there can be certain measures which can promote women's health. These can be the provision of accessibility and availability of health services at the door step. Women's education regarding health care will certainly result in the empowerment of women.

17.9 KEYWORDS

Reproductive Infection: A general term for various types of infections affecting the female ovaries, uterus, vagina, and related areas, including vaginal and cervical infections, genital ulcer diseases, and pelvic inflammatory disease.

Reproductive Years: The reproductive years of women are from puberty through menopause, and this is the period when most women experience important life events such as entry into sexual union, marriage and childbearing.

Fertility: The average number of children a woman will bear in her life time.

Morbidity: Morbidity refers to a diseased state, disability or poor health due to any cause.

Infant Mortality: The annual number of deaths among children under age 1 per 1,000 live births

Maternal Mortality: The annual number of deaths among pregnant women from complications of pregnancy and child birth per 100,000 live births.

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17.11 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

Check Your Progress - 1

1) Mention the extent of women's health in India.

Ans. The following factors are important to an extent of women's health in India.

- a) Infant Mortality
(Under 1)
-
- ```
graph LR; A["a) Infant Mortality
(Under 1)"] --> B["Male 56.3"]; A --> C["Female 57.7"]
```

b) Maternal Mortality: 178 per lakh population

c) Morbidity status refers to a diseased state, disability or poor health due to any cause.

d) Fertility- 2.45 children per woman

2) Define women empowerment.

**Ans.** Women empowerment refers to increasing and improving the social, economic, political and legal strength of the women, to ensure equal-right to women, and to make them confident to claim their choices and decisions. It also refers to creation of an environment so that they have complete control of their life, both within and outside of their home and workplace.

### Check Your Progress - 2

1) What are the determinants of women's health?

**Ans.** The following are determinants of women's health

- a) Individual Behaviour and psychological factor
- b) Biological factor
- c) Social and Cultural influences
- d) Health and Nutrition provision

2) How education and changes in social practice changes health of women.

**Ans.** Education and social practice plays very important role and their health. The upward trends of female education improved their socio-economic status and health. Education provides a sense of empowerment to deal with the health care services. Old orthodox social practices also effects women's health like, preference for sons, early age of marriage, lack of knowledge about nutrition and quality food, inequitable distribution of food.

### Check Your Progress -3

1) Develop Action Plan for improving health status of women.

**Ans.** The following action plan are important for health status of women: a) Expanding health services, b) Access to Quality Care, c) Informed Choice and d) Empower to Women (see details in the unit content).

2) How women's social empowerment promotes her health?

**Ans.** Women's social empowerment play significant role and promotes her health. Social empowerment indicates indicate her involvement and participation following arenas a) Economic value of work, b) Enhancement of Educational level, c) Delayed age at marriage, d) Health care during pregnancy and e) Provision of Nutritional food.

3) Illustrate how cultural practices inhibit health of women?

**Ans.** Culture includes everything what we posses in society and it also acts as pressure on individual and many times these practices inhibit health of women. These can be easily observe like, physical restrictions to visit health care, faith and belief related to illness and treatment, belief related to pregnancy and child care, widowhood status and patriarchy system.

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## UNIT 18 EDUCATION AND HEALTH

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### Structure

- 18.1 Introduction
- 18.2 Health Education: Meaning, Significance and Need
- 18.3 Principles of Health Education
- 18.4 Content of Health Education
- 18.5 Agencies of Health Education
- 18.6 Communication in Health Education
- 18.7 Strategies in Health Communication
- 18.8 Case Studies in Health Education
- 18.9 Let Us Sum Up
- 18.10 Keywords
- 18.11 References and Suggested Readings
- 18.12 Check Your Progress: Possible Answers

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### 18.1 INTRODUCTION

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Here, you will learn the basic issues of health education, its important content, ways and rationale for strengthening health systems. It becomes more significant in less developed regions with a heavy burden of diseases, high population growth and low life expectancy. This unit will introduce the principles and purpose of health education in terms of interest, participation, motivation etc. How communication is made in health education is elaborated at different levels. Means of communication used for health education are also mentioned in this unit. Content and agencies for the dissemination of health education are elaborated.

After going through this unit, the learner should be able to:

- a) what are the basic connotations and significance of health education,
- b) describe the basic principles and levels of health education,
- c) explain the important content of health education,
- d) discuss the role of communication in this process and agencies of health education.

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### 18.2 HEALTH EDUCATION: MEANING, SIGNIFICANCE AND NEED

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#### 18.2.1 Health Education: Concept and Meaning

Health education is a process of bringing desirable behavioural change in the health habits or practices of the people through their own initiative or action. It should provide people with the learning opportunities so that they could react to them favourably and set a chain reaction for the ultimate adoption of the same. The World Health Organization defined health education as “compris(ing) (of) consciously constructed opportunities for learning involving some form of communication designed to improve health literacy, including improving

knowledge, and developing life skills which are conducive to individual and community health (WHO: 1998:4)

Health education cannot be done in a vacuum; it has to form an integral part of a health programme or health service, to be developed on a well-informed basis. We must know the reasons behind the behaviour that cause and prevent illness if we want to encourage healthy ways of life and educate people about the same while selecting appropriate educational methods. Our thoughts and feelings which are largely shaped by our knowledge, beliefs, attitudes and values, can help us to decide whether to behave in a particular manner because of the influence of the people who are important to us as we tend to listen to them more attractively than to others. Behaviour of a particular type is also influenced by certain type of resources such as availability of facilities, money, labour, services, skills and so on. Finally, it is the culture in which people are born and brought up that influences the behaviour of illness. Before the introduction of a health education activity, it is necessary to have an understanding of the difficulties encountered by people, identify barriers to and promoters of change so that appropriate behaviour change activities could be built up for a desirable behaviour among them (WHO:1984).

### **18.2.2 Significance of Health Education**

Health education aims at altering the behaviour of an individual in a desirable direction, so that people have happier, fuller lives without disease, infirmity or handicap. Health education builds people's knowledge, skills, and positive attitudes about health. Health education teaches about physical, mental, emotional and social health. It motivates people to improve and maintain their health, prevent disease, and reduce risky behaviours.

Health education is an effective tool that helps in improving health of the people. It not only teaches prevention and basic health knowledge but also conditions ideas that re-shape everyday habits of people with unhealthy lifestyles. This type of conditioning not only affects the immediate recipients of such education but also future generations who benefit from improved ideas about health that will eventually be ingrained through health education.

Moreover, besides physical disease prevention, health education can also provide more aid and help people deal in a healthier way with situations of extreme stress, anxiety, depression or other emotional disturbances to lessen the impact of these sorts of mental and emotional constituents, which can consequently lead to detrimental physical effects.

### **18.2.3 Need for Health Education**

Although it has been mentioned that health education activities should be carried by all the professionals engaged in providing service to the patients and their relatives, yet the key question whether there should be a health educator in a hospital or not, needs to be answered. There is no doubt that to make health education more effective and meaningful in a formal setting, it is desirable to have a full-time trained health educator. But the danger it envisages is that the other professional staff may not become complacent in their roles so far as health education activities are concerned. They consider it only the responsibility of the health educator to look after health education activities. Nevertheless, it would be desirable to have trained health educators in hospitals. A health educator can be considered to play the role of planner, trainer, communicator, coordinator; and evaluator.

As a planner, health educator should be able to make a diagnosis of people's beliefs and practices in the context of various diseases; identify some of the socio-cultural barriers and promoters related to the treatment prevention and promotion of diseases; identify resources both internal and external; select suitable health education methods; and organise activities in different places of interaction. In developing a plan of operation, the health educator has to ensure involvement of the hospital administrator, doctors or workers of the hospital and some of the important persons of the community to which the hospital is providing services. This would help him to develop a realistic plan by fixing priorities or phasing the various activities in different hospital situations.

**Trainer**

As a trainer, a health educator has to develop and conduct in service programmes for all categories of professional staff in the hospital who could play key roles in providing health education to the patients and other relations. The emphasis here has to be orienting the staff towards the belief patterns of people; many do's and don't regarding scope and opportunities of integrating health education activities in their own situations, and highlighting the need, concept and methods of health education. The need to communicate with patients and relations at their level has to be stressed.

**Communicator**

As a communicator, a health educator has to communicate effectively with the professional staff in the hospital so that they could appreciate the need and importance of health education. Apart from changing the outlook of different professional staff, the health educator has to provide stimulus which might generate motivating forces for helping patients to change some of their beliefs and practices.

**Co-ordinator**

As a co-ordinator, the health educator should co-ordinate health education activities within as well as outside the hospital. Apart from co-ordinating the resources within the hospital, he should also co-ordinate with the outside agencies involved and interested in the health education programmes related to the hospital. In co-ordination, though a difficult task, the focus should include co-operation, involvement and participation of different personnel in the programmes.

**Evaluator**

As an evaluator, the health educator has to evaluate the health education activities conducted inside the hospital concurrently as well as to make an assessment of the impact of health education in making patients and their relations adopt some of the desirable health practices. This has to be carried out in relation to both the patients who stay in the hospital for some duration as well as to a sample population in the community, who have been the beneficiaries of medical services and education from the hospital. This is a big task and requires co-ordinated efforts of the different professional staff as well as of the volunteers from the community. The concurrent evaluation should help the health educator to make necessary modifications in the educational activities for their ultimate effectiveness in inculcating desirable health practices among the patients and their relatives.

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## 18.3 PRINCIPLES OF HEALTH EDUCATION

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Health education brings together the art and science of medicine, and the principles and practices of general education. Health education cannot be seen in isolation, it is interconnected with teaching, learning and inculcation of habits with the objective of healthful living. There is internal learning by which a man grows into an adult individual. It is possible to abstract certain principles of learning and use them in health education.

### 18.3.1 Interest:

It is a psychological principle that people are unlikely to listen to those things which are not to their interest. It is important to look into the interest of the people. Health education programmes which simply ask people to remain healthy do not work until one finds the real health need. It can also be called a 'felt need'. If a health programme is based on felt need, people will gladly participate in the programme. Very often, there are groups who may have health needs of which they are not aware. The health educator will have to bring about recognition of the needs before he proceeds to tackle them.

### 18.3.2 Participation:

It is a key word in health education. Participation is based on the psychological principle of active learning; it is better than passive learning. Group discussions, panel discussions, workshop all provide opportunities for active learning. Personal involvement is more likely to lead to personal acceptance.

### 18.3.3 Known to Unknown:

In health education work, we proceed from the unknown i.e. start where the people are and with what they understand and then proceed to new knowledge. We use the existing knowledge of the people as pegs on which to hang new knowledge. In this way, systematic knowledge is built up. New knowledge will bring about a new enlarged understanding which can give rise to an insight into the problem. The way, in which medicine serves us as an illustration, the growth of knowledge is also from the unknown to the known. It is a long process full of obstacles and resistance.

### 18.3.4 Comprehension:

In health education we must know the level of understanding, education and literacy level of people to whom teaching is directed. One barrier to communication is using words which cannot be understood. A doctor asks a diabetic to cut down starchy food, however, the patient does not have any idea of starchy food. In health education, we should always communicate in the language people understand, and never use words which are strange and new to people.

### 18.3.5 Reinforcement:

People can learn all that is new in a single period. Repetition at intervals is extremely useful. It assists comprehension and understanding. Every health campaign needs reinforcement.

### 18.3.6 Motivation:

There is a fundamental desire in every person to learn. Awakening this desire is called motivation. There are two types of motives- primary and secondary. Primary motives (e.g. Sex, hunger, and survival) are driving forces initiating people into action; these motives are inborn desires. Secondary motives are based on desires created by outside forces or incentives. Some of the secondary motives are praise and love, rivalry, rewards and punishment, and recognition. In health education, motivation is important factor. The need for incentive is a first step in learning. The incentives may be in positive and negative forms. If we tell an obese lady about problems associated with overweight, she might ignore it. However, if we tell her that by reducing her weight, she will look more beautiful and young, it might motivate her to reduce her weight. In health education, we make use of motivation.

### 18.3.7 Learning by Doing:

Learning is an action-process; not a “memorising” one in the narrow sense. Learning by doing is the best practice for communication.

### 18.3.8 Soil, Seed and Sower:

People are the soil, the health facts the seed and the transmitting media the sower. Prior knowledge of the people- customs, habits, taboos, beliefs, health needs- is essential for successful health education. The seed or the health facts must be truthful and based on scientific knowledge. The transmitting media must be attractive, palatable and acceptable. Unless these three elements are carefully and satisfactorily interrelated the message will not have the desired effect.

### 18.3.9 Good Human Relations:

Studies have shown that friendliness and good personal qualities of a health educator are more important than his technical qualifications. Good human relations are of utmost importance in learning. The health educator must be kind and sympathetic. People must accept him as their real friend.

### 18.3.10 Leaders:

Psychologists have shown and established that one learns best from people whom we respect and regard. In the work of health education, one tries to penetrate the community through the local leaders- the village headman, the school teacher, influential person in the community or the political worker. Leaders are agents of change and they can be made use of in health education work. If the leaders are convinced first about a given programme, the rest of the task of implementing the programme will be easy. The attributes of a leader are: the person who understands the needs and demands of the community; provides proper guidance, takes the initiative, is receptive to the views and suggestions of the people; identifies himself with the community.

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## 18.4 CONTENT OF HEALTH EDUCATION

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What will be the contents of health education for the various health personnel of the hospital, coming into contact with patients and their relatives? Health education, being mainly disease oriented, should focus on the causation, spread and prevention of the disease. The scientific knowledge about the causation of

the disease may remove some of the traditional beliefs held by the patients. That may rationalise their thinking to analyse the preventive aspects of the diseases. In addition, the sentiments and feelings of the patients in regard to pain, crises and care, may be understood to provide necessary help for overcoming the emotions. The personal hygiene, family planning and nutrition are some of the other areas for integrating the components of health education. Whatever may be the components of health education, the focus should be to develop a desire among the patients to change and adopt the desirable health practices.

The health education can be in the form of universal topics which are common to all and there are certain other health issues which are specific to certain communities. Health education in the form of personal growth, care, common diseases are for everybody irrespective of any community. Other universal forms of health education are also sex education, environmental health, mental health etc. There are certain specific problems which should be addressed in the health education curriculum if they occur in the community and they include: reproductive health care, child care, HIV/AIDS and sexually transmitted diseases, immunisation, oral health, tobacco and alcohol, nutrition, unsafe or inadequate sanitation and water.

#### **18.4.1 Human Biology**

Teaching pertaining to human anatomy is done at various levels of schooling. Children are taught about human body, its parts and functions. It is also taught how one should be keep fit. The effects of bad food, alcohol, drug abuse are also taught. Exercises, sleep, healthy daily routine, are also a part of school curriculum.

#### **18.4.2 Nutrition:**

The aim of health education is to impart knowledge about nutrition in various foods, so that one can keep oneself healthy. What food contains, what minerals, vitamins, and in turn deficiency of these results in the causation of disease or bad health. Nutrition is also required for energy, growth and repair of the body. Health education is also given about storage, preparation, cooking, serving and eating of food. In nutrition education, the primary aim is to help people to make the best use of the available resources.

#### **18.4.3 Hygiene:**

There are two components of hygiene: personal and environmental hygiene. Personal hygiene includes bathing, clothing, washing hands, personal appearance and inculcation of cleanliness. Personal hygiene is a part of socialisation which begins at a very early stage and carries forward.

#### **18.4.4 Environmental Hygiene:**

It is related with domestic hygiene and community hygiene. Domestic hygiene includes, washing of hands before and after eating food, and after defecating. To maintain hygiene, hands should be washed with soap and water. Need fresh air, ventilation, hygiene is storage of food, hygienic disposal of wastage are part of environmental hygiene. Food also needs to be protected from pests, rats, mice, and insects. Improvement of basic sanitary services consisting of water supply, disposal of human excreta are fundamental to health.

### 18.4.5 Family Health Care:

Family health care is entrenched around mother and child health; however, family is included as a comprehensive unit. Family health care programme include human growth and development, mother and child health, family planning, population dynamics, immunisation and other health related activities. The aim of health education is to strengthen and improve quality of life of family as a unit so that it can lead a healthy life.

### 18.4.6 Control of Communicable and Non-communicable Diseases:

There is a wide range of specific communicable and non-communicable diseases which need health education. These are: malaria, sexually transmitted diseases, trachoma, leprosy, tuberculosis, malnutrition, cardiovascular diseases, dental diseases, drug addiction, alcoholism, accidents.

### 18.4.7 Mental Health:

Mental health problems occur everywhere. The aim of education in mental health is to help people to keep mentally healthy and to prevent a mental breakdown. People should enjoy their relationships with others and learn to live and work without mental breakdown. There are certain special situations when mental health is of real importance- mother after child birth; child at entry into school for the first time, school child entering the secondary school, decision about a future career, starting a new family and at the time of widowhood. These are critical periods of life when external pressure tends to break down mental health. Health workers should help people achieve mental health by showing sympathy, understanding and by social contact.

### 18.4.8 Prevention of Accidents:

Accidents are a feature of the complexity of modern life. Accidents occur in the home, on the road and in the work place. Safety education should be directed to these areas. It should be the concern of safety departments and also the responsibility of the police department to enforce rules of road safety.

After going through basic concepts of health education, its significance and need, basic principles of health education, content of health education, now answer the questions given in Check Your Progress – 1.

#### Check Your Progress – 1

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) Discuss the significance of health education.

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- 2) What are the principles of health education?

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- 3) Mention the content of health education.

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## 18.5 AGENCIES OF HEALTH EDUCATION

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The content of health education has to be communicated to the individual, groups or in the community through certain agencies. Here, we will discuss about the stakeholders of health education and by whom it has to be delivered so that it makes an impact on them.

### 18.5.1 Hospitals and Health Education:

Functionally speaking, a hospital can be compared to a workshop where the physicians and their allies, with their technical know-how and specialties provide necessary treatment to the patient with an ultimate objective of providing recovery from sickness and to enable him to function as a normal individual in the community. With the emphasis shifting from individual oriented to community oriented health goals, the hospital as an institution has to play a bigger role in promoting health education activities. In addition to the increasing number of hospitals in the country, the number of patients attending these hospitals has also increased. Each patient on an average is accompanied by one or two of his relations. Thus, a large section of the population can be contacted for health education purposes.

Better medical facilities and technology has build up more confidence among people and they are now assured of a longer span of life. As such, hospitals have become the foci for better communication between physicians and members of the community. The psychological state of readiness to accept what is told, on the part of patients, is another important factor, facilitating the imparting of health education in hospital setting. Also, as a result of better means of communication, the feasibility of the medical care services from the hospital has increased manifold thereby providing more opportunities for health education to a larger

number of people. The social influence of familial group or friends accompanying the patients may be another factor instrumental in setting the desirable health practices accepted by the people in hospital setting.

### **18.5.2 Doctors and Health Education:**

Health education in the hospital has to be mainly disease-oriented. Patients suffering from various diseases, both of major and minor types, come into contact with doctors belonging to various specialities. As such, the role of the doctor becomes very important in imparting health education. The doctor enjoys a high status in the eyes of the patients and their relations and as such, the role of the doctor becomes very important in imparting health education. In addition, there are a number of medico-social workers, laboratory technician and X-ray, ultra-sound, and MRI technician who come into contact with patients and their relations. The nurse can play a more effective role since the frequency and duration of contact she has with the patients is more in her case than in the case of other professionals.

Health education activities should be carried out in in-patient and out-patient areas, situations of interactions providing communicating opportunities between patients and hospital components. In addition, the non-interaction situations like waiting halls, in-patient wards, etc. should also be utilised for imparting health education to the patients and their relatives.

### **18.5.3 Other entertaining measure and health education:**

Health education must be carried out through:

- Films and Puppet shows
- Group Talks
- Display of Posters and Exhibitions
- Distribution of Handouts, Pamphlets and Folders
- Demonstrations
- Health Programme Shows on Television
- Group Talks by Specialists

## **18.6 COMMUNICATION IN HEALTH EDUCATION**

Education and health have continued to grow in isolation from each other to the detriment of both. Health is essentially one of the individual responsibilities and it cannot succeed without education. It can give each individual the needed information, skills and value orientations. The key elements in the communication process are as follows:

### **18.6.1 Communicator**

The prestige of the communicator is not related to his economic status, education or influence but more so with his credibility. Such people make an immediate, better and lasting impact on their audience.

### **18.6.2 The Qualities of the Communicator:**

People may comprehend the message given by two separate communicators in an identical manner, but they may not necessarily accept the recommendations made by one person, while the other communicator may be more successful in changing their attitudes. Generally, the audience accept the recommendations of a person who is respected for his prestige and is reputed for his integrity, fairness, and unbiased character.

### **18.6.3 Target Group in Communication:**

#### **a) Group Salience:**

In every society, a majority of the people show great loyalty to the cultural and social norms of behaviour established by their peers in their respective ethnic or racial groups. This group salience determines their willingness to accept or reject certain recommendations made to them. As a general rule most people resist the views, which appear to be contrary to their traditional cultural and social ethos. They may accept minor modification in their existing practices but do not accept any major change suddenly. A person from their own cultural, ethnic or religious group can influence their attitudes and behaviour more successfully than a person from a different cultural milieu.

#### **b) Critical Judgement:**

If the audience is generally of higher intelligence it is often more critical, but these individuals learn or benefit from persuasive communication more readily than those with average intelligence.

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## **18.7 STRATEGIES OF HEALTH COMMUNICATION**

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The health education communication or messages generally comprise data or arguments, which substantiate a certain mode of action propagated by the communicators. These arguments may be of two types viz., those with a positive appeal explaining the benefits that will accrue to the individual, if the recommended course of action is adopted, or with a negative appeal or arguments, which tends to emphasise the hazards or unpleasant consequences, resulting from not accepting the recommended line of action.

It is unfortunate, that for promotion of the family planning programme, most health education experts in our country focussed in the earlier phases, on the negative aspects of over population by emphasising primarily on the hazards from rapid rise in population. It has been observed that strong negative appeal does not produce the desired results. On the other hand, it is often counterproductive, because the atmosphere of fear generates emotional tension, which threatens the social security of the individual and the value system of the audience. It is especially so if the psychological impact and tension created by the fear is not quickly relieved by some reassuring statement. Often the target group actually begins to ignore or minimize the importance of the implied threat. Millions of people continue to smoke in spite of the statutory warning printed on every cigarette packet, that smoking is dangerous for health. Available experimental evidence shows that mild fear produces better results than the strong horrifying statements.

### **18.7.1 Anticipatory Preparation of the Audience:**

It is needless to say that the audience should be reassured about the use of advocated health measures, but they should also be conditioned for the possibility of failure in some circumstances, even if the recommended course of action was followed faithfully and meticulously. This is absolutely vital, because even when a small fraction of the people experiences an unfavourable outcome from the proposed health activity, the entire community may lose faith in persuasive arguments. On the other hand, if the people are prepared for possible failures in a small proportion of cases, they take a balanced view of the pros and cons of a particular health activity. In such cases, they do not interpret a temporary setback or failure, as an act of wrong judgement or decision but often attribute it to their bad luck. In India, IUCD was widely prescribed for family planning often without adequate prior anticipatory preparation of women users. A miniscule proportion of failures and complications in a few women users of IUCD gave severe setback to the whole programme.

### **18.7.2 Both Sides of an Issue:**

It is desirable to present both sides of an issue to the audience. The people should be made aware of the arguments used by the opponents of the recommended health activity and their rebuttal by the public health administration. If this aspect is presented judiciously, the target group can be protected against subsequent hostile propaganda made by the opponents of the proposed health such as family planning or immunization. The target population is thus prepared in advance either to ignore or discard the opposing arguments.

### **18.7.3 Attitude of Acceptance:**

It has often been observed, that people accept an idea or argument most, if they are already familiar with it and it does not appear to be far removed from their own cultural views and traditional practices.

### **18.7.4 Incentives:**

In an effort to promote a socially desirable activity such as family planning methods, the administration may offer some incentives to the target population in the belief that it will bring about a desirable change in their attitudes. Controlled experiments by psychologists have conclusively demonstrated that whereas a mild incentive or inducement may be useful in changing attitudes, a very strong incentive may not achieve the objectives and may in fact be counterproductive. Major financial incentives may arouse suspicion in the minds of people, who may revolt or express resentment against the proposed recommendations, due to their scepticism. It is wrong strategy to offer attractive prizes or economic baits to persuade people to accept a new viewpoint or to get themselves sterilised. An assurance of a guaranteed health care or a better life for children may possibly be a better incentive for family planning motivation.

### **18.7.5 Sleeper Effect:**

A communication may not have an immediate effect on the behaviour of an audience. This need not be interpreted as a failure. It is often seen that the impact becomes evident after a lapse of time, because people take time to evaluate the pros and cons of arguments advanced by the health educators and are initially hesitant to take the initiative in adopting the proposed measures. This sleeper

effect is particularly noticed when the contents of the communication were generally considered reasonable and acceptable but the prestige of the communicator for credibility or reliability was low. However, even when the communicator has a poor stature he makes some impact on the people and this may show delayed results.

### **18.7.6 Role Playing:**

If a person is asked to give a health education talk, he eventually adopts the viewpoints expressed by him, as his own views, even though initially he was not especially enthusiastic about these. Thus, role playing influences his behaviour as that of the audience. This highlights the usefulness of active participation and use of the people in the community itself in modifying the attitudes of other hostile groups in that community. A person playing the role of health educator is compelled to improvise and invent new arguments and reasons for his lecture or communication. This gives him considerable satisfaction in his new role.

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## **18.8 CASE STUDIES IN HEALTH EDUCATION**

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Health education campaigns can be ineffective if there is no interactive communication between the people implementing the programmes and the members of the community. Before a strong stance on HIV was adopted by the governmental leadership in Thailand in the early 1990s, HIV/AIDS severely threatened national health infrastructure and stability of the country (AVERT: 2010). In an attempt to contribute to the national goals of HIV-transmission reduction, the Peace Corps made efforts to provide condom demonstrations for local villagers. However, these sessions were not successful in the old days as volunteers used bananas in the demonstration but switched to wooden replicas when they discovered that some participants went home and actually put condoms on bananas thinking it had some sort of power to keep them safe (Trill and Holland:1993). Education and prevention of HIV/AIDS is a large part of the work that Peace Corps volunteers carry out in health sectors of Africa, the Caribbean, Eastern Europe, and Central Asia. While encouraging condom use is “a critical element in a comprehensive, effective, and sustainable approach to HIV prevention and treatment,” the way in which the educational material is communicated to its target audience must be adapted to local cultural circumstances (WHO: 2004:1). Recognition and respect for such cultural factors and social obstacles can be achieved through “cultural competence”. Achieving this competence “implies having the capacity to function effectively as an individual and an organisation within the context of cultural beliefs, behaviours, and needs presented by consumers and their communities (National Prevention Information Network: 2004). This includes involving the community in pinpointing issues and generating solutions, collaborating with other local agencies to determine best practices, and evaluating receptivity to and outcomes of community-based endeavours. In addition to a closer examination of the culturally acceptable methods of knowledge dissemination, a “cultural broker”- a liaison between outsiders and insiders who understands the “health values, beliefs, and practices within their cultural group of community”- might have been helpful in the Peace Corps volunteers’ situation.

For the past two decades “cultural competency” has been discussed in the sociological literature to discuss the medical education for addressing the tensions of moments of clinical encounter in the western societies.

A case study by Metzl and Hansen (2014) cites that “A patient walks into the doctor’s room speaking local a dialect that the doctor struggles to understand. The patient points to his chest while making pain gestures, or mimics actions that suggests a seizure or fights to breathe. But the doctor is in his/her internship, having just moved to the public/patient interaction. He/she might have come from other part of the country; from urban area where he either grew up in French/English /or any other mother tongue. On the other hand, the patient might have grown up in other dialect/language background; in rural area where English is not a mother tongue”.

In this formulation of case study, it implies the trained ability to identify cross-cultural expressions of illness and health and to thus counteract the marginalisation of patients by race, ethnicity, social class, religion, sexual orientation, or other markers of difference. Clinical professionals learn diagnosis and treatment that take into account culturally specific sources of stigma, such as stigma of mental health diagnosis among Asian immigrants or the stigma of HIV and homosexuality in certain religious communities. Doctors train by analysing posters that reveals instances where cultural variables impact symptom presentations or attitudes about care.

### 18.8.1 Significance of Health Education Through Certain Mediums:

The attitudes of people are conditioned by self-interest, cultural ethos, demands and restrictions placed by their ethnic, religious or racial groups besides their personal experiences, traditional beliefs and lifelong practices. Therefore, the conventional methods of health education such as the use of posters, mass media, flip charts, slides, film strips make little impact on the attitudes of people belonging to the tradition-ridden conservative societies, if certain fundamental attributes for changing the attitudes of people are not kept in view.

Attitudinal change is brought about by a deliberate persuasive communication. Its effectiveness depends on three factors viz., the personal qualities of the communicator, the type of the target population, whose behaviour is proposed to be changed and the content of the communication used to influence their attitudes.

After going through this unit, particularly, communication and the content of the health education, various agencies involved in effective health education promotion and some successful case studies for health education, now answer the questions given in Check Your Progress – 2.

#### Check Your Progress – 2

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit.

1) Discuss the process of health communication.

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- 2) Mention the prerequisites for health educators in a formal structure.

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## 18.9 LET US SUM UP

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To sum up, health education in the hospital can be meaningful and effective, if the professional staff engaged in providing services to the patients have faith and conviction in the philosophy, principles and methods of health education. Secondly, if health education is made an integral part of their job responsibilities, and also if they communicate with the patients and their relatives at their level, health education in the hospital can become institutionalised to restore, promote and rehabilitate the health of the people.

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## 18.10 KEYWORDS

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**Health Education:** Health education is a process of bringing about a desirable behavioural change in the health habits or practices of people through their own initiative or through provision of learning opportunities.

**Motivation:** Motivation is a fundamental desire in every person to learn; and the awakening of this desire is called motivation.

**Health Communication:** The education regarding health is provided is called health education that is provided through formal or informal method of communication.

**Communicator:** A person who is respected and able to communicate the needed information and values to the masses is called communicator.

**Sleeper Effect:** When the communication becomes evident and effective after a lapse of time, it is called 'sleeper effect'.

**Human Biology:** Human biology is concerned about the anatomy of human body parts and their functioning.

**Nutrition:** Nutrition is the combination of minerals, proteins, vitamins and other elements found in food. Nutrition is required for energy, growth and repair of the body.

**Hygiene:** Hygiene includes bathing, clothing, washing hands, personal appearance and cleanliness.

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## 18.11 REFERENCES AND SUGGESTED READING

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## 18.12 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

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### Check Your Progress-1

1) Discuss the significance of health education.

**Ans.** Health education aims at altering the behaviour of an individual in a desirable direction, so that people have happier, fuller lives without disease, infirmity or handicap. It is an effective tool that helps in improving health of the people. It not only teaches prevention and basic health knowledge but also conditions ideas that re-shape everyday habits of people with unhealthy lifestyles.

2) What are the principles of health education?

**Ans.** Principles are basic guideline for any development initiative, similarly principles of health education means the guidance, learning and use of them in health education. The following guidelines are important effective health education: interest, participation, known to unknown, comprehension, reinforcement, motivation, learning by doing, soil. seed and sower, good human relations.

3) Mention the content of health education.

**Ans.** The content of health education refers to the scientific knowledge about the causation of the disease that may remove some of the traditional beliefs held by the patients. The following contents are significant: a) understanding of human biology, b) nutrition, c) hygiene, d) environmental hygiene, e) family health care, f) control of communicable and non-communicable diseases, g) mental health, h) prevention of accidents and i) accessibility to health services.

## Check Your Progress – 2

1) Discuss the process of health communication.

**Ans.** The health communication or messages play a significant role in health education for the masses, it comprises data or arguments, which substantiate a certain mode of action propagated by the communicators. These five points are very important in this process- a) Anticipatory preparation of audience, b) Attitude of acceptance, c) Incentives, d) Sleeper effect, and e) Role playing.

2) Mention the prerequisites for health educators in a formal structure.

**Ans.** The prerequisites for health educators in a formal structure are as following:-

- a) Planner
- b) Trainer
- c) Communicator
- d) Co-ordinator
- e) Evaluator



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## UNIT 19 POVERTY AND HEALTH

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### Structure

- 19.1 Introduction
- 19.2 Economy and Health
- 19.3 Poverty and Health Linkages: Past and Present
- 19.4 Challenges of Poor Health
- 19.5 Poverty and Health Status in India
- 19.6 Let Us Sum Up
- 19.7 References and Suggested Readings
- 19.8 Check Your Progress: Possible Answers

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### 19.1 INTRODUCTION

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According to WHO, roughly 1.2 billion people in the world live in extreme poverty (i.e. less than one dollar per day, later enhanced to 1.9 dollar). It has been observed that poverty is the cause as well as consequence of poor health. Poor economic status and such environment is considered as the cause of ill health, higher occurrence of child mortality and maternal mortality as well as overall low life expectancy. History of health reveals that inadequate income, lack of access to resources (nutritious food, shelter), stress and drug abuses are often the major cause of poor health. In this unit you will read about how economy influences human survival particularly health conditions, linkages between poverty and health, important health challenges and the health status of India with changing times particularly after independence.

After going through this unit you will be able to:

- a) explain the meaning of poverty and how it is linked with the concept of health,
- b) describe various factors of health posing challenges to mankind,
- c) discuss the poverty dynamics and health challenges in India.

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### 19.2 ECONOMY AND HEALTH

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Economic conditions have strong influence on different spheres of society including polity, social relation, environment, education, health, science and development. Karl Marx (1818 - 1883) viewed economy as basic structure of any society on which super structures are built like political structure, family, legal system and other institutional development. He explained it as 'economic determinism' and considered that economic institutions (means of production) determine the development of other institutions in society (relations production) including health and education. Broadly, the relationship between health and economy can be looked with two different perspectives- first, the linkages between health and economy i.e. economic growth and the distribution of income. Secondly, role of economy for health care delivery institutions, health finances and policies. It has been observed that illness reduces individual / family efficiency and their income as a result of which lag in other human development indicators- education and demographic structures. Ultimately, this led to vicious circle of poverty and

poor economic condition. Contrary to this, poor economic status deprives individual from basic livelihood needs- food, housing, education and health. A region or country with low income has higher fertility rate, higher mortality rate and lower life expectancy. Higher dependent population and less productive population (higher dependency ratio); whereas wealthier countries are more developed in human capital and spend higher percentage of their income on health and rely more on public sector health finance than the low income countries.

**Graph-19.1**

**Linkages between Health and Economy**

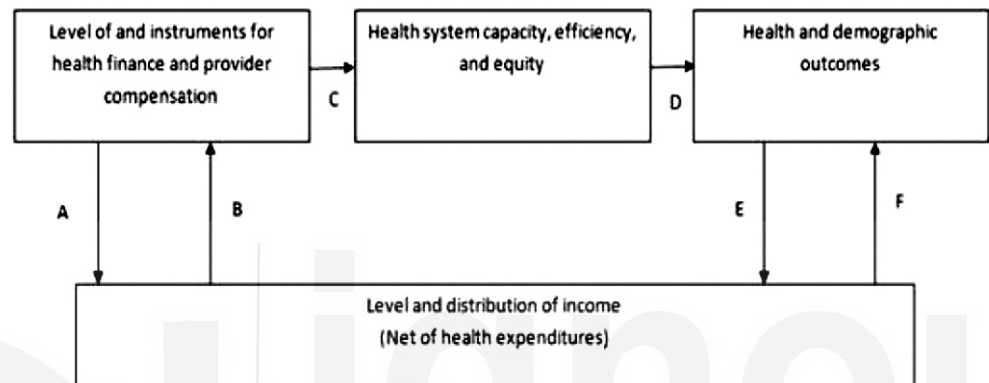


Figure 1: Health, Health Policies and Economic Outcome (Adapted from Michael H Merson, R. E. Black and A. J. Mills (2006) International Public Health: Diseases, Programs, Systems and Policies. Jones and Barlett's Publishers, USA.

Hence, economy plays a critical role for health finances, both public health expenditure and individual health spending. It also exerts pressure for effective health policies with health education and other health related programme like, immunisation, preventive health care, awareness and sustainable environment.

### 19.2.1 COCEPT OF POVERTY AND ITS IMPLICATION

Usually poverty is viewed as a state of person's economic status showing insufficient money or material condition for their survival. Keeping these in mind the concept of poverty line has evolved to measure the proportion of poor population in a region/ country. It differs with place and time owing to variation in market condition and other factors. Poverty is determined by not only lack of consumption and income criteria but also non-economic factors like social and political conditions which includes education, access to basic utilities, health care, security and freedom. E. J Hobsbawm distinguished three types of poverty: social poverty, pauperism and moral poverty. Social poverty characterises not merely economic inequality i.e. prosperity, income, standard of living but also social inequality i.e. inferiority, dependence, or exploitation. This perpetuates for a longer period until and unless poor's mindset or culture changes. Second category of poverty called pauperism refers to those people unable to maintain without outside support or assistance. It is extreme state of poverty with inadequate food and clothing for long periods of time owing to insecurity of employment, shelter. Third category of poverty, moral poverty, defines the place of poverty in value system. In stratified societies several values of poverty coexist as one social act will be shame for one group while same social act is pride for other group. Sometimes it crisscrosses with earlier two forms of poverty.

Amartya Sen and Jean Dreze Omnibus (1999) see poverty concept in three successive approaches: a) biological approach, b) minimum nutritional requirement, and c) food cost as minimum requirement. All these perspectives have basic thrust to measure malnutrition and deprivation in order to examine famine.

- 1) Biological approach, the earliest approach defines poverty as a condition where a family's total earning is insufficient to obtain the minimum necessity for the maintenance of physical efficiency. This was often considered as bench mark of poverty line. Later on this approach was severely criticized on physical feature, climatic condition, dietary behavior and nature of work. Further added that this approach has rooted in human needs and left the scope for modification.
- 2) Second approach, minimum nutritional requirement certainly emerges from earlier biological approach with major correction. According to this, minimum nutrition and food requirement depends on choice of 'diet problem' and cost components (minimum cost diet). Here, actual income for 'specified nutritional requirements' depends further on consumption habits in particular context.
- 3) Third approach is based on non-food item. Here it is based on the proportion of income spent on food i.e. total income spent on food. Further question emerged that expenditure on food varies with many factors- culture, social categories, food habit and others factors.

However, mainly there are two types poverty often discussed by the economist i.e. absolute poverty and relative poverty for planning and poverty eradication programmes. Absolute poverty indicates the minimum level of requirement for survival of human being leveled as poverty line / bread line often measured by two of the following methods.

- a) Minimum amount of money (in currency) incurred for survival
- b) Minimum energy (in calories) required for survival

Both these methods have limitations with time and place. Cost of food item varies with time owing to market conditions and monetary status. Similarly availability of nutritious food and social construct varies with society and regional produce. According to the Planning Commission, an individual in rural areas must get 2400 calories and in urban areas 2100 calories per day. In 1979-80 in rural areas 51 per cent and in urban areas 40 per cent of the people were living below the poverty line. The 66th Round NSSO data (2009-10) says anyone who has Rs. 28 to spend daily is above poverty line.

Whichever be the criteria of measurement, today poverty stretches across the globe and almost half of the population is suffering with basic survival needs- adequate nutrition, food, shelter, health, education and other support owing to low income and unequal distribution of resources. The highest implications are in Africa and Asia. The prevalence of undernourishment in Africa is 23 percent, however, the proportion has declined but the number has enhanced. Similarly, south Asia including India, Pakistan and Bangladesh the prevalence of undernourishment is 11.5 percent, increasing

trend from last 9.4 percent (UN FAO 2017). Poverty heavily influences human health in various ways from lack of food, inadequate nourishment, poor housing to change living environment. World Bank Report (2019) 250 million children under five are at risk of not reaching their developmental potential because of stunting or extreme poverty in low- and middle income countries. Worldwide, more than 87 million children under age 7 have spent their entire lives in conflict affected areas and they suffer from extreme trauma and toxic stress which impair their brain development and skill enhancement. Similarly, children also suffer basic education rights, only half of children between 3 to 6 year old have access to pre-primary education globally and in low-income countries this share is one-fifth. Thus, poverty is not only a consequence but also a cause for low literacy, poor health and denial of resources and acts upon individuals as vicious process of continuity.

### 19.3 POVERTY AND HEALTH LINKAGES: PAST AND PRESENT

After understanding the nature and dynamics of poverty now we will see its influence on our basic health conditions. Important health and economic development indicators reveals how poverty is strongly associated with public health parameters and continuing vicious circle of poverty. Global demographic indicators in last century (particularly 1950 onward) till now reveal major improvement in mortality rate, fertility rate, infant mortality rate and life expectancy which also indicate the progressive changes in health and development. Apart from this, these changes are not uniform across the world rather more developed region have been early achievers of the above mentioned indicators than the less developed regions. For instance, infant mortality rate was 149 per 1000 in less developed regions whereas corresponding IMR was 43 in more developed regions during 1950-55, (United Nations, Population Division). These figures clearly express the close association between health and poverty (see Table-19.1 of unit-1, block-1).

**Table-19.1: Health and Economic Development Indicators of High Income to Low Income Countries**

| Sl. No. | Indicators                                                        | High Income countries | Low & Middle Income countries | Low Income countries |
|---------|-------------------------------------------------------------------|-----------------------|-------------------------------|----------------------|
| 1       | Population (2015)                                                 | 1187.1 million        | 6159.6 million                | 638.3 million        |
| 2       | Life expectancy at birth (2017)                                   | 81                    | 71                            | 63                   |
| 3       | Fertility rate (per 1000 women, year 2017))                       | 1.6                   | 2.6                           | 4.6                  |
| 4       | Adolescent fertility rate (10-19 years per 1000 women, year 2015) | 13                    | 48                            | 96                   |
| 5       | Maternal mortality rate (per 100,000, year 2015)                  | 10                    | 237                           | 496                  |

|    |                                                                        |               |               |               |
|----|------------------------------------------------------------------------|---------------|---------------|---------------|
| 6  | Births attended by skilled staff (in percentage of total, year 2014)   | 99            | 78            | 58            |
| 7  | Child mortality under 5 year (per 1000, year 2015)                     | 06            | 46            | 76            |
| 8  | Immunisation (% of children aged 12-23 months, year 2017)              | 96            | 85            | 77            |
| 9  | HIV prevalence (percentage of population aged 15-49)                   | Not available | 1.1           | 2.4           |
| 10 | Aggregate GDP (2018)                                                   | 54,108,061.21 | 31,713,927.46 | 572,219.39    |
| 11 | GDP per person (2018)                                                  | 44,705.9      | 4967.8        | 811.2         |
| 12 | Public health expenditure (per person in percentage of GDP, year 2016) | 12.59         | 5.42          | 5.38          |
| 13 | Child Malnutrition and Stunting (% under 5 years 2008-15)              | 2.6           | 25.5          | 37.3          |
| 14 | Vulnerable employment (% of total employment, 2012-16)                 | 09            | Not available | Not available |

**Source:** World Bank (2017) World Development Indicator, International Bank for Reconstruction and Development, Washington, USA.

Therefore above statistics on low and middle income countries clearly show poor health facility, higher mortality and fertility, lesser life expectancy (table 3.2). It also reveals that poverty makes people more vulnerable to diseases and health problems. According to World Bank, an estimate of 1.4 billion people lived on less than 1.25 dollar per day in 2005, while 1 billion people lived on less than 1 dollar a day, the lowest 'bottom billion' in 2009. Hence, the distribution of multidimensional poverty across the world are also uneven around 31 per cent of people were in South Asia in 2011 (reduced to 13.5 percent in 2017) and half of the people in sub-Saharan Africa lives on 1.25 dollar per day or less in 1990 (reduced to 36 percent in 2017). The majority of them typically lack access to food, education, employment, safe drinking water and adequate sanitation, health information and professional health care. These people cannot obtain essential drugs, and large shares of women giving birth are assisted by unskilled birth attendants.

Poverty is directly associated with poor sanitation that leads to poor health conditions. It is a surprise that while one out of nine people is hungry, whereas 1/3rd of food is wasted and 12.9 percent of the population is undernourished worldwide. The higher proportion of them is living in low and middle income countries. Sub-Saharan Africa has the highest hunger prevalence i.e. one out of

every four person is undernourished. Asia is also home to large number of hungry people (World Food Programme). However, it has been observed that the number in southern Asia has fallen in recent years but in western Asia it has slightly increased. Poor nutrition causes nearly 45 percent of deaths in children under five year children each year, large number of underweight among infants and school going children, anemic problem among women. Besides food and hunger, non-food reasons are also associated with health care i.e. smoking, drug abuse, alcohols. Tobacco epidemic is biggest threat to the world public health system and one of the key components of Sustainable Development Goals is to accomplish to zero tobacco consumption by 2030. This epidemic is killing 8 million people and 1.2 million non-smokers every year. The higher chance of tobacco usage is found among poor (approximately 84 percent) and they find it very difficult to quit owing to poverty and lack of education. Tobacco also increases the poverty of individual and families.

**Table-19.2: Health Expenditure in Selected Developed & Developing Countries (2017)**

| Country   | Out of Pocket Health Expenditure (%) | Percent of GDP | Public expenditure (Percent) |
|-----------|--------------------------------------|----------------|------------------------------|
| US        | 11.1                                 | 17.1           | 81.8                         |
| UK        | 15.1                                 | 9.8            | 80.2                         |
| Japan     | 13.5                                 | 10.9           | 83.6                         |
| China     | 35.9                                 | 5.0            | 58.0                         |
| India     | 64.6                                 | 3.7            | 25.4                         |
| Sri Lanka | 50.1                                 | 3.9            | 43.1                         |
| Nigeria   | 75.2                                 | 3.6            | 13.0                         |
| Zambia    | 12.1                                 | 4.5            | 38.3                         |

**Source:** World Development Indicators, World Bank, <http://wdi.worldbank.org/tables> (accessed on 27/9/2019)

In this section, you have gone through basic concepts of poverty and types of poverty which has core concern of development since beginning. You have also read about the impact of poverty on health and global efforts to reduce these challenges. Now attempt following questions to see your progress given in Check Your Progress-1.

### Check Your Progress 1

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) What is poverty?

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2) How poverty is related to health and development.

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## 19.4 CHALLENGES OF POOR HEALTH

Poverty deprives poor from adequate nutrition, access to education, sanitation, housing, potable water and other essential requirement to survive and maintain a sound health. Besides these, drug and tobaccos abuse are widely used among poor, which also harms the health conditions among poor. Historically, These factors have shown high correlation with health of individuals.



Graph-19.2: Factors of Poor Health

### 19.4.1 Nutrition

Nutrition has multiple roles for growth and development of any living being. The access to safe food is essential for physical and cognitive development. The knowledge of nutrition and dietary behavior and how this affects human body, its metabolism to maintain a good health is known before the emergence of nutrition science. Since ancient period nutrition has been viewed as fundamental component of life. Aristotle and Galen viewed that nutrition is vital for health, prevention of disease, performance and healing. Each element of our body functions with the food intake and proper nutrition. However, disparity in nutrition particularly malnutrition and over nutrition has observed across the globe which led to various diseases and health disorders among individuals, community and population at large. This has significantly visible effects during childhood stage and adolescent stage for rapid growth. Women are also facing severe nutritional problem like, deficiency of iron and other necessary nutrients. Almost 11 percent of burden of diseases worldwide are due to mother and child under nutrition. Malnutrition also leads to stunting (the anthropometric indicator with age and faltering growth), wasting (low weight-for-height) and deficiencies of essential micronutrients. In 2005, an estimated 20 per cent of children (under 5 years) in poor countries were regarded as underweight, with countries in South-Central Asia and eastern Africa having the highest proportions. Similarly, 40 countries were estimated to have a

stunting prevalence of 40 per cent or more, including 23 in Africa and 16 in Asia. Apart from this, it has been observed that under nutrition is directly correlated with infectious diseases.

**Table-19.3: Prevalence of undernourishment in the world, 2005–2018**

|                                        | 2005            | 2010            | 2015            | 2016            | 2017            | 2018*           |
|----------------------------------------|-----------------|-----------------|-----------------|-----------------|-----------------|-----------------|
| <b>WORLD</b>                           | <b>14.5</b>     | <b>11.8</b>     | <b>10.6</b>     | <b>10.7</b>     | <b>10.8</b>     | <b>10.8</b>     |
| <b>AFRICA</b>                          | <b>21.2</b>     | <b>19.1</b>     | <b>18.3</b>     | <b>19.2</b>     | <b>19.8</b>     | <b>19.9</b>     |
| Northern Africa                        | 6.2             | 5.0             | 6.9             | 7.0             | 7.0             | 7.1             |
| Sub-Saharan Africa                     | 24.3            | 21.7            | 20.9            | 22.0            | 22.7            | 22.8            |
| Eastern Africa                         | 34.3            | 31.2            | 29.9            | 31.0            | 30.8            | 30.8            |
| Middle Africa                          | 32.4            | 27.8            | 24.7            | 25.9            | 26.4            | 26.5            |
| Southern Africa                        | 6.5             | 7.1             | 7.8             | 8.5             | 8.3             | 8.0             |
| Western Africa                         | 12.3            | 10.4            | 11.4            | 12.4            | 14.4            | 14.7            |
| <b>ASIA</b>                            | <b>17.4</b>     | <b>13.6</b>     | <b>11.7</b>     | <b>11.5</b>     | <b>11.4</b>     | <b>11.3</b>     |
| Central Asia                           | 11.1            | 7.3             | 5.5             | 5.5             | 5.7             | 5.7             |
| Eastern Asia                           | 14.1            | 11.2            | 8.4             | 8.4             | 8.4             | 8.3             |
| South-eastern Asia                     | 18.5            | 12.7            | 9.8             | 9.6             | 9.4             | 9.2             |
| Southern Asia                          | 21.5            | 17.2            | 15.7            | 15.1            | 14.8            | 14.7            |
| Western Asia                           | 9.4             | 8.6             | 11.2            | 11.6            | 12.2            | 12.4            |
| Western Asia and Northern Africa       | 8.0             | 7.1             | 9.2             | 9.5             | 9.8             | 9.9             |
| <b>LATIN AMERICA AND THE CARIBBEAN</b> | <b>9.1</b>      | <b>6.8</b>      | <b>6.2</b>      | <b>6.3</b>      | <b>6.5</b>      | <b>6.5</b>      |
| Caribbean                              | 23.3            | 19.8            | 18.3            | 18.0            | 18.0            | 18.4            |
| Latin America                          | 8.1             | 5.9             | 5.3             | 5.5             | 5.7             | 5.7             |
| Central America                        | 8.4             | 7.2             | 6.3             | 6.1             | 6.1             | 6.1             |
| South America                          | 7.9             | 5.3             | 4.9             | 5.3             | 5.5             | 5.5             |
| <b>OCEANIA</b>                         | <b>5.5</b>      | <b>5.2</b>      | <b>5.9</b>      | <b>6.0</b>      | <b>6.1</b>      | <b>6.2</b>      |
| <b>NORTHERN AMERICA AND EUROPE</b>     | <b>&lt; 2.5</b> | <b>&lt; 2.5</b> | <b>&lt; 2.5</b> | <b>&lt; 2.5</b> | <b>&lt; 2.5</b> | <b>&lt; 2.5</b> |

**Source:** FAO (2019) The State of Food Security and Nutrition in the World: Safe Guarding Against Economic Slowdowns and Downturns, United Nations, Rome.

Globally 10.8 percent (820 million) of population in the world are still hungry. Since 2015, hunger is on the rise in almost all African sub-regions, making Africa the region with the highest prevalence of under nourishment (about 20 percent). Similarly, Asia and Latin America also observed slow but upward moving trend, whereas downward the Caribbean prevalence is still high 18.4 (2018) and experience severe food insecurity. South Asia has highest hunger, food insecurity and malnutrition in Asia but is slowly decreasing. Food security and nutrition is one important component of the sustainable development goals (SDGs) and has a target to achieve nutrition as well as food for all by 2030. Before this, United Nations launched the Millennium Development Goals (MDGs) in 2000 with special attention for poverty and health comprising a set of eight goals given below:

- Eradicate extreme poverty
- Achieve universal primary education
- Promote gender equality, empower woman
- Reduce child mortality
- Improve maternal health
- Combat HIV/ AIDS, Malaria and other diseases
- Ensure environment sustainability
- Global partnership for development

Most of the goals directly or indirectly focused on poverty and health. Till 2015, above mentioned goals could not be accomplished as targeted, therefore, they were further envisaged under SDGs covering a set of seventeen goals comprising of 169 targets that seek to reduce poverty, improve environmental sustainability including enhance the health financing and improving the quality of life. In contrast to the previous MDGs which focus on poor countries, the SDGs have a broader global reach and implemented with extensive consultation process with representatives from over seventy countries. The SDGs have added goals covering human rights, the environment, and gender equality to accomplish unachieved targets of MDGs.

### 19.4.2 Sanitation

Sanitation and hygiene is critical for not only for health but overall survival and sustainable development. Effective waste disposal, hygiene, availability of toilet and latrines, effective drainage are essential components for sanitation. Centre for Disease Control and Prevention observed that it is surprise that many low and middle income countries were severely suffering with sanitation problems owing to poverty and huge population size which resulted in poor health conditions. It has been observed that sanitation services increased from 28 per cent (2000) to 45 per cent (2017), with the greatest increases occurring in Latin America and the Caribbean, sub-Saharan Africa and East and South-East Asia. However 701 million people still practiced open defecation in 2017. Apart from these, only 60 per cent of the people worldwide practice basic hand washing behavior with soap and water facilities at home, while only 38 per cent in least developed countries in 2017. Altogether, throughout the world it has been estimated that 2.4 billion people (32 percent) do not have access of basic sanitation. Studies also reveals that hand washing behavior with soap and water reduces diarrhoeal diseases and acute respiratory infections in developing countries, this risk is also associated with intestinal infections and shigellosis. The number of diarrhoea deaths that could be averted by hand washing is about a million (R. I. Ejemot-Nwadiaro et.al. 2015). In 2016, outdoor air pollution in both cities and rural areas caused an estimated 4.2 million deaths worldwide. WHO reported 8,70,000 people died due to unsafe water, sanitation and lack of hygiene. In India, few programmes initiated for sanitation like, Nirmal Bharat, Swach Bharat Abhiyan for effective cleanliness drive and 'open defecation free' scheme.

### 19.4.3 Education

Poverty is not only reflects low income of the individuals rather it also reflects a multi-dimensional problem including human development and education. Education is closely associated with individual's economic status and poor supply

of basic needs. It is critical to get other basic needs and promotion of sustainable development. An Individual can attain education and health facility if he/ she has paying capacity. Poor have less chances access to education and develop human capital owing to financial constraints. Contrary to this, education considered a tool for development, social mobility and reducing poverty, hence early thinkers viewed that a certain proportion of state budget must be invested for education (Plato, Adam Smith). Economist Alfred Marshall (1890) said “the most valuable of all capital is that invested in human beings”.

Education not only enables people for fetching better employment but also improve their behavior and life style, particularly health behaviour, awareness of health services, prevention of diseases and other risk factor. Today, most of the low and middle income countries have low literacy levels due to less budget allocation towards health services and development needs. Similarly, poor health also affects the attainment of education and employability and trapping the poor in vicious circle of poverty. Thus, education and health education plays significant role towards eradication of poverty.

#### **19.4.4 Drinking Water**

Potable drinking water is next important determinants for good health, survival and development. Earth has abundant water sources. Almost 2/3 of earth is covered with water but fresh water sources are limited i.e. only 2 percent. Within this limit pure potable water is lesser due contamination with toxic chemical and heavy metals. Under MDGs from 2000 and 2015, the availability safe drinking water services have increased from 61 to 71 per cent of the population, but no substantive improvement has been recorded thereafter. An evaluation of SDGs shows that out of 172 countries, 80 per cent have medium-low implementation of integrated water resources management. Progress of attaining SDGs in 22 countries observe, mostly in the Northern Africa, Western Asia region and Central and Southern Asia region with huge water stress level i.e. above 70 per cent, indicating the strong probability of future water scarcity. In 2017–2018, 157 countries reported average implementation of integrated water resources management of 48 per cent. Keeping the importance of safe drinking water, a significant step has been initiated in India so that every house is provided potable tap water by 2025 and a new Ministry of JAL Sakti has been created to fulfill this task. However, under SDGs it has been projected that at this pace 60 per cent of countries are unlikely to reach the target of full implementation by 2030.

#### **19.4.5 Culture**

Culture is the core concern of human behavior and practice of the people. E. B Tylor viewed culture as a ‘complex whole which includes knowledge, belief, art, law, morals, custom, and any other capabilities and habits acquired by man as a member of society’. Poverty also enables poor to develop a culture of survival, specific lifestyle, surrounding environment and choice of health and educational services. Poverty make people struggle towards their basic necessity to survive—that is food and shelter. Beyond that health preferences are secondary if available to them within their paying capacity. All conditions emerge as specific culture in poor areas known as slums, ghettos in urban areas and similar clusters of marginalized and poverty stricken areas in rural pockets. There is roughly 33 percent of urban population living in slums worldwide with higher proportions in low and middle income countries. The situation of rural poverty is more severe

owing to single migration, alienation, broken family. About 1.4 billion people are under this category (WHO 2010). Slums are the place where unhygienic conditions, overcrowded area, lack of appropriate utilities like, safe drinking water and sanitation, and other environmental risks often prevalent. It has been found to be a breeding ground for infectious diseases, diarrhoeal diseases, air borne diseases, violence, injury, and mental health problem.

The 'Culture of poverty' concept given by Oscar Lewis in his book, *Five Families: Mexican Case Studies in the Culture of Poverty* (1959) on the basis of studies conducted on poor families in Mexico and Puerto Rico. It refers to those conditions in which values of people play a significant role in perpetuating poor life style and impoverishment from one generation to next generation through poor subculture. The culture of poverty theory states that living in this condition of pervasive poverty will lead to the development of a culture or subculture adapted to those and characterises by pervasive feelings of helplessness, dependency, marginality, and powerlessness. This theory has played important role in making public policy for poverty 1960s onward as well as antipoverty legislation as a part of welfare reform. Following this theory, further empirical studies emerged across the globe such as Daniel Patrick Moynihan (1965), David B. Miller (1976), Dominique Lapierre (1985), John H. Goldthorpe (2000).

#### **19.4.6 Environment**

Environmental factors are considered as the root cause of death, disease and disability globally and more in developing countries (low income and middle income countries). The environment refers external physical, chemical and microbiological exposure and its process that impinge upon individual and groups. It ranges from water quality, its access, air pollution, disposal of waste, climate change such factors resulted an estimated over 25 percent of death and disease globally. Vector-borne diseases are frequent owing to poor management of air, water and solid waste which can be avoided. WHO and UNEP report (2004) finds that every minute, 5 children in developing countries die from malaria or diarrhea, every hour more than 100 children die with indoor smoke from solid fuels, every day almost 3000 people die from road traffic injuries, every month nearly 19,000 people die from unintentional poisonings (toxic chemicals and pesticides or harmful environments) in low and middle income countries. Increasing toxic element and heavy metal have been observed in human body through various studies (Monisha Jaishankar et. al. 2014, D N Jha 2019). Hence, the environmental risks and related illness kill millions of people worldwide that varies region wise, higher in poverty stricken region and lower in developed region.

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### **19.5 POVERTY AND HEALTH STATUS IN INDIA**

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South Asia is vibrant, dynamic and fast growing region in the world and a home to almost 25 percent of population. The region is densely populated, witnessing rapid urbanisation and a burden of maternal and child health problems including rising non-communicable diseases, smoking, mental illnesses, and injuries. Conflicts, natural disasters, and infectious disease outbreaks also periodically stall progress of health indicators. All these reasons makes the region highly vulnerable for health. The rapid growth of private health sector due to globalization and privatisation, the shrinking public health services due to lack of finances to

public health has led to health inequality and over-burdened diseases. In 1990, the region has high poverty and low health indicator but the intervention of Millennium Development Goals (MDGs) and other initiatives changed both poverty and health conditions, extreme poverty reduced from 45 percent to 15 percent between 1990 to 2013 and correspondingly health indicators like, maternal mortality reduced more than 60 percent between 1990 and 2015, infant mortality and burden of communicable disease also come down during this period. Therefore, poverty and poor health are shown to be closely associated as observed in south Asia.

**Table 19.4: Poverty Trends in India, 1973-74 to 2011-12**

| Year      | % of population | Total population in below poverty line poverty (millions) | Rupees Per capita/month |        | Population below 2700 Kcal per day of household calorie intake per consumer unit |       |
|-----------|-----------------|-----------------------------------------------------------|-------------------------|--------|----------------------------------------------------------------------------------|-------|
|           |                 |                                                           | Urban                   | Rural  | Urban                                                                            | Rural |
| 1973-74   | 54.9            | 321.3                                                     | 49.63                   | 56.76  | Data not enumerated during this period                                           |       |
| 1977-78   | 51.3            | 328.9                                                     | 56.84                   | 70.33  |                                                                                  |       |
| 1983      | 44.5            | 322.9                                                     | 89.50                   | 115.65 |                                                                                  |       |
| 1987-88   | 38.9            | 307.1                                                     | 115.20                  | 162.16 |                                                                                  |       |
| 1993-94   | 36              | 320.3                                                     | 205.84                  | 281.35 | 64.9                                                                             | 57.5  |
| 1999-2000 | 26.1            | 260.2                                                     | 327.56                  | 454.11 | 64.5                                                                             | 60.7  |
| 2004-2005 | 27.5            | 301.7                                                     | 356.30                  | 538.60 | 70.1                                                                             | 66.2  |
| 2011-12   | 21.9            | 273.1                                                     | 1000.00                 | 816.00 | NA                                                                               | NA    |

**Source:** Adapted from India Cronic Poverty Report (2011), Planning commission (1997), Public Information Bureau (2001, 2007).

India's poverty trend reflects massive reduction in poor population from 54 percent in 1973-74 to 21.9 percent in 2011-12. Thereafter, enhanced GDP and per capita income has enable the states to invest in development programmes and in eradication of poverty. However, still our economy lags what it had before British period. Agriculture and allied industries based on agricultural produce were major source of economy in this sub-continent. These two sectors were not only the largest source of income to the state but also were the source of livelihood to the large majority of people in India. Irrigated area was small as it is mainly dependent on monsoon. There cattle population was more than Europe but yield was less. Broadly, the collection of revenue from two sources i.e. the land and trade. Not only this, a number of handicraft industries produced high quality cotton textiles, jute, silks jewellery, decorative sword and weapons which were lost during British period and could not be revived. Therefore, Despite all the progress India could not emerge as global leader unless there is a parallel change in agriculture sector, health facility, education opportunity, reducing inequality, social divide, regional disparity and other development domains. So far as the health is concern, India has deep rooted history of healthcare knowledge since 6th century BC and traced through Veda and well known physician Charaka, Dhanvantari and Sushruta (surgeon). It is also true that this knowledge of health care services was based on

ayurvedic system and not widely known. However, unlike modern allopathic medicine Indian traditional ayurvedic medicine were widely available as they were extracted from plants and herbs. Similarly, the region had sound economic status owing to heavily dependent on agriculture till Moghul empire. Therefore, poverty and inequality was also less. After British period, Indian economy changed and the emergence of poverty, inequality and which influenced the health care system too. After independence, India had low economic growth, large population size, poor health services and lagged in other development indices. Keeping these situations in mind, initial planning process gave thrust to ending poverty, disease and inequality of opportunity as major priorities which are reflected in the Directive Principles of State Policy. During the initial planning process the country had rapid industrialisation, urbanisation and population growth which resulted in increasing health problems. Despite having separate allocation for health budget in India, it was insufficient to cater the need of huge population. Besides this, the health being a state subject led to every state having its own plan which has again given lower priority to health owing to economic constraints. According to the 1951 Census, India's population was 361 million and only 18.33 percent of the total population was literate while female literacy was only 8.86 percent, the overall life expectancy was 32 years, the infant mortality rate (IMR) was 145.6/1000 live births, Maternal Mortality Ratio (MMR) in the 1940s was 2000/100,000 live births (which had come down to 1000 in the 1950s), and there were only 725 primary health care centers. In 1950-51, India had 1.7 registered medical practitioners and 3.2 hospitals (all types) for per 10,000 population, This has improved after 50 years, in 1999-2000, with the changes in registered medical practitioners, hospitals.

**Table- 19.5: Trends of Health Status in India**

| Indicator        | 1951 | 1981 | 2000 | 2016  |
|------------------|------|------|------|-------|
| Life Expectancy  | 36.7 | 54.0 | 64.6 | 68.56 |
| IMR              | 146  | 110  | 70   | 37    |
| Crude Birth Rate | 40.8 | 33.9 | 26.2 | 20.4  |
| Crude Death Rate | 25   | 12.5 | 8.7  | 6.4   |

**Source:** Adapted from Sample Registration System, National Health Profile

The Planning Commission prepare a plan for the most effective and balanced utilization of the country's resources. Indian has made consistent efforts to enhance health services, health infrastructure and develop and train manpower through various public policies and also constituted several committees like, Bhore Committee, Mudaliar Committee, Chadha Committee, Jain Committee, Kartar Singh Committee, Srivastava Committee, Bajaj Committee, national state health policies and national health policies towards development of health sector in India. The following are brief descriptions of these initiatives.

**Sir Joseph Bhore Committee (1943):** This is the first health committee constituted before independence to suggest health services and health organisation in India. It found that public health services neither were extremely inadequate both in terms quality and quantity as well as the manpower neither sufficient nor trained. It has given short term and long term recommendations. For short term recommended the establishment of PHCs and integration of preventive and

curative health services. Long term suggestion focused on creation of three tier system of health services- primary, secondary and tertiary health centers; education and training of medical and paramedical work force, priority to health programmes in budgetary allocation. It is left on the government to adopt any of models of implementation- free for all, by payment or through insurance.

**Mudaliar Committee (1959):** It evolved through earlier committee to establish Health Planning and Survey Committee to assess the progress and further recommendations for the future plan. It had recommended in the control of epidemic diseases such as plague, cholera, malaria, and eradication of smallpox. The committee observed poor status of PHCs and suggested it must cater the health services of 40,000 population. Strengthening of sub divisional and district hospitals was also advised. It was emphasised that a PHC should not be made to cater to more than 40,000 population and recommended strengthening of secondary and tertiary health centers. It has also suggested that extensions of Employees of State's Insurance Scheme (ESIS) and Central Government Health Scheme.

**Chadha Committee (1963):** The committee was formed under the chairman of Dr. M.S. Chadha who was the Director General of Health Services. It has advised about the National Malaria Eradication Programme, rural health services, developing multipurpose health workers, importance of health data collection and family planning.

**Jain Committee (1966):** A study group was constituted to measure the health services in India under the chairmanship of A P Jain for strengthening health services. Improving capacity at PHC with 1 bed per 1000 population, taluka level health services with a capacity of 50 bed and strengthening infrastructure at district level hospital. It has twin focus on enhancing maternity health and health insurance coverage for entire population.

**Kartar Singh Committee (1973):** It was constituted to study of integrated health services, training and mobile services. It has focused on integration of health services, family planning and nutrition component in training of paramedical and supporting staff. The committee has recommended at least one FNM/ ANM for 10,000 populations, PHC (supported by sub-centers within its area) can cater up to 50,000 people.

**Srivastava Committee (1974):** It was formed to see the medical education and manpower status in India by J B Srivastava. The committee observed that the linkages need to be strengthen and referral services to link PHC and higher level hospitals, inclusion of health education with health services and family planning, creation of administrative and financial machinery to recognise health education with medical services.

**Bajaj Committee (1986):** The committee was constituted to assess the health manpower planning and development with special thrust to supporting vocational education. It has strongly suggested effective education and training to widen health skills and focused towards carrier oriented vocational health education. It recommended the establishment of health related vocational courses- ANM, health worker, radiographer, lab technician, ophthalmic assistant, dental hygienists, pharmacist, and housekeeper.

All these health committee's reflected upon the health status and planned changes in India. Following their recommendation various programmes and schemes were implemented to eradicate various diseases like- Polio, Tetanus, Diphtheria, Anaemia, Filarial, Malaria, Kala Azar, leprocy, AIDS, Tuberculosis, Cancer, Diabetes, Cardiovascular Diseases, Stroke, mental health, blindness, deafness and many others health disorders. In this regard various healthcare programmes also launched in India like, National Leprosy Eradication Programme (started 1955 revised 1983), National Goitre Control Programme (1962), National Programme for Control of Blindness and Visual Impairment (1976), National Mental Health Program (1982), National Iodine Deficiency Disorders Control Programme (1992), National AIDS Control Programme (1992), National Maternity Benefit Scheme (1995), Revised National TB Control Programme (1997), The Pradhan Mantri Swasthya Suraksha Yojana (2003), National Vector Borne Disease Control Programme (2003), Integrated Disease Surveillance Project (2004), Janani Suraksha Yojana (2005), National Programme for Prevention and Control of Deafness (2007), The National Tobacco Control Programme (2007), Rashtriya Swasthya Bima Yojana (2008), Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (2010), Janani Shishu Suraksha Karyakaram (2011), National Programme for Prevention & Management of Burn Injuries (2014), Rashtriya Kishor Swasthya Karyakram (2014), Pradhan Mantri Surakshit Matritva Abhiyan (2016), Senior Citizen Health Insurance Scheme (2016), Ayushman Bharat –National Health Protection Mission (2018),

India had also three successive national health policies (1983, 2002 and 2017), National Policy on Older Persons, Maintenance & Welfare of Parents & Senior Citizens Act (2007), The National Mental Health Policy (2014) and flagship health programmes to cover healthcare of nationwide population such as, National Rural Health Mission (2005), National Urban Health Mission (2013) and National Health Mission (2014). Apart from these, private and public health insurance schemes have been also implemented for marginalised and poor groups. Recently launched Ayushman Bharat is the biggest health insurance schemes covering almost 500 million deprived people. Despite all efforts, government health expenditure is quite low 1.2 percent of GDP. The neighbouring countries, Thailand (2.6 percent), Sri Lanka (1.9 percent), China (1.9 percent) and Nepal (1.3 percent) are having better health expenditure than India (Zodpey SP & Negandhi PH 2018). However, national health policy (2017) targeted for enhancement for future health planning.

After going through this unit you must have an idea about the relationship between poverty and health particularly the significant factors of health challenges and status of health in India, now evaluate your progress through Check Your Progress-2.

### Check Your Progress 2

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) Describe important factors of healthcare.

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- 2) What are important recommendation of Bhore Committee (1943).

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## 19.6 LET US SUM UP

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Poverty is a crucial threat for human development. It is both the cause and consequence of poor health and development. The gradual change in poverty also enhanced the status of demographic health, hunger and nutritional problems, health services, health infrastructure and health education. However, the increasing socio-economic inequality also developed global health inequality. The gaps between developed countries and low developed countries also impact the world with environmental threat, health inequality and changed health condition form communicable to non-communicable diseases.

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## 19.7 REFERENCES AND SUGGESTED READING

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## 19.8 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

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### Check Your Progress-1

- 1) What is poverty?

**Ans.** Poverty refers a person's economic status showing insufficient money or material condition for their survival. It differs with place and time owing to variation in market condition and other factors. It is not only lacks of consumption and income criteria but also non-economic factors like, social and political conditions which includes education, access to basic utilities, health care, security and freedom.

- 2) How poverty is related health and development.

**Ans.** Poverty is strongly associated with public health parameters and continuing vicious circle of poverty. Global demographic indicators in last century (particularly 1950 onward) till now reveals major improvement in mortality rate, fertility rate, infant mortality rate and life expectancy which also indicates the progressive changes health and development. These changes are not uniform across the world rather more developed region shown early achiever than less developed regions.

### Check Your Progress 2

- 1) Describe important factors of healthcare.

**Ans.** Poverty deprives poor from adequate nutrition, access of education, sanitation, housing, potable water and other essential requirement to survive and maintain a sound health. Besides these, drug and tobaccos abuse are wide used among poor, which also harm health conditions among poor.

- 2) What are important recommendation of Bhore Committee (1943).

**Ans.** Bhore health committee constituted before independence and played significant role for health services and health organisation in India. It found public health services was inadequate in terms quality and quantity and suggested short term and long term plan- the creation of three tier system of health services- primary, secondary and tertiary health centers; education and training of medical and paramedical work force, budgetary allocation.

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## UNIT 20 HEALTH CARE OF THE MARGINALISED

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### Structure

- 20.1 Introduction
- 20.2 Marginalisation- An overview
- 20.3 Marginalisation and Marginalised Groups
- 20.4 Marginalisation and Health Inequalities
- 20.5 Factors Influencing Health Status of the Marginalised
- 20.6 Measures to Improve Health Status of Marginal Groups
- 20.7 Let Us Sum Up
- 20.8 References and Suggested Readings
- 20.9 Check Your Progress: Possible Answers

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### 20.1 INTRODUCTION

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Marginalisation is a process in which certain groups are excluded in development and social change process owing to social, political and economic factors. It can often be observed in terms of race, ethnicity or other socio-cultural factors. Ethnicity includes minority groups, deprived castes, tribes, religious groups, language, region, and gender dimensions. Owing to exclusion of these groups they are unable to access development benefits like education, healthcare services, employment and other socio-economic opportunities. In this unit, we will study how they are deprived of healthcare services and continue to be trapped under marginalisation, burden of disease and extreme poverty. It deals with basic connotations of marginalisation: an overview; development, marginalisation and health inequalities; factors influencing health status of the marginalised and; sustainable development goals with affirmative action.

After studying this unit you should be able to:

- a) explain the concept of marginalisation and its major forms,
- b) discuss how marginalisation influences health inequalities and enhances burden of disease in India,
- c) describe factors influencing health status of the marginalised,
- d) explain the role of sustainable development goals (SDGs) and affirmative action taken to reduce marginalisation.

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### 20.2 MARGINALISATION- AN OVERVIEW

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Marginalisation is the process whereby groups or individuals are pushed to the edge and accorded lesser importance. This is predominantly a social phenomenon which excludes the groups or individuals and ignores their needs and desires. They are treated as insignificant and peripheral. Marginalisation can occur at individual and group level. There are reasons why some individuals or groups are marginalised and there is a need to identify the factors leading to their marginalisation and develop the means to end it. This is needed because

marginalisation lead to exclusion and discrimination. Individuals and groups are marginalised on the basis of social and physical identity. Caste, tribe, colour, race, ethnicity, class, region, religion and gender form some of the important faces of marginalisation.

It is a process by which a group or individual is denied access to important positions and symbols of economic, religious, or political power within any society. Marginalisation is dependent on the historical and socio-economical context of a society. Thus, marginalisation is a multidimensional, multi-causal, historical phenomenon. There are no general laws to understand and comprehend the complex nature of marginalisation. To marginalise a group of people means to make them feel isolated and unimportant and distance them from power and resources that enable self-determination in economic, political, and social settings. Those in the margin have poor access to economical and other recourses like education and social services and self-determination is low.

Marginalisation causes social exclusion through systemic barriers to effective participation and equality of opportunity. Social exclusion is both process and outcome, and can hold governments and institutions accountable for their policies. The nature of marginalisation varies in different settings. For example, the marginalisation of women in Arab countries is not the same as in India. The two important edifices of marginalisation are discussed below.

### Social Exclusion

Social Exclusion is the experience of systemic barriers to effective participation and equality of opportunity. It refers to the position, in which someone cannot access and benefit from the opportunities available to other members of a society. Social inclusion is the political response to exclusion. It has a value as process and as a goal, and should be approached pro-actively, not as a passive defending of rights, but as active interventions, rooted in community (self) organization and leading to real policy changes by transforming given structures. Social inclusion therefore, is both process and outcome, and can hold governments and institutions accountable for their policies.

### Discrimination

Social exclusion leads to the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, ethnicity, region, language and gender. This is discrimination. It is the practice of treating one person or group

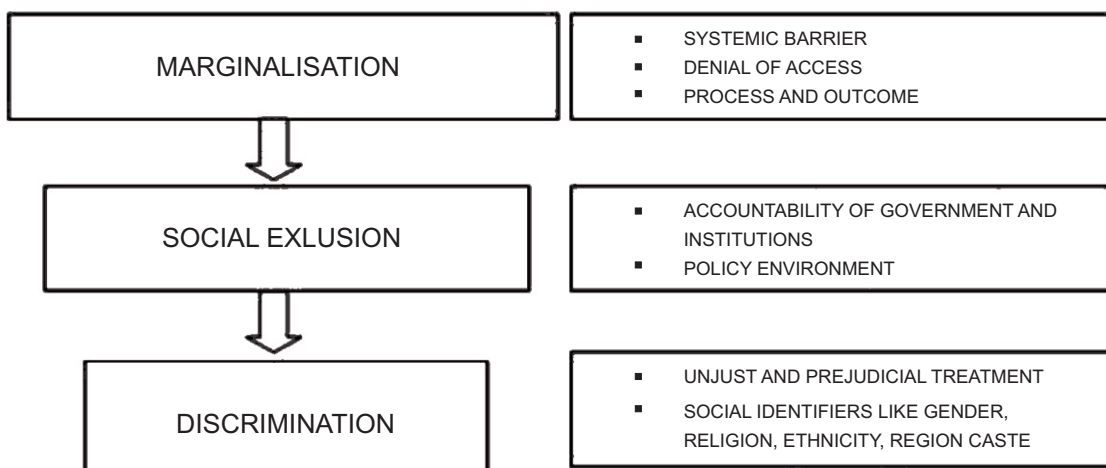


Fig. 20.1: Marginalisation to Discrimination

of people less fairly or less well than other people or groups. Discrimination is the act of treating someone differently or unjustly based upon some characteristics. It is treating a person or particular group of people differently, especially in a worse way from the way in which other people are treated. Thus, marginalisation, social exclusion and discrimination are interlinked (Figure: 4.1).

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## 20.3 MARGINALISATION AND MARGINALISED GROUPS

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Marginalisation is the process of pushing a particular group or groups of people to the edge of society by not allowing them an active voice, identity, or place in it. Some individuals identify with multiple marginalized groups, and experience marginalisation as a result of their intersecting identities. The marginalised groups of people are observed all over the world. The marginalised groups experience exploitation, distress, agonies, pain and suffering. The social, political, economic, geographical factors contribute to their marginalisation and are deeply rooted in their consciousness. Most of the marginalised groups are identified on the basis of their minority status, religion, ethnicity, language, gender and social identity, which make them vulnerable. They can be migrants and ethnic minorities, homeless people, drug addicts, sex workers, youth with risk behaviour, the elderly, people with disabilities. They face higher risks of social exclusion and marginalisation. Thus, gender, culture, language, race, sexual orientation, lifestyle and the socio-economic position are factors, which influence the position of an individual or a group in the society. Their problems can be related to homelessness, unemployment, poor access to social and health services, low health status and poor living conditions.

The marginalised groups are distanced from power and resources that enable self-determination in economic, political, and social settings. Those in the margin have poor access to economic and other recourses like education and public services, their participation and self-determination is low. Identification of the marginalised groups is dependent on the historical and socio-economical context of any society. Globally it has been observed that ethnic minority, women, refugee and migrants, people with disability, elderly population and others who are unable to access development are often considered marginalised in society. According to UNDP (2017), almost one- third population are in live under this category, while 300 million are in developed regions / countries. Whereas UNDR report (2019) reveals that 244 million people live outside their home country, many of them are economic refugees to enhance their livelihoods, however, around 65 million forcibly displaced without jobs with poor healthcare. However, with time and space these compositions of marginality and exclusion can vary.

Similarly, India has marginal social groups who are disadvantage in long social history like scheduled castes, scheduled tribes, other backward classes, women, religious minority groups, elderly people, people with disability, homeless migrant people, and other deprived groups. The details of a few major marginalised groups in India are mentioned below.

### **Scheduled Castes (SCs)**

Caste based marginalisation is an outcome of structural exclusion. It is based on socio-cultural inequality. Those at the lowest end of the social ladder are rendered

untouchables. They are at bottom of caste hierarchy and are denied civic and religious rights, and have poor access to economic opportunities, health and education facilities. Besides being untouchables, historically, they were socially and physically isolated and excluded. Therefore, they have remained without (at best with minimum) assets and access to resources to acquire education, health and other facilities and amenities.

### Scheduled Tribes (STs)

Scheduled Tribes are also a legal category like scheduled castes (SCs) in which more than 700 indigenous communities are included in the schedule or list called STs. Neither this list is permanent nor encompasses all tribal communities. These communities have a distinct culture- dialects, food habits, religion/ taboo, dress and means of production and spread in 645 districts of India comprising around 8 percent of total population. A. R. Desai, sociologist, considered tribes as 'Backward Hindus' owing to similarities between Hindu socio-cultural system and tribal culture. Thus tribal populations who have lived in geographical isolation and cultural distinction from masses even differ from other tribal groups, but their isolation is not structural.

### Other Backward Classes (OBCs)

The Other Backward Class is a social category including those persons/ groups who are educationally and economically deprived but do not suffer from untouchability. These social groups are also isolated in terms of social and physical opportunities also called social educational backward class (SEBC). It encompasses large number of caste-based communities which vary with provincial State and Union list.

### Differently Abled

Differently abled people are a critical concern of any society for its continuous progress and development. Studies finds persons with disabilities experience worse educational and economic conditions and are more likely to be poor than persons without disabilities (Pradeep Kumar et. al. 2018). Roughly there are more than 10 percent disabled or differently abled population across the world. Disability induced marginalisation happens due to stigma associated with it. There can be mental, physical and disease induced disability leading to marginalisation.

| Proportion of Differently Abled Population in India                                |                   |
|------------------------------------------------------------------------------------|-------------------|
| Nature of Differently Abled                                                        | Proportion (in %) |
| Locomotive                                                                         | 20                |
| Hearing                                                                            | 19                |
| Seeing                                                                             | 19                |
| Multiple                                                                           | 8                 |
| Speech                                                                             | 7                 |
| Mentally Retarded                                                                  | 6                 |
| Mental illness                                                                     | 3                 |
| Any other                                                                          | 18                |
| <b>Source:</b> National Health Profile 2018, MOHFW, New Delhi (as per 2011 Census) |                   |

### Gender

The patriarchal ideology, orthodox religious beliefs and superstitions validate the son preference and consign the girl child to subordinate marginal position.

These convictions hamper the acceptance of a female child. The 'Vedas' attribute a social position to only sons and not to daughters. Both men and women are constituents of humanity but women get marginalised by society, family and by men. However, Indian constitution gives equal rights to women, but they are treated as subordinate in family and society; and their health is relegated to the last priority.

Gender disparity is present across societies as an outcome of patriarchy and subjugation of women, marginalising them on the basis of physical identity and thus from access to resources and services. Women from Scheduled Castes (SCs) and Scheduled Tribes (STs) have an additional identity by virtue of the caste and tribe they respectively belong to. The SC women are marginalised and excluded because of religious practices like 'devadasi'. Isolation, ethno-linguistic differences marginalise ST women. Affiliation to some minority religions, physical attributes and disabilities also marginalise women. The SC women suffer from caste based marginalisation.

After reading in this section the meaning of marginalisation, its prevalence in society and its effect on health, now answer the following questions given in Check Your Progress – 1.

### Check Your Progress 1

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) What is the marginalisation?

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2) How is marginalisation associated with social exclusion and discrimination?

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## 20.4 MARGINALISATION AND HEALTH INEQUALITIES

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Health inequalities are strongly related to socio-economic determinants. Marginalisation influences the well-being of individuals and groups. There is an association between social and material disadvantages; and poor mental and physical health. Factors such as employment, housing and education are identified

as social determinants of health. When employment levels, access to housing and educational attainment is good, health inequalities are low. Poverty is deprivation in multiple dimensions. Often defined by income, socio-economic status, and living conditions, it is regarded as the largest single determinant of ill health. People with a lower level of education, occupation and income tend to die at younger ages, and experience higher prevalence of health problems (Mackenbach, 2005).

There are systematic differences in health status between different socio-economic groups. These inequities are socially produced and unfair. In practice, all differences in health between socio-economic groups are unfair and avoidable, and therefore regarded as inequities. This is based on universal human rights principles (Whitehead and Dahlgren, 2006). Despite progress on social welfare, inequalities in health exist.

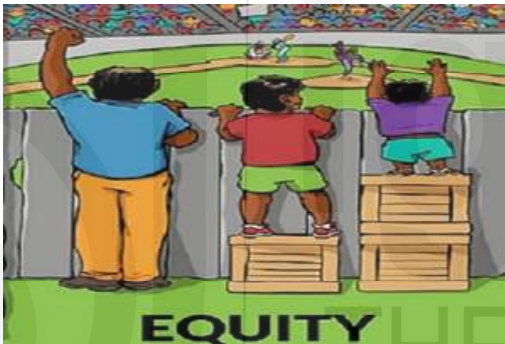
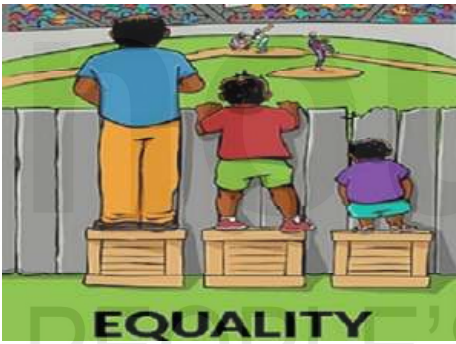
Ensuring health and well-being has been the concern of governments all around the world. The Constitution of India decrees health as the responsibility of state. It makes every state of the nation responsible for raising the level of nutrition and the standard of living of its people and improvement of public health is among its primary duties. The Constitution assigns the states predominant responsibility for the provision of health enhancing services along with the central government. However, the efforts to materialise this have encountered many barriers. Access to any public service, including health, is the outcome of awareness, information, knowledge and conducive environment to use these services. A conducive environment is likely to be created when the infrastructure is available; health personnel are empathetic and sensitive towards the needs of the users; and the users have the ability both economic and social, to use the services. Ideally a conducive environment should result in enabling all. But contrary to the very purpose, the environment is conducive to some but not all. Health seeking behaviour is determined by economic propensity and health infrastructure as much by social identity of users and providers of health care services. Attitude of the users and providers, when devoid of empathy and sensitivity, is likely to affect access (Acharya, 2003, 2010), making way for inequitous access to health.

### **20.4.1 Equality and Equity in Health**

Inequalities are socially unjust and inequitable. In health, inequality is examined as differences in the prevalence and incidence of illness among people across social groups. It is often defined as the absence of systemic and potentially remediable differences in one or more aspects of health across populations disaggregated by social, economic, demographic and geographical characteristics. Health inequality, therefore, is treating 'equals' equally; and equal access to those in equal need of healthcare. Provision of health, in this framework, is based on 'need' rather than 'propensity to pay'. Another framework requires treating unequal differently. Richer should pay a higher proportion of their income for accessing health care services compared to poor (Banerji, 1982). A third dimension incorporates the benefits or public subsidies for health care services. The health status differs on the basis of income, education, occupation, place of residence, gender, ethnicity and religion. There is evident association of low health status with poor, female gender, rural place of residence, tribal ethnicity, scheduled castes and specific minorities groups. Despite improvements in health indicators since independence, gap across social groups remains wide. Therefore, the need

is to revisit policy implementation regime and environment to ensure health equity (Table 20.1).

**Table 20.1: Equity and Equality**

| Equity                                                                                                                                  | Equality                                                                                                                      |
|-----------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------|
| Equity aims to understand the needs of each individual and distribute the resources fairly.                                             | Equality involves ensuring that every individual gets the same amount of resources regardless of the differences between them |
| Equity takes into consideration the natural differences between individuals such as height, weight, gender, physical disabilities, etc. | Equality treats all individuals in the same manner                                                                            |
| Considers individual needs of people                                                                                                    | Considers paying capacity                                                                                                     |
| Equity involves treating each individual according to his/her needs                                                                     | Equality treats every individual in the same manner, irrespective of their differences.                                       |
|                                                       |                                            |

The following are infant and mother health indicators of marginal groups with ethnicity indicate their health and equity status.

**Table: 20.2: Early Childhood and Maternal Health Indicators by Ethnic Background**

| No. | Ethnicity              | Infant Health Indicator<br>(in per 1000) |                  |                      | Maternal Health Indicator<br>(in percent) |                        |
|-----|------------------------|------------------------------------------|------------------|----------------------|-------------------------------------------|------------------------|
|     |                        | Neonatal mortality                       | Infant Mortality | Under-five mortality | Anaemia in Women                          | Institutional delivery |
|     | Scheduled Castes       | 36.8                                     | 49.6             | 61.3                 | 55.9                                      | 78.3                   |
|     | Scheduled Tribes       | 33.4                                     | 47.7             | 61.3                 | 59.9                                      | 68.0                   |
|     | Other Backward Classes | 33.4                                     | 46.1             | 56.0                 | 52.2                                      | 79.8                   |
|     | Others                 | 27.7                                     | 38.2             | 45.4                 | 49.8                                      | 62.9                   |
|     | Hindu                  | 33.9                                     | 46.2             | 56.2                 | 55.7                                      | 80.8                   |
|     | Muslim                 | 31.8                                     | 45.2             | 56.9                 | 50.6                                      | 69.2                   |
|     | Christian              | 19.0                                     | 31.0             | 40.6                 | 47.5                                      | 78.5                   |
|     | Sikh                   | 23.6                                     | 34.5             | 40.9                 | 52.0                                      | 92.5                   |
|     | Buddhist/ Neo-Buddhist | 22.1                                     | 31.3             | 38.2                 | 51.6                                      | 92.2                   |
|     | Others                 | 30.1                                     | 43.8             | 62.5                 | 39.2                                      | 51.0                   |

**Source:** Adapted from National Family Health Survey 2015-16

## 20.5 FACTORS INFLUENCING HEALTH STATUS OF THE MARGINALISED

Globalisation, migration, economic development have influenced people. Gender, culture, language, race, sexual orientation, lifestyle and the socio-economic position or class are factors, which influence the position of an individual or a group in the society. Vulnerable groups like migrants and ethnic minorities, homeless people, drug addicts, sex workers, youth with risk behaviour, elderly, and people with disabilities face social exclusion and marginalisation. Their problems can be related to homelessness, unemployment, poor access to social and health services, low health status and poor living conditions. There is need to increase the labour market participation of immigrants and ethnic minorities to the same level as the majority population, and to promote their participation in social, cultural and political life. Thus, factors which influence health are as following:-

- a) **Historical and Socio-cultural Context of a Society:** Marginalisation is deeply embedded in historicity and socio-cultural system of any society. Globally racism/ ethnicity and regional gaps (rural- urban) exist almost everywhere. Similarly, the caste hierarchy and differential behaviour has evolved in south Asian region.
- b) **Access to Political or Economic Power:** Marginalised groups facing denial of power in terms of political and economic and higher chances to fall into poverty. It has been observed the Scheduled Tribes and Scheduled Castes children's mortality is higher than other groups (Economic Times, 08 December 2014).
- c) **Poor Access to Economic and Other Resources, Like Education and Social Services:** Economic status is the backbone for upliftment and access to basic services in society, poor are often neglected for proper nutrition, adequate food, education, housing, potable drinking water and other basic needs. Deprivation of these basic needs also leads to poor health condition. (see details in Poverty and Health, Block-5, Unit-3)
- d) **Participation and Self-Determination:** 'Self' is a social concept which develops during socialisation, a child develops 'self' according to society. Self-determination refers to a situation where individuals take conscious and rational decisions without any compulsion and social pressure. Active participation is not possible without the development of self.

## 20.6 MEASURES TO IMPROVE HEALTH STATUS OF MARGINAL GROUPS

Health inequalities cannot be tackled by the health system alone but only with inter-sectoral co-operation and multidisciplinary approaches. Successful strategies involve wider determinants – the underlying causes; and measures to reduce the consequences of unhealthy circumstances. These involve efforts to address the macro socio-economic environment (e.g. efforts to ensure that national policies promote human development and reduce social inequalities). They also entail improving access to education, healthy working conditions, reducing unemployment, social and community inclusion policies. Other measures ensure

that lifestyle related programmes (tobacco control, alcohol misuse, nutrition, physical activity and mental health) as well as health care services address the more vulnerable or disadvantaged groups of society.

Some of the recommendations to improve the situation are:

- a) Improve visibility and gather data
- b) Ensure equal uptake of prevention and health promotion measures
- c) Involve key actors and encourage partnerships across policy areas
- d) Develop capacities for implementation
- e) Support the context specific policies
- f) Strengthen the evidence base and get it into practice.

Social inclusion is a process that enables groups to access and benefit from the opportunities available to members of a society. Social inclusion should be approached pro-actively, not as a passive defending of rights, but as active interventions, rooted in community (self) organisation and leading to real policy changes by transforming given structures. The objectives of social inclusion are as following:-

- a) Removal of systemic barriers to effective participation and focus on equality of opportunity.
- b) Develop a comprehensive vision that cuts across all the areas of injustice; address removal of barriers with a comprehensive vision that includes all.
- c) This is measure of good government which advances the well-being of the most vulnerable and most marginalised in society.
- d) It promotes advocacy and transformation through political struggle and political will to remove barriers to full and equitable participation in society by all.

### **The Indian context**

The Millennium Development Goals in 2000 set up a challenging task of reducing morbidity and improving health condition through a number of targets. The Sustainable Development Goals (SDGs) have aligned the third goals with health. The NHP 2017 builds on the progress made since the last NHP 2002. It aims to achieve the highest possible level of health and well being for all at all ages, through a preventive and promotive health care orientation in all developmental policies, and universal access to good quality health care services without anyone having to face financial hardship as a consequence. This would be achieved through increasing access, improving quality and lowering the cost of healthcare delivery across social groups. The policy recognises the pivotal importance of Sustainable Development Goals (SDGs). There is emphasis on equity. Reducing inequity would mean affirmative action will reach the unreached. It would mean minimising disparity on account of gender, poverty, caste, disability, other forms of social exclusion and geographical barriers. It would imply greater investments and financial protection for the unreached who suffer the largest burden of disease. The other important aspect is prevention of exclusion on social, economic grounds or grounds of current health status. Systems and services need to be designed to cater to the entire population- including excluded and marginalised groups.

## 20.6.1 Health Care Programmes for the Marginalised

Indian state also implemented several health programmes to cater the health needs of marginalised and poor people in order to achieve overall development. These programmes are given below:

- 1) **Ayushman Bharat National Health Protection Mission (2018):** This is the largest scheme of health protection, comprising over 100 million poor and vulnerable families (approximately 500 million beneficiaries) to provide coverage upto 5 lakh rupees per family per year for secondary and tertiary healthcare.
- 2) **Pradhan Mantri Surakshit Matritva Abhiyan (2016):** The objective of this programme is to provide the quality antenatal care including diagnostics and counselling services as part of the Reproductive Maternal Neonatal Child and Adolescent Health (RMNCH+A) Strategy.
- 3) **National Health Mission (2014):** The NHM encompasses its two sub-missions, the National Rural Health Mission (NRHM) and the National Urban Health Mission (NUHM) focussed on both Communicable and Non-Communicable Diseases for universal access, equitable, affordable and quality health services.
- 4) **National Programme for Prevention & Management of Burn Injuries (2014):** The objective is to ensure prevention of burn injuries, by providing timely and adequate treatment to reduce mortality, morbidity, ensuing disabilities and to provide effective rehabilitative services.
- 5) **The National Mental Health Policy (2014):** The vision is to prevent mental illness, enable recovery from mental illness, promote de-stigmatisation and desegregation, and ensure socio-economic inclusion of persons affected by mental illness by providing accessible, affordable and quality health and social care to all persons through their life span, within a rights-based framework.
- 6) **Rashtriya Kishor Swasthya Karyakram (2014):** The objective of this programme is to improve nutrition, improve sexual and reproductive health, enhance mental health, prevent injuries and violence and prevent substance misuse.
- 7) **Janani Shishu Suraksha Karyakaram (2011):** The initiative entitles all pregnant women delivering in public health institutions to absolutely free and no-expense delivery and all expenses relating to delivery in a public institution are borne by the government. Roughly more than 12 million pregnant women get benefitted.
- 8) **Programme for Prevention and Control of Cancer, Diabetes, Cardiovascular Diseases and Stroke (2010):** It was launched in 100 districts across 21 states with the aim to prevent and control these diseases thorough awareness, change in behaviour and life style, early diagnosis of persons with high levels of risk factors.
- 9) **National Vector Borne Disease Control Programme (2003):** It is an umbrella programme for prevention and control of vector borne diseases-

Malaria, Dengue, Chikungunya, Japanese Encephalitis, Kala-Azar and Filaria (Lymphatic Filariasis). It is an integral part of the National Health Mission (NHM) of India.

- 10) **National AIDS Control Programme (1992):** In 1992, this programme launched with an objective of slowing down the spread of HIV infections so as to reduce morbidity, mortality and impact of AIDS in the country, and National AIDS Control Organisation (NACO) was constituted to implement the same.
- 11) **Revised National TB Control Programme (1997):** The revised Tuberculosis Programme initiated with firm steps to early quality diagnosis and quality TB care for all.
- 12) **National Mental Health Program (1982):** To address the huge burden of mental disorders and shortage of qualified professionals in the field of mental health.
- 13) **National Programme for Control of Blindness and Visual Impairment (1976):** The goal is to reduce prevalence of blindness to 0.3 percent by 2020.

Apart from these, polio eradication programme successfully achieved the target and other health programmes are running or sub-sumes under new programmes like, National Programme for the Health Care of Elderly (2010), National Programme for Prevention and Control of Fluorosis (2008), Rashtriya Swasthya Bima Yojana (2008), National Programme for Prevention and Control of Deafness (2007), The National Tobacco Control Programme (2007), The Pradhan Mantri Swasthya Suraksha Yojana (2003), Janani Suraksha Yojana (2005), Integrated Disease Surveillance Project (2004), National Iodine Deficiency Disorders Control Programme (1992), National Leprosy Eradication Programme (1983).

### 20.6.2 Health Expenditure Support for Selected Marginalised Groups

The National Sample Survey Office (NSSO) Social Consumption: Health Survey conducted during first half of 2014, and the findings of the survey released in mid 2015 reveals that 86 percent of the rural population and 82 per cent of the urban population in India were not covered under any scheme for health expenditure support. The proportion of ailing persons in total population was reported to be 8.9 per cent in rural areas and 11.8 per cent in urban areas. The proportion among children aged below four years is 10.3 per cent whereas it is lowest among 10-30 year age group, but increases with age after that. The health survey also found that health expenditure schemes covered only 19 per cent of households in the top monthly per capita expenditure (MPCE) quintile. In the lower MPCE quintile (i.e. 20 per cent and below), only 11 per cent were covered. About two-third of households in the bottom quintile of MPCE met medical expenses from their own savings, 5 per cent arranged the same from friends/relatives, whereas 28 per cent borrowed or sold their assets. The worst affected population is the labourers. When their health is affected, the family faces the acute challenge of meeting medical expenses as well as day-to-day household expenses considering that more dalits are poor.

Recognising the need for health protection for the poor, the Rashtriya Swasthya Bima Yojana (RSBY) was launched in India in 2008 by the Ministry of Labour

and Employment. Initially, it covered households below the poverty line, but later was extended to other category of households of informal sector workers such as vendors, domestic workers, construction workers and MNREGS workers. Of the 69 million households to be targetted by RSBY by the end of 2017, by mid-2014, about 54 per cent are enrolled with wide variations across regions. As per guidelines of RSBY, 2015, two other schemes, namely, Aam Admi Bima Yojana (AABY) and Indira Gandhi National Old Age Pension Scheme (IGNOAPS) were aligned with RSBY to provide facilities under different schemes through single 'smart health card'. However, the RSBY has been lagging behind its targets. Its implementation has been better in some states where the local government has taken special interest (IIPS and ICF, 2017).

It may be important to highlight that only a quarter of the households have health insurance, mostly covered under RSBY. The share of private health insurance is less than 10 percent even among the non-SC/ST/OBC population. Therefore, it is a point to ponder why is private health insurance being projected as an important support for health care (Table 20.3).

**Table 20.3: Health Insurance of Marginal Groups**

| Social Category      | Percent of HH Insured of total HH | Percent RSBY of total insured | Percent Private HI of total insured |
|----------------------|-----------------------------------|-------------------------------|-------------------------------------|
| Schedule Caste       | 31.1                              | 36.2                          | 1.8                                 |
| Schedule Tribe       | 30.1                              | 51.6                          | 1.2                                 |
| Other Backward Class | 30.5                              | 27.0                          | 3.1                                 |
| Other                | 23.6                              | 37.0                          | 9.7                                 |
| Don't Know           | 20.0                              | 42.8                          | 5.5                                 |
| <b>Total</b>         | <b>28.7</b>                       | <b>33.8</b>                   | <b>4.1</b>                          |

**Note:** HH- Household, HI- Health Insurance, RSBY- Rashtriya Swasthya Bima Yojana ;

**Source:** Table 11.13 NFHS 4 (2015-16)

While these schemes and infrastructure have been designed to feed into the gap in health care services to all, the outcome indicators do not reflect the same. The tertiary level hospitals in the metropolitan cities remain overburdened, with the peripheral regions remaining with no infrastructure or poor infrastructure. The RSBY seems to be unavailable to the poor of whom a large share is the excluded groups. Health promotion is done through stopping the spread of communicable and non-communicable diseases and promoting physical activity. Economic vulnerability of certain social groups makes them more prone to such diseases. Development of health education programme for all including socially marginalised groups; and improving effectiveness of health promotion by creating awareness at the grassroots level especially among socially marginalised groups is also needed. Behaviour change communication that focusses on ways that encourage people to make healthy choices is likely to be effective. Pre-service training for medical workforce to be sensitised towards the social identity based disparities in access and outcomes in health is extremely important.

After studying this unit on marginalisation and health inequality, factors influencing health status, global goals to address health inequality and health

expenditure supported by state and international agencies, now attempt the following questions in Check Your Progress – 2.

### Check Your Progress 2

**Note:** a) Write your answer in about 50 words.

b) Check your answer with possible answers given at the end of the unit

1) Explain the association between marginalisation and health inequality.

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2) Describe the factors influencing health status.

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3) Discuss the important measures taken to improve health.

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## 20.7 LET US SUM UP

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Marginalisation acts as a barrier to access resources and services, excluding the groups and/or individuals from access to opportunities for enhancement of individual and/or group attributes like educational and health status, employability and self-worthiness. It denies access to opportunities for enhancement of capacities among the marginalised groups. Social inclusion is the most viable way through which access to opportunities, resources and services can be improved so as to yield better employability and self-worthiness which in turn would impact on health outcomes.

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## 20.8 REFERENCES AND SUGGESTED READING

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## 20.9 CHECK YOUR PROGRESS: POSSIBLE ANSWERS

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### Check Your Progress-1

- 1) What is the marginalisation?

**Ans.** Marginalisation is the process through which groups or individuals are pushed to the edge and accorded lesser importance. This is predominantly a social phenomenon which excludes the groups or individuals and ignores their needs and desires. They are treated as insignificant and peripheral. This translates in differential access to opportunities, resources and services, especially those pertaining to health.

- 2) How is marginalisation associated with social exclusion and discrimination?

**Ans.** Marginalisation is a process by which a group is denied access to important positions and symbols of economic, religious, or political power within any society. It is dependent on the historical and socio-economic context of a society. It causes social exclusion through systemic barriers to effective participation and focus on equality of opportunity. Social exclusion leads to the unjust or prejudicial treatment of different categories of people, especially on the grounds of race, age, ethnicity, region, language and gender.

## Check Your Progress 2

- 1) Explain the association between marginalisation and health inequality.

**Ans.** Marginalisation influences the well-being of individuals and groups. Health inequalities are strongly related with socio-economic determinants. If an individual / group is socially and materially disadvantaged as well as poor mental and physical health which led to poor economic status, under employment/ unemployment, uneducated and poor housing. Lesser and no marginalisation is likely to yield lesser or no health inequality, thus, both concepts are directly correlated.

- 2) Describe the factors influencing health status.

**Ans.** The following factors of health are very influencing in any society: a) historical and socio-economical context of a society, b) access to political or economic power, c) poor access to economic and other recourses like education and social services, and d) participation and self-determination.

- 3) Discuss the important measures taken to improve health.

**Ans.** Some of the important measures to improve health are a) Improved health data, (prevention and health of promotion; b) Partnerships across policy areas, c) Develop capacities for implementation, d) Support the local level policies, e) Strengthen the evidence base and get it into practice. In addition to this, social inclusion to the access excluded, removal of systemic barriers, and good governance supports the well-being and improves health status.

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