

WOLLO UNIVERSITY
Department of sociology

Module for the course Medical Sociology

BY:

Molla Yismaw

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CHAPTER- ONE

Definition and subject matter of medical sociology

Dear students! Welcome to the course medical sociology. This chapter will introduce you about the concepts of medical sociology, the relevancies and development of medical sociology within the academic and practical endeavors. In addition, biomedical model and the recognition of limitations in biomedical model and the development of sociological studies that encompass socio-economic, cultural and political determinant of health will be reviewed. Moreover, the concept and the application of sociology in medicine and sociology of medicine within the health care system will be discussed. Finally, the implication of sociology within the health care institutions will be addressed.

1.1. Definition of medical sociology

According to Cockerham, medical sociology is the study of health, health behavior, illness and medical institutions'. Medical sociology is concerned with the relationship between social factors and health, and with the application of sociological theory and research techniques to questions related to health, illness and the health care system.

Medical sociology is also the sociological analysis of medical organizations and institutions; the production of knowledge and selection of methods, the actions and interactions of healthcare professionals, and the social or cultural (rather than clinical or bodily) effects of medical practice. The field commonly interacts with the sociology of knowledge, science and technology

studies and social epistemology¹. Medical sociologists are also interested in the qualitative experiences of patients, often working at the boundaries of public health, social work, demography and to explore phenomena at the intersection of the social and clinical sciences.

Furthermore, in addition to the above definition Medical sociology; it is the study of individual and group behaviors with respect to health and illness. The focus is not only on medical professionals or their behaviors, but also focuses on human behavioral responses to health and illness. Medical sociology is concerned with individual and group responses aimed at assessing well-being, maintaining health, acting upon real or perceived illness, interacting with health care systems, and maximizing health in the face of physiologic or functional derangement. It also analyzes the impact of the psychological conditions resulting from our environment on our health.

In general, as an academic discipline, sociology is concerned with the social causes and consequences of human behavior. Thus, it follows that medical sociology is concerned with the social causes and consequences of health and illness. Recognize of the significance of the complex relationship between social factors and the level of health characteristic of various groups and societies. Medical sociology brings sociological perspectives/theories and methods to the study of health, illness, and medical practice. Medical sociology is the study of the social and cultural dimensions of health and health problems and people's attempts to solve them.

¹ **Social epidemiology:** study of disease distribution, impairment, and general health status across a population. Contemporary epidemiology concerned with epidemics, and also non-epidemic diseases, injuries, drug addiction and alcoholism, suicide, and mental illness.

1.2. Illness and Health as Cultural Phenomena

Question: what are some reasons to view health and illness as cultural and social phenomena?

Illness and health is socio-economic and cultural phenomenon. There are at least four reasons to view health problems as social and cultural phenomena: first, *health and illness often find their origin in people's living and working conditions (socio-economic status, gender position) and lifestyles (behaviors)*. Poverty is associated with many diseases, Women are particularly vulnerable due to both their reproductively and their position in society, Lifestyles (such as smoking, an unbalanced diet or intravenous drug use) and specific customs, dietary restrictions and other culturally determined health practices may also contribute to ill-health. Second, they are communicated to others in ways that are culturally prescribed. For example, in one culture a sick person may be expected to show his pain, while in another she or he is expected to do the opposite. Again, a patient in one culture may seek the company of others, while in another cultural setting she or he suffers in isolation. For examples there are societies who segregate mothers while they give birth. Third, they are explained and labelled in accordance with existing, cultural concepts. Dominant cultural beliefs that provide illness explanations include hot/cold ideas belief in spirits, fear of witchcraft or trust in natural science. Finally, illness and health are experienced in a way that has been influenced by prevailing cultural ideas. Whether an illness is regarded as serious or harmless can vary from one culture to another. Such ideas also affect how the patient experiences the illness episode. For example how rape and leprosy treated in rural and urban areas.

1.3. Critique of biomedical model and the development of medical sociology

1.3.1. Biomedical Model

Medical model is the term cited by psychiatrist Ronald D. Laing in his *The Politics of the Family and Other Essays* (1971) for the "set of procedures in which all doctors are trained." This set includes complaint, history, physical examination, ancillary tests if needed, diagnosis, treatment, and prognosis with and without treatment. The medical model is an approach to pathology that

aims to find medical treatments for diagnosed symptoms and syndromes and treats the human body as a very complex mechanism.

The medical model refers to the conception of disease established in the late nineteenth and early twentieth century's, based on an anatomo-pathological view of the individual body.

Other definition Medical Model is a term in psychology which is the view that abnormal behavior is the result of physical problems and should be treated medically. The rise of modern scientific medicine during the 19th century has a great impact on the development of the medical model.

Basically, biomedical model has the following characteristics.

1. In the medical model, the physician was traditionally seen as the expert, and patients were expected to comply with his/her advice. The physician assumes an authoritarian position in relation to the patient. However, in recent years, the move towards patient-centered care has resulted in greater patient involvement in many cases.
2. In the medical model, the physician may be viewed as the dominant health care professional, as they are the professionals trained in diagnosis and treatment.
3. An ill patient should not be held responsible for his/her condition. The patient should not be blamed or stigmatized for his/her illness, whether it is cancer, high blood pressure, AIDS, depression.
4. Under the medical model, the disease condition of the patient is of major importance. Social, psychological, and other "external" factors, which may influence patient behavior, may be given less attention.

1.3.2. Criticisms of the Medical Approach to Health Care

The medical model is the dominant paradigm of psychiatry. Over the past forty years it has become the target of a rising tide of criticism. The fundamental problem with the medical model arises from the questionable impact of medical intervention on the overall health of populations.

- a) Medical knowledge is not only scientific, but shapes and is shaped by the Society in which it develops

- b) Anyone who becomes the object of psychiatric attention, voluntarily or involuntarily, is viewed through the medical model and is subject to being labeled as ill.
- c) The medical model deeply flawed and that the flaws are ignored for social, Political and economic reasons.
- d) Medical model over stated medication².

1.3.2. The development of medical sociology

Unlike law, religion, politics, economics, and other social institutions, medicine was ignored by sociology's founders in the late nineteenth century because it did not appear to shape the structure and nature of society. Medical sociology was established as a specialized field in the United States during the 1940s. However, medical sociology did not begin in earnest until after World War II, when significant amounts of federal funding for socio medical research first became available. T. **Parsons** study showed that in the most socially and economically disadvantaged segments of society were found to have the highest rates of mental disorder in general and excessively high rates of schizophrenia-the most disabling mental illness-in particular. This study attracted international attention and is the best-known single study in the *world of the relationship between mental disorder and social class*. Parsons was the first to demonstrate the controlling function of medicine in a large social system in 1951, and he did so in the context of classical sociological theory. Having a theorist of Parsons's stature rendering the first major theory in medical sociology called attention to the young sub discipline-especially among academic sociologists.

A. Sociology in medicine

Throughout the 1950s sociology applied to the field of medicine was used to assist the dissemination of medical knowledge and to encourage patient compliance with medical directives. In this relationship medicine was the senior partner, and the interaction occurred within a broader cultural context that saw medicine as the paragon of science and of the rational application of scientific principles and technology to human beings. Within sociology this was

² **Medicalization** describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorders.

the period of dominance of the structural-functionalist perspective. After Parson, the direction taken by medical sociology early in its development is best summarized by Robert Straus (1957). Straus suggested that medical sociology had become divided into two separate but closely interrelated areas of **sociology in medicine and sociology of medicine**. The sociologist in medicine is one who collaborates directly with the physician and other health personnel in studying the social factors that are relevant to a particular health disorder. The work of the sociologist in medicine is intended to be directly applicable to patient care or to the solving of a public health problem. This period was the *subordination of sociology to medicine*. Sociologists in medicine usually work in medical schools, nursing schools, public health schools, teaching hospitals, public health agencies, and other health organizations. They may also work for a governmental agency, in the capacity of biostatisticians, researchers, health intervention planners, and administrators

B. Sociology of medicine

In the 1960s and 1970s sociologists were tried to *challenge the organization of medicine* because within the healthcare system there were unfair distribution of accesses for medical services. *Medicine incorporated many sociological insights without problems and schools of behavioural medicine, community medicine and primary care medicine were. Medicine and sociology may have had different emphases, and sociology may even have been making some very challenging propositions about the medical model, but basically they shared the same outlook, and sociology saw itself working with medicine. To put it quite clearly, sociology had a medical bias. Or rather biases.* The sociology of medicine has a different emphasis. The sociology of medicine shares the same goals as other areas of sociology and may consequently be characterized as research and analysis of the medical environment from a sociological perspective. This idea give attention for the discipline sociology and work of sociologist in the health care system and Sociology of medicine, in contrast, focuses on testing sociological hypotheses, using medicine as an arena for studying basic issues in social Stratification, power and influence, social organization, socialization, and the broad context of social values.

And in the third phase a new type of relationship emerged in the 1970s and 1980s .Sociologists apart from challenging their work, they criticize the medical model and emphasizes on social

factors as a cause for illness . Sociologists argue that germs or viruses may be necessary for a disease to occur; but that they are not sufficient in themselves.

The social environment comes between the germ and the individual, and it is responsible for whether or not a disease develops (Twaddle, 1982). Sociologists demonstrated that the prevailing social conditions had to be right before a germ developed into a disease (McKeown, 1979).

Sociology in medicine	Sociology of medicine
Mainly from 1950s to 1960s	Mainly since the end of 1960s
Problem orientated research	Sociological theory orientated practical research
Uses sociological perspectives and knowledge to investigate medically orientated questions	examines medicine with sociological questions and uses sociological concepts
That is, solve medical problems and improve medical care	Employs sociological theory
somewhat accepting of medical categories	Adopts a more critical / analytical approach
trying to satisfy objectives of health care providers & policy makers	Questions categories of biomedicine
improving effectiveness of practitioners	Questions the power of medicine
e.g. evidence of social causes / consequences of disease	E.g. studies of institutions, health inequalities, professions

Table: comparison between sociology of medicine and sociology in medicine

1.4. Health from sociological perspectives (Sociological Model of Disease)

The sociology of health examines the impact of both **morbidity and mortality**³ on social life and social life on morbidity and mortality. Diseases and conditions once attributed mainly to genetic predispositions are increasingly being looked at under a more global microscope with factors such as family, education, religion and economic standing all playing key roles in understanding the issue.

³ **Morbidity**: incidence of disease in a given population

Mortality: incidence of death in a given population

One sociologist, who has developed such a model of disease, focusing on social causes rather than disease processes, is Peter Davis, professor of public health at Christchurch University in New Zealand (Davis, 1994). Davis' argument is that rather than focusing on individual diseases and individual bodies, health research and health policy should be directed to the economic, political and cultural institutions that produce disease. Thus he proposes classifications of disease based on the economic, social, cultural and political determinants of ill health and disease. In the economic sphere, the institution of the labor market, inside an economic framework of capitalism, which results in **profit being placed before safety**, would be shown to be the cause of industrial death and accident.

The social shaping of disease, through the institutions of family and kinship, working themselves out in the context of urbanization and social mobility, would be targeted as contributory or causative in hypertension and mental illness. Cultural factors of beliefs, practices and lifestyles, usually manifest in different consumption patterns, especially of diet and alcohol would be seen as key factors in obesity, bowel cancer and lung cancer. At the political level are those diseases which are a product of the structures of power and the different participation rates of different groups within unequal society, which result in diseases due to problems of access to services and equity in the distribution of services.

1.5. The Role of sociology in medical sociology

Health and illness are central to our lives and are major areas of work, policy and debate in society. More than a century ago, realizing that many theoretical and practical problems (interpersonal relationships, Professional status and roles, efficiency of the relationships between patients and Physicians, quality of services and equal rights on health, application of technology and the dehumanization of medical work) are a field of interest to those who deal with the Sociology of medicine and the concern of the field of sociology. The discipline sociology enables the society to critically apply the key theories and concepts used in the Sociology of Health and Illness to understand important dimensions of modern society. What is more, equip society to demonstrate knowledge and understanding of classic and, used to apply critical sociological arguments to current problems, debates and controversies about understand and critically review historical, current and emerging developments in the broad and dynamic field of sociology of health and illness, relationships between health, medicine and society.

In general:-

- I. *Sociologists can study how social forces promote health and illness and why some social groups suffer more illness than others do. Sociologists can study how historical changes in pattern of social life can explain change in pattern of illness. For example, to understand why rate of breast cancer have increased, some researchers have studied the impact of women's changing social roles, and others have studied the impact of political forces that promote increased meat consumption.*
- II. *Instead of studying broad pattern of illness, sociologists can study the experiences of those, who live with illness on a day-to-day basis – exploring, for example, how illness affects individuals' sense of identity, relationships with family, or ideas about the causes of illness.*
- III. *Sociologists can focus on the impact of factors on health care providers. For example, some sociologists have analyzed how the status and power of different occupations have shifted over time, and others have investigated how power affects interactions between health care occupations (such as doctors and nurses). Still others have examined interactions between health care workers and patients, asking, for example, how doctors can maintain control in their discussions with patients or whether doctors treat male and female patients differently.*
- IV. *Sociologists can analyze the health care system as a whole. Sociologists have examined how health care systems have developed, compared the strengths and weaknesses of different systems, and explored how systems can be improved.*

For example, some have studied how and why: health insurance companies sometimes make it difficult for people – who needed care. The topics researched by sociologists of health, illness and health care overlap in many ways with those studied by health psychologists, medical anthropologists, public health workers, and others. What most clearly differentiates sociologists from these other researchers is the *sociological perspective*, which we will see in other chapter.

CHAPTER –TWO

Key concepts in Medical Sociology

Dear students! Welcome again to chapter two. Chapter two will familiarize you with the concepts of medical sociology such as health, diseases, illness, sickness, stigma, medical pluralism, ethno medicine, illness narratives, risk, medicalization and demedicalization of social phenomena. In this chapter, we will discuss how those basic concepts defined in various context and how those definitions and understandings matters in our health conditions.

2.1. Health

There is no single, all-purpose definition of health that fits all circumstances, but there are many concepts such as health as normality, the absence of disease, or the ability to function (Blaxter 2004). However, most studies suggest that **laypersons**⁴ tend to view health as the capacity to carry out their daily activities. That is, many people consider health to be a state of functional fitness and apply this definition to their everyday lives.

The World Health Organization (WHO) defines health as a state of ***complete physical, mental, and social well-being***, and not merely the absence of disease or injury. This definition calls attention to the fact that-being healthy involves much more than simply determining if a person is ill or injured. Being healthy also means having a sense of well-being. You feel good, you look good, nothing really bothers you, and life is wonderful, you seem to feel like doing more”. (Blaxter 2004:52) Thus, feelings of well-being are more than the perceived absence of disease and disability.

⁴ **laypersons** are those who are non professional, amateur, outsider non-expert, non specialist and a man who is not a cleric, But he or she may be family member, peers, neighbors, religious leaders, community leaders which they give suggestions about our health issues including, possible course of action.

2.1.1. Two aspects to health

Most people accept that health can be divided into two broad aspects - physical and mental health

a. Physical health

For humans, physical health means a good body health, which is healthy because of regular physical activity (exercise), good nutrition and adequate rest. As a country's or region's people experience improved nutrition, health care, standards of living and quality of life, their height and weight generally increase. Another term for physical health is *physical wellbeing*. Physical wellbeing is defined as something a person can achieve by developing all health-related components of his/her lifestyle. Fitness reflects a person's cardio respiratory endurance, muscular strength, flexibility, and body composition. Other contributors to physical wellbeing may include proper nutrition, bodyweight management, abstaining from drug abuse, avoiding alcohol abuse, responsible, hygiene, and getting the right amount of sleep. Physical health divided into two separate sections.

I .Structural health - this refers to sound bones, muscles, organs etc. That the structures in the body are performing the functions they were made for properly.

II. Chemical Health - good chemical health means that the chemicals in the person's body are correct, that tissues contain the right balance of nutrients, etc., and there are no toxic chemicals. We may inhale or swallow natural and synthetic chemicals; they can also get into our body through skin which may affect our health.

B .mental health

mental health refers to people's cognitive and emotional well-being. A person who enjoys good mental health does not have a mental disorder. According to WHO, **mental health is "a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community"**.

No matter how many definitions people try to come up with regarding *mental health*, its assessment is still a subjective one.

Most people agree that mental health refers to the "absence of mental illness". For some, this definition is not enough.

2.1.2. Determinants of health

The health of individual people and their communities are affected by a wide range of contributory factors. People's good or bad health is determined by their environment and situations - what is happening and what has happened to them. According to WHO the following factors probably have a bigger impact on our health than access and use of health care services.

- Where we live
- The state of our environment
- Genetics
- Our income
- Our education level
- Our relationship with friends and family

2.2. Disease

“Disease ... is a pathological process and it is the definition of a health problem by medical experts. Disease refers to the doctor's perspective on ill-health. This view is based on scientific rationality and assumes that diseases are universal in form, progress and content. This perspective does not include the social or psychological dimensions of disease, the context in which it appears, or its culturally defined meaning. The quality which identifies disease is some deviation from a biological norm. There is objectivity about disease which doctors are able to see, touch, measure and smell. Diseases are valued as the central facts in the medical view.

The concept of “disease” is central to the medical model. In general, “disease” refers to some deviation from normal body functioning that has undesirable consequences on the individual.

2.3. Illness

*“Illness ... is a feeling, an experience of unhealthy which is entirely personal, interior to the person of the patient. Often it accompanies disease, but the disease may be undeclared, as in the early stages. **Sometimes illness exists where no disease can be found.** Illness reflects the patient's perspective (the emic⁵ approach). It is influenced by the cultural, social and emotional context in which it occurs and by an individual's background and personality.*

⁵ **emic**: insider view or perspective.

Traditional medical education has made the deafening silence of illness-in-the-absence-of-disease unbearable to the clinician. The patient can offer the doctor nothing to satisfy his senses. Illness also refers to the socio-cultural context within which disease is experienced.

Disease	Illness
Biological and/ physiological malfunctioning (the clinical perspective)	The experience and perception of disease within the socio-cultural context; including spirituality and religion.
Doctors perspective	Patient perspective

2.4. Sickness

Sickness ... is the external and public mode of unhealthy. Sickness is a social role, a status, a negotiated position in the world, a bargain struck between the person henceforward called 'sick', and a society which is prepared to recognize and sustain him. The security of this role depends on a number of factors, not least the possession of that much treasured gift, the disease. Sickness based on illness alone is a most uncertain status. But even the possession of disease does not guarantee equity in sickness. Disease then, is the pathological process, deviation from a biological norm. Illness is the patient's experience of ill health, sometimes when no disease can be found. Sickness is the role negotiated with society. Most patients most of the time however, probably can be classified as having a disease, or feeling ill, or being recognized as sick. Example those adults who fail to fulfill their social responsibilities due to addiction and alcoholism considered as sick.

2.5. Stigma

Stigma refers to a negatively defined condition, attribute, trait or behaviour conferring 'deviant' status, which is socially, culturally and historically variable.

The term stigma has a long lineage, predating the advent of the social sciences as we know them today. The Greeks, in fact, originated the term to refer to bodily signs, cut or burnt into the body, which were designed to expose the bearer as a slave, a criminal or a social outcast; someone 'ritually polluted' who was to be avoided, especially in public places. Today however, the term is applied more widely to any condition, attribute, trait or behaviour that symbolically marks the bearer off as '**culturally unacceptable**' or '**inferior**' and has, as its objective referent, the notion of shame or disgrace. Perhaps the key point of reference, for present purposes, is Goffman's

pioneering study of 1963, tellingly entitled *Stigma: Notes on the Management Of Spoiled Identity* (presentation of a discredited or discreditable self)

A full account of Goffman's study is beyond the scope of this class. Suffice it to say that three distinct types of stigma are identified by Goffman: namely,

- a) Stigmas of the body (such as blemishes or deformities)
- b) Stigmas of character (the mentally ill or the criminal. for example)
- c) Stigmas associated with social collectivities ('racial' or tribal), all of which he stresses are socially, culturally and historically variable..

2.6. Illness narratives

Illness narratives refer to the story-telling and accounting practices that occur in the face of illness. Narrative analysis seeks to understand the 'plot' of the account given and its social and motivational dimensions. It is a common observation that human cultures are rooted in myths and narratives, that is, in the construction and telling of stories. Narratives provide the opportunity for using metaphors and other linguistic devices to convey and produce meaning, especially in difficult or threatening circumstances.

2.7. Risk

It involves exposure to a given danger or hazard. The language of risk is now frequently used in both popular and expert discourse especially when it comes to discussing health issues. In pre renaissance times the dominant popular discourse was that of 'fate' in which personal misfortune and disaster were explained in terms of chance, personal destiny and the will of the Gods. In this period, dangers such as floods and epidemics were perceived as natural events and the idea of human fault or responsibility was not considered. According to Lupton (1999), modernist notions of risk also recognized that risk become common with the development of modern technology. For example biological weapons, nuclear power, industrial wastes etc...make society to live in the risky world if they are not managed properly.

2.8. Ethno medicine

Those beliefs and practices relating to disease which are the *products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine*" (Hughes 1968). Beginning with their earliest field research, 100 years or more ago, anthropologists routinely have gathered data on the medical beliefs of the peoples they studied,

in the same way and for the same purpose that they have gathered data on all other aspects of culture: to have as complete an ethnographic record as possible.

Traditional medicine is contrasted with biomedicine. Most traditional medical theories have a social and religious character and emphasize prevention and holistic features. Traditional medical practices are usually characterized by the healer's personal involvement, by secrecy and a reward system. Biomedical theory and practice show an almost opposite picture: asocial, irreligious, curative and organ-directed; professional detachment, public knowledge and-until recently-'free of charge'. It is suggested that local communities do not expect that basic health care will improve when traditional healers become integrated into the service. They ask instead for improvement of basic health care itself: more services with better access, more dedication and respect from doctors and nurses, more medicines and personnel. Fieldwork needs to be done at the community level to arrive at a better understanding and assessment of the community's opinion concerning a possible role of traditional medicine in basic health care. Traditional Medicine is used by many people to managing numerous conditions. It is accessible and effective. It therefore plays a significant role by reducing life-threatening ailments of humanity. In developing countries like Africa in general and Ethiopia in particular the situation in health care has become so complex that medical or biological terms alone cannot effectively assess it. The people have a notion of classifying a sickness in to those that are caused by spirits and those, which are caused by other natural. After the Second World War particularly concomitant with the development of international public health programs the need to get information on the cultural and social factors that affect health paved a way for the contribution of anthropologists. This increased acceptance of cultural influence on health has led to the frequent use and elaboration of terms like illness, sickness and disease. It also examines the conceptual differences of disease, illness, and health.

For example, like other African countries various studies conducted in Ethiopia by researchers in different times and localities revealed that traditional medicine is still employed by the people together with modern medicine. The majority of the population first exhausts traditional drugs before resorting to modern medicine. The people recognize and name the various body organs like “lib” (heart), “sanba”, (lung), and so on. According to Concept of health, disease, illness and therapy among the people of Addis Ababa a study conducted by Teshome-Bahiru claim that the following conditions lead to the experience of un health condition:-

- a. Exposing oneself to direct sunrays without washing mouth properly after eating
- b. Exposing a nursing breast to direct sun rays (for women)
- c. Being naked and immediate exposure to direct sunlight
- d. When sitting or sleeping on the ground recently moistened by rain showers, or urine of any type .i.e. humans as well as animals. The symptoms of gerifta are mastitis, scabies, rash, and furuncle (boils). Furthermore, the healers added that staying facing a direct sunlight could cause blindness and headache.

In general disease is something created by some spiritual or natural being because of lack of fulfillment on one's role and expectation for that **super natural being**, where our illness and sickness is an abnormal condition of individual which is caused by spiritual being as a penalty for lack of commitments and illness and sickness are not that much isolated, most of the time illness is not considered as sickness unless it causes a lot of suffering.

2.9. Medical pluralism

Medical pluralism can be defined as the employment of more than one medical system or the use of both conventional and complementary and alternative medicine (CAM) for health and illness. Medical systems in all human societies regardless of whether they are indigenous or state based consist of a dyadic core consisting of a healer and a patient. Medical system of a society consists of the totality of medical subsystems that coexist in a cooperative or competitive relationship with one another. For example, the application of traditional medicine, modern medicine and holy water for illness condition considered as medical pluralism.

2.10. Medicalization

Medicalization describes a process by which non-medical problems become defined and treated as medical problems, usually in terms of illnesses or disorder. It is the process by which human conditions and problems come to be defined and treated as medical conditions, and thus become the subject of medical study, diagnosis, prevention, or treatment. Medicalization can be driven by new evidence or hypotheses about conditions; by changing social attitudes or economic considerations; or by the development of new medications or treatments.

In general, Medicalization refers to the process of labeling social and emotional phenomena as medical, which, by consequence, ask for medical intervention. "medicalization" occurs "when previously non medical problems are defined and treated as medical problems, usually in terms of illnesses or disorders. Socio-cultural norms may call someone ill because of a certain behavior which may not be socially acceptable. The way in which societies increasingly label socially unacceptable behaviour as sickness has been criticized as medicalization. Examples are addictive behaviour (excessive drinking, substance abuse or gambling), anxiety, deviant sexual behaviour.

Medicalization is now established as a key sociological concept yet it is difficult to be specific about when it entered the social scientific conditions.

According to Conrad and Schneider (1980), medicalization can occur on three distinct levels:

- a) Conceptually when a medical vocabulary is used to define a problem;
- b) Institutionally, when organizations adopt a medical approach to treating a problem in which they specialize; and
- c) At the level of doctor-patient interaction when a problem is defined as medical and medical treatment occurs. As these distinctions illustrate, the process often involves physicians and their treatments directly. However, this is not necessarily so, as in the case of *alcoholism* where the medical profession may be only marginally involved or not involved at all.

Sickness and disease are the product of social arrangements, both in terms of what it is we get sick from, as well as in terms of who it is that gets sick. Thus sickness and disease are *not static categories of nature*, but are part of the *ongoing social processes* of life.

We live in a medicalized society, one in which we explain problems in medical terms. For example, responding to social encounters with heavy drinking is explained as alcoholism. Inappropriate behavior in the classroom is labeled hyperactive disorder. *Suicide is explained in medical psychiatric terms, as mental stresses*. Often people's gender preferences, especially if

they are homosexual ones, are explained as the outcome of medical abnormalities. However, those examples are social problems other than medical problems.

2.10.1. Stages of medicalization

There are five stages with in the process of medicalization.

1. some behaviour is defined as deviant
2. the behaviour is defined as a medical problem in e.g. a professional journal
3. medical and non-medical interest groups make claims
4. claims are legitimized
5. medical deviance designation is institutionalized

For example, gambling is another example which shows the historical process by which a behaviour becomes a medical problem requiring professional help.

Demedicalization: medicalization is not only a one way process. It is also possible for demedicalization to occur if a problem ceases to be defined in medical terms and medical treatments are no longer seen as an appropriate solution. Homosexuality until 1973 was defined as illness. But now it become normal in one society and social problem in onther society with it become against the mainstream culture like Ethiopian society.

Chapter- Three

3.1. Theoretical perspectives in Medical Sociology

Dear students! Welcome to the theoretical foundation in medical sociology. In this chapter the concepts of main sociological theories in relation to health, illnesses, sickness and diseases will be examined. More importantly, how socio-economic condition, cultural context and political ideology affect human health will be discussed. Furthermore, sociological theories such as, structural functionalism, conflict theory, symbolic interaction theory and post modernist theory will be assessed.

Question:

Why people become ill? What solutions should be taken? Answer those two questions based on the main sociological theories.

What is theory? Theory is asset of proposition that explains the flow of events in the universe so sociological theory means asset of proposition that explain the flow of events in the social universe. The sociological perspective shifts our focus from individuals to social groups and institutions. Different sociological perspectives on society give rise to different accounts of the role of medical knowledge, and of the social causes of disease. They are also based in different sociological models of society, in part complementary, in part contradictory. Marxist approaches emphasize the causal role of economics in the production and distribution of disease, as well as the role that medical knowledge plays in sustaining the class structure. Parsonian sociology emphasizes the role of medicine in maintaining social harmony, pointing to the non-market basis of professional groups. At the same time its critical sociological edge is maintained by the way it highlights the social control function of medicine in enforcing compliance with social roles in modern society. Parsons' work both contradicts Marxism – by highlighting the importance of the

non-economic sphere of society – but also adds to it in providing a description of the sick role as a social role that is shaped by the social strains of modern society. Thus Parsons is both conservative and critical at the same time. Foucault, too, highlights the social role of medical knowledge in controlling populations, and like Parsons emphasizes the diffuse nature of power relationships in modern society. Also, like Parsons, he sees the professions, especially the helping professions, playing a key role in inducing individuals to comply with ‘normal’ social roles. For Foucault, modern societies are systems of organized surveillance with the catch being that individuals conduct the surveillance on themselves, having internalized ‘professional’ models of what is appropriate behavior. Marxist-feminists identify the ways in which class and patriarchy interact to define the subordinate position of women in society, and the central role that medical knowledge plays in defining women as childcares’ and housewives.

3.1. Structural functionalism

The first approach to be examined is *functionalism*. This theoretical approach is based on an analogy between society and a biological organism. Just as the body is made up of different but inter-related and interdependent parts, so society is made up of a number of different systems and sub-systems. These different parts achieve a unity in so far as they function to sustain the whole, in this example the wider social structure. So, when part affect by illness the other will be also affected unless illness managed properly within the health system.

Structural functionalism was the dominant theoretical perspective between 1920 and 1960. Its basic tenets are still very much alive and are even considered as self-evident. Social and cultural phenomena are seen as functionally interconnected and basic to the structural maintenance of society. The sociologists’ task is to show how the different elements interact to make society into what it is. An often used metaphor of this perspective is the human body whose various organs and limbs have differing functions which contribute to the overall functioning of the body. Society then is seen as a system in equilibrium, just as the human body. This model was also applied to the field of medical sociology/ anthropology. Illness in this view is a dysfunctioning of the body and health care contributes to the maintenance of society as a whole by 'repairing' the

sick individual. It shows that a patient's reaction to illness is socially prescribed and it analyses the role of medicine as a form of social control. Parsons' important work in medical sociology is one reason for a review of structural functionalist. Parsons has shown how medicine contributes to the maintenance of society. He describes the 'sick role' as temporary deviance, permissible on condition that the patients try to recover as soon as possible. Attempting to get well implies seeking treatment and complying with it.

In Parsons' analysis individual exemption from social obligations is tolerated to prevent more fundamental threats to society. If society causes people to be sick, they must be allotted 'time-out' to recuperate; meanwhile society remains unchanged. Medicine thus assumes a role of social control. Parsons' analysis is still widely accepted. Parsons, however, approved of the social control function of medicine whereas more contemporary authors tend to criticize it as 'medicalisation'.

Emilie Durkheim: - structural functionalism macro level process important for human beings. Social process is external to individual and individual are passive factual values are primary motivators .

Medicine, in the works of Talcott Parsons (1958), who was the major theorist of this position, served as a key illustration of the way in which an institution functioned through ***the harmonious interrelationship of the social roles people played within it. He identified a shared set of expectations between the patient and the doctor.*** The doctor was a highly skilled professional who applied scientific knowledge to the patient's trouble, without regard to factors such as race, gender, or religion. The patient, on the other hand, sought out the doctor and complied with the doctor's directives so as to get better.

In a time then, medical knowledge and practice held sway (influence) and shaping health sociologists' views of the field and setting their research agendas for them. The main task of applied sociological research was to increase ***patient compliance with the doctor's commands.*** Medicine incorporated many sociological insights without problems and schools of behavioral medicine, community medicine and primary care medicine were established throughout the late 1960s and 1970s.

In summary, The Functionalist Perspective: This perspective views medicine and the systems of health care as important social institutions; and it focuses on the functions and roles played by the institution in maintaining order and stability in society. The medical institutions whether scientific or traditional and the various practitioners exist to meet the needs of individuals and society.

3.2. The Political Economy (conflict theory)

Other researchers, drawing their inspiration from the work of Marx, view culture mainly as the outcome of political and economic circumstances. Health - or the lack of it - and the quality of health care are largely determined by social competition between groups of people (**classes**) and the unequal distribution of scarce resources (**economy**). Problems in the field of health and health care in developing countries are often linked to social and economic inequality and poverty which are often seen as the consequence of the penetration of the capitalist economy.

Morbidity and mortality patterns reveal statistical associations with socio-economic parameters, and qualitative case studies demonstrate how poverty and exploitation constitute enormous barriers for healthy living. According to the Marxist orientation, disease is not only 'caused' by the capitalist economy, it can also be 'constructed' by it. Remember Parsons' view of medicine as an agent of social control. 'Inventing' a disease can be a useful device to get rid of undesirable workers or to restore calm in an enterprise. Psychiatric hospitals in particular serve as reservoirs to contain those who do not fit into the ordinary production process or perhaps even pose a threat to it. Denying the existence of disease can also serve the interests of capitalism. Not only illness but also health care is affected by modes of production. Modern health care is both a product and a producer in a capitalist tradition. It is part of a process in which the creation of surplus (profit maximization) and the accumulation of capital are the primary aims. Health care remains a scarce commodity which, in informal and less obvious ways, is more ***accessible to those who can pay, and who have political and/or social influence.***

A common topic studied from a politico-economic perspective is the sale of pharmaceuticals in developing countries. Pharmaceuticals are typically commodities representing a capitalist mode of production. *The primary objective of their distribution is the accumulation of capital*

rather than the prevention or alleviation of disease. It is this profit motive which explains why some essential drugs are extremely scarce in a particular society while other, useless and perhaps even harmful, medicines may be dumped there in abundance.

We act in accordance with the social motivator; functional values are not primary motivators. Various group struggle for their interest and our universe is in the arena of conflict. Welfare benefits the upper class and poor are always in risk health condition and labor value for the worker is maintenance value while profit is the unpaid labor for the working class according to Marx and class struggle is existing reality. For example, *Marx claims that inequality of owner of means of production lead to different health condition. He is critical conflict ideologist which is theory and practice should not separate. On the other hand for Weber, inequalities in power make variations in status /prestige. He is analytical conflict ideology which is theory and practice should separate. Both agreed on health determined by either economic inequality or power inequality.*

In general, *The Conflict Perspective* also called the “ political economy” is an approach which stresses on the socio-economic inequality in power and wealth which in turn significantly affects the health status and access to health care facilities. Individuals, groups, communities and even nations thus tend to have unbalanced share of health resources; and these often leads to the unequal distribution of morbidity and mortality patterns among a given society; those in power and dominance enjoy better health in the expenses of the poor and the marginalized groups suffer from the burden of diseases (Turner, 1987). Marxist theory is used to question the ‘naturalness’ of capitalist relations and to unmask the reality of what is fundamentally an exploitative relationship. *Medical profession’s alliance with the ruling classes in terms of their shared willingness to perpetuate the belief that the principal causes of ill health are personal and physical rather than social. Therefore, the alliance between the ruling classes and the medical profession serves the interests of both by maintaining the professional dominance of the medical professional and by sustaining a reasonably healthy working population for the ruling class to maintain their power.*

3.3. Symbolic interactionist theory

In small group social process interaction are mediated by language which is symbol. Herbert Blumer meaning is social because it is created and maintained in the social interaction. Meaninginteraction -----interpretation. *Symbolic interactionism* is based on the premise that there is a fundamental difference between the subject matter of sociology and that of the natural sciences. While the study of the natural world deals with physical, inanimate objects, the subject matter of sociology consists of people whose actions are motivated by human consciousness. Symbolic interactionism is, therefore, concerned with how people see and understand the social world. This theoretical approach is concerned less with the larger social system or structure than with interpreting human behavior.

There is on a simple process in social interaction when we think about health.

- ❖ Health is socially constructed. E.g. headache in rural and urban constructed differently.
- ❖ Sickness is socially constructed. E.g. Who is lazy it varies across societies.
- ❖ Treatment is socially constructed. E.g. use of modern or traditional medicine or forgone it.

Symbolic interactionism is concerned with examining the interaction between the different role players in the health and illness drama. The focus is on how illness and the subjective experience of being sick are constructed through the doctor–patient exchange. Illness is constructed and the existences of objective reality. The argument here is that illness is a social accomplishment among actors rather than just *'People constructing understandings of themselves and of others out of experiences they have and the situations they find themselves in. These understandings have consequences in turn for the way in which people act, and the manner in which others react to them.'*

Interactionist sociology asserts that the social **identities and self** we possess are influenced by the reactions of others. So if we demonstrate some abnormal or 'deviant' behavior it is likely that the particular label that is attached within a society at a particular time to this behavior will then become attached to us as individuals. This can bring about important changes in our self-identity. A disease diagnosis could be once labeled for the sick. Becker defines **deviance**⁶ as any act that is perceived as deviance is a label attached to the behavior of an individual, rather than a quality of their behavior.

⁶ **Deviances** are people who are not conform with (violate) societal values and norms. E.g. Criminals

To summarize, Symbolic interactionist approach focuses on the social and cultural constructions of health, illness and disease and view illnesses and health are not just things that exist "out there"; they are productions of the complex social interactions; and health and illness are highly shaped by the manner in which people as actors give meanings to them and how the actors respond to them in socio-culturally sanctioned ways.

3.4. Post- modernist

Period after modernity (roughly since mid/late 20th century. Time of constant change. No universal laws possible. Idea of progress gets blurred. No linearity of thought, some even claim no truth, no right or wrong, nothing moral or immoral E.g. Killing some one in the time of war and in occasional case which shows everything is relative, flexible and dynamic. Individuals have dramatically increased knowledge about themselves and thus to manipulate and control aspects of themselves which were not previously possible.

All knowledge is socially constructed and has no independent reality apart from the minds of those who create it. All worldviews are mediated by language and knowledge. The dominant language of society is the language of the rich and powerful and by virtue of owning the dominant language their point of view and their health is privileged.

Post-modernist theories veer (turn) away from all embracing theories such as those described above that attempt to explain all social phenomena. The term 'post-modern' also refers to a particular paradigm or worldview. In this case, what is being challenged is the certainty of our ***knowledge about the social world, the ability of sociological theory to uncover the 'truth' about the social world, and the desirability of this.***

This is manifest in such issues as self-monitoring and shaping of the body. The knowledge produced by science is "truth," and is eternal. Reason is the ultimate judge of what is true, and therefore of what is right, and what is good (what is legal and what is ethical). Freedom consists of obedience to the laws that conform to the knowledge discovered by reason. Rejection of totalizing theories; pursuit of localizing and contingent theories. **Skepticism of progress and they are have** anti-technology reactions and believe in new age religions or individual morality. Post modernist denies structure and agency dichotomy.

Thus, the emphasis within this particular approach is less on producing an all-embracing theory which explains all aspects of the social structure, and more on inquiring into *the nature of knowledge* itself. Foucault argued that in order to understand science and medicine we have to think about them as ‘**discourses**’ about the body, health and the natural world, rather than accepting these disciplines as objective descriptions of reality. The concept of discourse is an important one within contemporary sociology and represents a distinct way of thinking, seeing and conversing about particular phenomena, all of which create a virtual ‘arena’, ruling some ways of thinking as legitimate and others as not. Medicine is often described as a dominant *discourse* in relation to the study of health, disease and the body because western biomedicine has become the accepted, and therefore legitimate, way of thinking, talking about and seeing these aspects of human experience.

Post modernists believe that there is no one single explanation or theory and single institution or medicine to deal with health and illness, rather various alternatives should be uncovered which may not be discovered yet. For them there is no perfect knowledge yet to explain health and illness without any limitation.

Post modernist theory makes two main contributions to the study of health and disease: *first*, they are offered a way of challenging the dominance of medicine and questioning what appears to be scientific, true and objective. *Second*, they can appreciate the way in which knowledge discourses can be used to discipline us. According to Bilton et al. (1996), medicine cannot be seen, then, as merely and actively associated with clinical healing; ‘the medicalisation of the body has to be understood as a process of *social control*’ (Bilton et

al. 1996: 424). For example, the regulation of pregnancy and childbirth through the application of medical techniques and knowledge often results in the ***control and regulation of patients***.

3.5. Feminist theory

‘Feminism’ is a broad concept that explains social structures as fundamentally based on ***inequalities between women and men***.

Feminism is a set of theories & strategies for social change that take gender as their central focus in attempting to understand social institutions, processes, and relationships. Mainstream feminism holds the view that women suffer oppression & discrimination in a society run for men by men who have passed laws and created customs to perpetuate their privileged position. Gender and power rather than class and power are their center of analysis. Women poor health condition is a result of men exploitations and discrimination.

In general, feminist sociologists have challenged the traditional preoccupation of the discipline with the effects of industrialization and the world of paid work and institutional politics. Such an approach, it is argued, has ignored the significant elements of society such as the ***family and gender relationships***.

Feminist critics argued that the founding fathers of sociology (classical sociologist) were concerned with a narrow range of topics such as social class, the division of labor in industrial society and the role of the state and ignore the exploitative relationship. Industrialization influence specifically upon women, compared to men. It was assumed that the natural area of study for sociology was the ‘public’ world of paid work, politics and the state. Since these were also the areas where men were dominant, it was this aspect of the social world that came to be associated with them. Women, on the other hand, remained within the ‘private’ sphere of the home, family and unpaid work. The former sphere was clearly seen as open to change, while the latter was assumed unchanging and ‘natural’. The result of this conceptual split was an unquestioning acceptance of women and men as fundamentally different from one another and an assumption that these ***‘natural’ differences could not be distorted***. One rather controversial concept used to explain this inequality is that of ***‘patriarchy’, literally meaning the rule of men over women***. In terms of uncovering what is distinct about women’s lives as compared to men’s,

the concept of patriarchy provides a unique insight into many aspects of women's lives. Writers such as Oakley (1984) have argued that women's lives have been *subject to far greater control and regulation* by the medical profession than have men's. Particular examples can be seen in relation to pregnancy and childbirth, where what was previously seen as a 'natural' event attended by women, rapidly became the focus of medical intervention, and now principally takes place in hospital, with the profession of obstetrics being dominated by men.

3.6. Other approaches to health and illness

3.6.1. The Medical Ecological Perspective

This perspective focuses on the human biological and behavioral adaptations to diseases in different ecological and environmental contexts. Hence, diseases evolve in line with specific ecological niches, and people's responses to health problems have also evolved in the context of their specific local ecosystems (McElroy and Townsend, 1989).

3.6.2. Lay Theories of Illness Causation

Lay theories of illness causation have been widely studied in medical sociology/ anthropology and various classifications have been suggested. Young (1983) distinguishes internalizing and externalizing beliefs. **In an internalizing view**, as is the case in biomedicine, the origins of ill-health are mainly located within the individual: the responsibility for the illness fall either on the **patient (incorrect behaviour), or as the result of personal vulnerability**. *Externalizing beliefs attribute the causes of an illness episode to the natural world (natural, environment, climate, infections), to the social world (witchcraft, sorcery or the evil eye) or to the supernatural world (gods, spirits or ancestors)*. An externalizing perspective on illness is often expressed through a narrative account. The patient is able to tell 'story' about the events which eventually led to her or his sickness.

To sum up, theories of illness causation open the way to illness prevention. If one knows who or what causes a disease, one also has ideas on how to prevent it. Where a particular agent, an evil person or deity, is held responsible, people can take measures to protect themselves against her or his actions or to temper her or his anger. Where a disease is explained by bacteriological concepts, preventive action concentrates on stopping dangerous organisms from entering the body by improved hygiene and sanitation. Vaccination has become another major strategy to prevent the spread of disease.

Theory	Model of Society	Cause of Disease	Role of the Medical Profession
Marxist	Conflictual and Exploitative relationship	Putting profit and status ahead of health	To discipline and control the working class; and provide individualized explanations of disease
Parsonian	Basically harmonious and stable set of interlinked social demands of social roles and structures	Social strain caused by meeting the demands of social roles	Rehabilitate individuals to carry out their social roles
Foucaultian	A net of power relations, with no one dominant source-administered surveillance	'Diseases' are labels used to sort and segregate to make easier to control population	To enforce compliance with 'normal' social roles; and to ensure that we internalize these norms
Feminist	Exploitative and repressive of women through patriarchy	Carrying out the social role enforced by patriarchal men the medicalization of woman around her reproductive life cycle	To enforce conformity with patriarchal norms of femininity and motherhood

Table: summary of sociological theories in medical sociology

Chapter: Four

Prominent Figures in Medical Sociology

4.1. Max Weber

Max Weber is one of the early sociologists and proponent of medical sociology and developed the ideas of formal rationality and life style and he identified two types of life style.

1. Life conducts - self direction behavior.

2. Life chance - is the opportunities each individual has to improve his or her quality of life. The concept was introduced by German sociologist Max Weber. It is a probabilistic concept, describing how likely it is, given certain factors, that an individual's life will turn out a certain way. **It is also** a class position and associated with a person's probability of finding satisfaction of interests' wants and needs. Life chance is the chance that people have because of their social situation.

Life chances are structural but life conduct agencies and the two interact with other to shape life style outcomes.

Life conduct	life chance
Agency	Structure
A behavior/direction to drink, smoke, addiction	social situation such as, age ,gender , race, class circumstance, collectivity kinship

❖ In general the interaction between life chance and life conduct become cause for good bad implication for our health.

Max Weber formed a three-component theory of stratification in which social difference is determined by class, status, and power.

- **Class** is a person's economic position, based on birth and individual achievement.
- **Status** is one's social prestige or honor, which may or may not be influenced by class.
- **Power** The ability to get one's way even in the face of opposition to one's goals.

Social class is a strong social determinant of health.

- Social class is correlated to environmental hazards that increase one's risk of contracting a disease or sustaining an injury; low access to fresh produce, exercise facilities, and

preventative health programs are all environmental hazards that negatively impact health outcomes.

- Health inequality refers to the unequal distribution of environmental hazards and access to health services between demographic groups, including social classes, as well as to the disparate health outcomes experienced by these groups.
- In addition to environmental hazards, lower socioeconomic classes have lower levels of health insurance than the upper class. Much of this disparity can be explained by the tendency for lower status occupations to not provide benefits to employees.
- **Health inequality**= The unequal distribution of environmental health hazards and access to health services between demographic groups, including social classes.
- **Social determinants of health** =the economic and social conditions that influence individual and group differences in health status.
- **Environmental Hazards Risk factors**= related to social and economic conditions that may produce negative health outcomes, including pollution and distribution of grocery stores, for example.

A person's social class has a significant impact on their physical health, their ability to receive adequate medical care and nutrition, and their life expectancy. While gender and race play significant roles in explaining healthcare inequality, ***socioeconomic status (SES) is the greatest social determinant of an individual's health outcome***. Social determinants of health are the economic and social conditions that influence individual and group differences in health status. Social determinants are environmental, meaning that they are risk factors found in one's living and working conditions (including the distribution of income, wealth, influence, and power), **rather than individual factors (such as behavioral risk factors or genetics)**. Social determinants can be used to predict one's risk of contracting a disease or sustaining an injury, and can also indicate how vulnerable one is to the consequences of a disease or injury. Individuals of lower socioeconomic status have lower levels of overall health, less insurance coverage, and less access to adequate healthcare than those of higher SES.

Individuals with a low SES experience a wide array of health problems as a result of their economic position. They are unable to use healthcare as often as people of higher status and

when they do, it is often of lower quality. Additionally, people with low SES tend to experience a much higher rate of health issues than those of high SES. Many social scientists hypothesize that the higher rate of illness among those with low SES can be attributed to environmental hazards. For example, poorer neighborhoods tend to have fewer grocery stores and more fast food chains than wealthier neighborhoods, increasing nutrition problems and the risk of conditions, such as heart disease. Similarly, poorer neighborhoods tend to have fewer recreational facilities and higher crime rates than wealthier ones, which decrease the feasibility of routine exercise. In addition to having an increased level of illness, lower socioeconomic classes have lower levels of health insurance than the upper class.

Health inequality refers to the unequal distribution of environmental health hazards and access to health services between demographic groups, including social classes. For example, affluent/rich and urban communities are geographically close to each other and to hospitals. Still, the affluent communities are more likely to have access to fresh produce, recreational facilities for exercise, preventative healthcare programs, and routine medical visits. Consequently, affluent communities are likely to have better health outcomes than nearby impoverished ones. The role of socioeconomic status in determining access to healthcare results in health inequality between the upper, middle, and lower or working classes, with the higher classes having more positive health outcomes.

4.2. Pierre Bourdieu

A seminal study of the relationship between social class and health lifestyles was that of French sociologist Pierre Bourdieu (1984), who investigated class competition and reproduction, as expressed in cultural tastes and styles. Bourdieu analyzed eating habits and sports preferences that described how **a habitus, or class-based set of durable dispositions** to act in particular ways, shaped particular facets of health lifestyles. People from the same social class tended to share the same habitus, because they typically have the same life chances.

The working class enjoyed soccer, while people in the professions (upper middle class) liked tennis. As for food, the working class typically favored foods that were cheap, nutritious, and abundant, while professional people were more concerned about body image and opted for foods

that were light, tasty, and low in calories. Bourdieu formulated the notion of "**distance from necessity**" that is a key explanation of class differences in lifestyles. He found that the more distant a person is from foraging for economic necessity, the more freedom and time that person has to develop and refine personal tastes in line with a more privileged class status. Lower social strata, in turn, tend to adopt the tastes consistent with their class position, in which acquiring items of necessity like food and shelter is paramount.

4.3. Cockerham: A Theory of Health Lifestyles

Drawing upon the theoretical perspectives of Weber and Bourdieu, Cockerham has formulated theory of health lifestyles, encompassing a broad range of relevant variables. Four categories of social structural variables are listed that have the potential to shape health lifestyles: (1) class circumstances; (2) age, gender, and race/ethnicity; (3) collectivities; and (4) living conditions. The first category is class circumstances, which is the likely the most powerful influence on lifestyle forms.

The first category is class circumstances, which is the likely the most powerful influence on lifestyle forms. The lifestyles of the upper and upper-middle classes are the healthiest and those of the lower class the least healthy. Virtually every study confirms this. As for the second category, that of age, gender, and race/ethnicity, age affects health lifestyles because people tend to take better care of their health as they grow older. They do this by showing more careful food selection, more relaxation, and either abstinence or reduced use of tobacco and alcohol.

Gender is highly significant in that women eat more healthy foods, smoke less, visit doctors more often for preventive care, wear seat belts more frequently when they drive, and with the exception of exercise have more healthier lifestyles overall than men. Race and ethnicity are presumed to be important, but there is little research showing this is the case. Most studies on race address differences in morbidity and mortality rather than health lifestyle practices. These studies often suggest that racial disparities in health are largely but not exclusively determined by class position. Disadvantaged socioeconomic circumstances promote poor health among many racial and ethnic minorities, while those minorities of higher social standing have better health. Social class also exercises a powerful influence on age and gender, since adults on the higher

ranks of the social ladder have more effective health lifestyles, regardless of how old they are or whether they are male or female. Collectivities are collections of actors linked together through particular relationships, such as kinship, work, religion, and politics. Their shared norms, values, ideals, and social perspectives reflect a particular collective viewpoint capable of influencing the health lifestyles of their members. Religion is an example of such a collectivity. Several studies suggest that religious attitudes and behaviors can have a positive effect on numerous health-related activities. These include prohibitions on smoking, drinking, and multiple sexual relationships and the promotion of nutrition, hygiene, and exercise.

Living conditions are a category of structural variables pertaining to differences in the quality of housing and access to basic utilities (electricity, gas, heating, sewers, safe piped water), neighborhood facilities (grocery stores, parks, recreation), and personal safety. To date there has been little research linking living conditions to health lifestyles but the connection is important. Mildred Blaxter found, in her nationwide British survey, that the conditions within which a person lives can have either a positive or negative impact on implementing a healthy lifestyle. Although socioeconomic status is perhaps the major factor in lifestyle selection and participation, it is not the sole determinant of lifestyles. Since Weber's time, other research has shown that more is involved in lifestyle selection than social class, and this generalization is particularly true of health lifestyles. What is suggested by these findings is that any concept of health lifestyles needs to go beyond an emphasis on socioeconomic status and consider other variables that influence health practices.

4.4. Talcott Parson

An alternative analysis of medicine is provided by Talcott Parsons, who argued that modern societies, while having a capitalist economy, have non-capitalist social structures. He argues that the medical profession is one such structure. Medical professionals are motivated by factors other than making money, such as caring for their patients. They perform a key noneconomic function by acting in the interests of the whole community, treating individuals specifically for their disease, without passing judgment on them, and utilizing the best of scientific knowledge. They are, if you like, a balance to the fly-wheel of competitive capitalism in which the market would otherwise run over individuals. At the same time, Parsons goes on to make the important

point ***that medicine is a major institution for controlling deviance in modern societies***. It is not just a benign institution based on scientific care, but acts to check the deviant tendencies of individuals, who otherwise might try to escape their social roles. Parsons argues that the strains of modern life may be so great as to drive people into the sick role to escape their normal responsibilities, and this tendency needs to be checked. So while he has a more favorable perspective on medicine than the *Marxist*, *he still sees it as performing a social function that is beyond its claim to be the purely scientific treatment of disease*. Parsons' analysis shows how the medical profession acts to control motivated deviance and provides an account of illness as a response to social strain. Parsons' concept of the sick role is a very useful concept for problematizing the idea of disease as natural and biological, but is limited in its focus on acute illness episodes/problems. Overall, Parsons' 'consensus' focus on modern societies as stable is not as true as it appeared to him, writing in the 1950s. Neither is his picture of the altruistic workings of the medical profession as persuasive as it might once have been.

4.5. Erving Goffman

Goffman's main contribution to Sociology has been his treatment of the interaction order as a distinct unit of analysis .dramaturgy, everyday life, the back and the front stage, asylum, total institution, mental health in the interaction Order. The practice of medicine was not just the application of scientifically factual and value-free techniques. Erving Goffman's book *Asylums* (1961) opened up the **critique of medicine as a value-loaded system of social control operating under the guise of science**.

Asylums were a key text in the development of deinstitutionalization which explains the first sociological examinations of the social situation of mental patients, the hospital. Based on his participant observation field work, Goffman's theory of the "total institution both classes of people know their function and social role in the total institution. In *Asylums*, Goffman is mainly engrossed with the details of having been hospitalized to a psychiatric hospital and the nature and effects of the process he defines as 'institutionalization'. He describes how the institutionalization process socializes people into the role of a good patient, someone harmless and inconspicuous', which in turn **reinforces** notions of chronicity in **severe mental illness**. A basic process of Goffman's asylums is mortification (degradation) of self. A patient's notions of

self are subjected to a dramatic change for the worse due to the debilitating atmosphere in all total institutions, regardless of how therapeutic or non-therapeutic a hospital is. While people come from a social context in which they have some sense of a personal identity and **occupy different roles**, these aspects of their lives are systematically **stripped** from them as their sense of themselves are mortified, pathologized and negated, leading to what Goffman defines as **disculturation**.

Rather than curing or reducing the illness, this process leads to demoralization, skill deterioration and role dispossession and renders people less capable of managing life in the outward world. In addition to disculturation from their identity and previous roles, acculturating inmates to life in a total institution does little, if anything, in preparing them for the contingencies they will encounter once again after discharge and prepares them only for remaining within the setting.

Goffman concludes from his investigation that taking a mentally ill person out of his or her life context, hospitalizing him or her to a psychiatric hospital and then returning the person to the same life context is similar to taking a drowning man out of a lake, teaching him how to ride a bicycle and putting him back into the lake. Human needs are handled in an impersonal and bureaucratic mode. The social distance between the staff and inmates is great, and each group tends to be unfriendly toward the other.

Deinstitutionalization is the process of replacing long-stay psychiatric hospitals with less isolated community mental health services for those diagnosed with a mental disorder or developmental disability. Deinstitutionalization works in two ways: the first focuses on reducing the population size of mental institutions by releasing patients, shortening stays, and reducing both admissions and readmission rates; the second focuses on reforming mental hospitals' institutional processes so as to reduce or eliminate reinforcement of dependency, hopelessness, learned helplessness, and other maladaptive behaviors.

4.6. Michel Foucault

In analyzing the development of French medicine at this time, social theorist Michel Foucault (1973) noted the emergence of two distinct trends in medical practice what he called "**medicine**

of the species" and **"medicine of social spaces."** Medicine of the species pertained to the strong emphasis in Western medicine upon classifying diseases, diagnosing and treating patients, and finding cures. The human body became an object of study and observation in order that physiological processes could be demystified and brought under medical control. Physicians perfected their so-called clinical gaze, allowing them to observe and perceive bodily functions and dysfunctions within a standardized frame of reference. Clinics were established both to treat patients and train doctors, with the clinic providing the optimal setting for physicians to exercise authority and control over their patients. The medicine of social spaces was concerned not with curing diseases, but preventing them. Prevention required greater government involvement in regulating the conduct of daily life-especially public hygiene. Physicians served as advisers in the enactment of laws and regulations specifying standards for food, water, and the disposal of wastes. The health of the human body thus became a subject of regulation by medical doctors and civil authorities, as social norms for healthy behavior became more widely established. In such a context, Foucault found that scientific concepts of disease had replaced notions that sickness had metaphysical (religious, magical, superstitious) origins. Disease was no longer considered an entity outside of the existing boundaries of knowledge, but an object to be studied, confronted scientifically, and controlled. Awareness that disease could be caused by unhealthy social conditions and lifestyles spread through common sense and practical experience.

It is with the development of the category of disease, the product of the *professionalization of medicine*, that Foucault is concerned. Michel Foucault calls attention to another important aspect of modern society: it is an administered society, in which professional groups define categories of people – the sick, the insane, the criminal, the deviant – on behalf of an administrative state. For Foucault, medicine is a product of the administrative state, policing normal behavior, and using credentialed professionals to enforce compliance with the ‘normal’. Modern society is a version of **Max Weber’s Iron Cage**, in which the profession (and its disease categories) provides a totalizing surveillance of citizens. Foucault also makes the important point that most of us, most of the time, have internalized these norms of behaviour and rarely require the services of the helping professionals. As will be seen, his argument raises serious questions for the Marxist and the feminist positions. For feminists modern society is patriarchal and men wield power over women who are forced to comply with men’s definitions of how they should appear and perform. However, Foucault’s theory of power emphasizes its diffuseness and the

willingness of most of us – men and women – most of the time to comply with societal norms. Equally Foucault's argument challenges Marxist accounts that focus on power as centralized in the hands of the capitalist class. For Foucault power is not the property of any one group, whether based in class relationships or patriarchy. The usefulness of Foucault's position is the way in which he historically locates medical knowledge, especially allowing for the development of the sociology of the body. By showing how the body is historically constructed, Foucault has been appropriated and extended by feminists who show that it is the construction of gender specific bodies that needs analysis.

4.6.1. Sociology of the body

Sociology of the body is the study of the representations and social use of human body in modern society. It is these professional and institutional developments of the nineteenth century, Foucault argues, that show the 'body' as a transient social and cultural artifact, and not a part of nature. In the context of medical thought, Foucault argues that the crucial concepts of the body and disease must be seen as historical products. Foucault gives special attention to the body because it is centrally located in the disciplines of criminology (atavists or born criminals by Lombroso known criminologist who tried to identify crimples by their physical shape, medicine and sexology. As a consequence of its location in these fields of power/knowledge we experience ourselves as subjects and as objects. Put another way, we have an image of our own body, and we are a body. This distinction has been captured in German by two distinct words. 'Leib' is our lived body, and 'Körper' is our physical body (Schilder, 1950). So the paradox is that the perception of our body is fundamental to our sense of self image, but as an object it is what connects us with others by its shared status as black, white, male, female, as the body of a child, a youth or an elderly person. The body is important in the analysis of health for example diet, physical exercise, shape, obesity, self hygiene, smoking, plastic surgery, transplanting organs, child preferences and others directly or indirectly individuals and society which in turn have an impact on health.

Foucault identifies two periods in the conceptualization and control of the body, the transition between them involving a process in which legal and medical transformations are interlinked. These two periods are clearly dependent on Durkheim's distinction between mechanical and

organic types of solidarity. Foucault argues that the medicine of the sixteenth and seventeenth centuries produced an anatomico-metaphysical register of the body. By and large sickness, insanity and criminality were not distinguished. The sole aim of ‘therapy’ was to physically discipline the body through incarceration, bleeding and leeching, to force it back to ‘normality’. Under a system of retributive justice the focus was on the physical breaking of the body to enforce conformity and obedience, in a society characterized by centralized power.

Modern medicine, however, produces a technico-political register of the body for submission and use. Rather than breaking the body, the aim is rehabilitation of the body/mind through the regulations of the factory, the prison, the hospital and the asylum. The body has been reconstructed: ‘a materialist reduction of the soul and a general theory of dressage, at the centre of which reigns the notion of docility which joins the analyzable body to the manipulable body’ (Foucault 1977). Under a system of restitutive justice the focus is on the moral reintegration of the individual by specialized institutions and workers – hospitals, prisons and asylums, doctors, criminologists, sociologists and psychiatrists. At the centre is the internalization of scientific concepts of ‘health’ and ‘normality’, which are administered by professional groups on the basis of their claim to scientific knowledge. But precisely because the ***body is the site of social, political, economic and gender struggles to construct it, it is also the site of opposition to that structuring.*** Our bodies are socially constructed within the context of class, gender and ethnicity, and therefore reflect the structures of legitimation and domination of these constructs.

Chapter: Five

The Social Context of Health

Health is resource /value/ which is not evenly distributed. As our good health depends on the context of our lives, praising or criticizing people for their good or bad health is wrong. Most of the factors that contribute towards our good or bad health are out of our control.

Epidemiology- the study of distribution, origin and disparities of disease by collecting scientific and relevant data from sources for uncover health problems. The primary concern of epidemiologists is not individual rather a group.

Cause - refers to an instance of disorder illness or injury involving a person.

Incidence – the numbers of new cause of health problem in population during a certain period of time.

Prevalence - the previous and the new cause incidence rate of a health condition in a certain area.

Morbidity -refers to the perceived frequency of a health problem as has happened to people. It is subjected to statistical sources because health problem data took from hospital but most people who face for health problem may not get medical examination .women have high morbidity than men because they frequently visit hospitals.

5.1. The development and recognition of social cause of illness

Primitive humans were closer to the animals in that they, too, relied upon their instincts to stay healthy. Yet some primitive humans recognized a cause and effect relationship between doing certain things and alleviating symptoms of a disease or improving the condition of a wound. Since there was so much that primitive humans did not understand about the functioning of the body, magic became an integral component of the beliefs about the causes and cures of health disorders. In fact, an uncritical acceptance of magic and the supernatural pervaded practically

every aspect of primitive life. So it is not surprising that early humans thought that illness was caused by evil spirits. Primitive medicines made from vegetables or animals were invariably used in combination with some form of ritual to expel the harmful spirit from a diseased body. During the Neolithic age, people living in what is today the Eastern Mediterranean and North Africa, are known to have even engaged in a surgical procedure called trepanation or trephining, which consists of a hole being bored in the skull in order to liberate the evil spirit supposedly contained in a person's head. The finding by anthropologists of more than one hole in some skulls and the lack of signs of osteomyelitis (erosion of bone tissue) suggest that the operation was not always fatal. Some estimates indicate that the mortality rate from trepanation was low, an amazing accomplishment considering the difficulty of the procedure and the crude conditions under which it must have been performed.

One of the earliest attempts in the Western world to formulate principles of health care, based upon rational thought and the rejection of supernatural phenomena, is found in the work of the **Greek physician Hippocrates**. One of his most famous contributions, the **Hippocratic Oath, is the foundation of contemporary medical ethics**. Among other things, it requires the physician to swear that he or she will help the sick, refrain from intentional wrongdoing or harm, and keep confidential all matters pertaining to the doctor-patient relationship. Hippocrates also argued that medical knowledge should be derived from an understanding of the natural sciences and the logic of cause and effect relationships. *Hippocrates pointed out that human well-being is influenced by the totality of environmental factors: living habits or lifestyle, climate, topography of the land, and the quality of air, water, and food.* Concerns about health in relation to living habits, lifestyles, and the quality of air, water, and places are still very much with us today. In their intellectual orientation toward disease, Hippocrates and the ancient Greeks held views that were more in line with contemporary thinking about health than was found in the Middle Ages and the Renaissance. Much of the medical knowledge of the ancient world was lost during the Dark Ages that descended on Europe after the fall of the Roman Empire. The knowledge that survived in the West was largely preserved by the Catholic Church. The church took responsibility for dealing with mental suffering and adverse social conditions such as poverty, while physicians focused more or less exclusively on treating physical ailments.

Modern medicine traces its birth to Western Europe in the late eighteenth century. The human body was regarded as a machine-like entity that operated according to principles of physics and chemistry. The result was that both Western religion and medical science sponsored the idea "of the body as a machine, of disease as a breakdown of the machine, and of the doctor's task as repair of the machine" (Engle 1977). In analyzing the development of French medicine at this time, social theorist Michel Foucault (1973) noted the emergence of two distinct trends in medical practice what he called "**medicine of the species**" and "**medicine of social spaces.**" (*For detail refer chapter 4 section 4.6*). The health of the human body became a subject of regulation by medical doctors and civil authorities, as social norms for healthy behavior became more widely established and awareness that disease could be caused by unhealthy social conditions and lifestyles spread through common sense and practical experience. A most significant development occurred when it was realized that uncontaminated food, water, and air, as well as sanitary living conditions, could reduce the onset and spread of communicable diseases. Prior to the advent of modern medicine, high mortality rates from communicable diseases such as typhus, tuberculosis, scarlet fever, measles, and cholera were significantly lowered through improved hygiene and sanitation. Thus, the late eighteenth and early nineteenth centuries are conspicuous for the systematic implementation of public health measures. Noting the link between social conditions, lifestyles, and health, some nineteenth-century physicians argued that improvement was necessary in the living situations of the poor. They advocated governmental recognition of the social as well as medical nature of measures undertaken to promote health.

By the late 1960s, polio and smallpox were largely eradicated and infectious diseases had been severely curtailed in most regions of the world. This situation produced a major change in the pattern of diseases, with chronic illnesses-which by definition are long-term and incurable-replacing infectious diseases as the major threats to health. This "**epidemiological transition**" occurred initially in industrialized nations and then spread throughout the world. It is characterized by the emergence of chronic diseases such as cancer, heart disease, and stroke as the leading causes of death. **Despite the vast sums spent on cancer research, no magic bullet** has been found to cure it. As for heart disease, coronary heart disease had become the leading cause of death in Western society with the aging of the population. "Public understanding of risk

factors-smoking, diet, obesity, lack of exercise-improved, and lifestyle shifts made a fundamental contribution to solving the problem and the recognition of social, cultural, economic and political causes of diseases highly recognized. Many of the most respected figures in medicine were insistent that treating the body as a mechanical model would not produce true health. Porter describes the situation as follows: *Diseases became conceptualized after 1900 as a social no less than a biological phenomenon, to be understood statistically, sociologically, and psychologically even politically. Medicine's gaze had to incorporate wider questions of income, lifestyle, diet, habit, employment, education and family structure-in short, the entire psychosocial economy. Only thus could medicine meet the challenges of mass society, supplanting laboratory medicine preoccupied with minute investigation of lesions but indifferent as to how they got there.* Lifestyles and social behavior play an important role in the transmission of infection, in sexual activities, drug use, travel, dietary habits, and living situations. Therefore, the study of social factors relevant to the prevention and spread of infectious diseases is likely to take on increased importance for medical sociologists in the twenty-first century. Among the social context of health some basic concepts will be discussed next.

5.2. Age and Health

Definition: *In the context of health and medicine, age is a property of human individuals and groups that denotes the duration of the life span since birth and the membership of a specific cohort or generation. Sociologists concerned with aging usually work in social gerontology⁷, a subfield of gerontology that deals primarily with the nonphysical aspects of aging.*

As the nineteenth century epidemiologists observed, overall mortality is closely related to age. It is not however a simple linear relationship but rather a lopsided 'U'-- curve. This is because mortality is still, despite major improvements since the nineteenth century, relatively high in infants under one year old; mortality then declines rapidly before picking up again in middle age and rising steeply in the elderly. In keeping with this distribution of all deaths, many specific causes of death are similarly closely related with increasing age. For example, cancer and ischemic heart disease, the major causes of death in the Western World, are much more common

⁷ Social **gerontology deals** primarily with the nonphysical aspects of aging and the ways in which the elderly adjust to their society and how society adapts to the elderly.

in the elderly than in the young. On the other hand, some diseases stand out as being only found in younger age groups: for example, certain leukemia's are mostly found in childhood. This pattern for mortality and its link with age is therefore clear-cut. There is similar supportive evidence to suggest that morbidity in general is closely linked with age. The elderly report more illnesses; in studies of the prevalence of chronic illness. However, it is possible to argue that ageing is also a socio-cultural process, and some of the health problems of older people relate to the social process of ageing rather than biological. Support for this argument can be obtained from three sources:

- A. The massive improvement in overall life expectancy over the last century or so suggests that many deaths are not as biologically inevitable as once believed. It is now known that one of the prime determinants of infant mortality is not the fixed biological nature of the infant, but rather its environment. **Improvements to standard of living**, such as have occurred since the nineteenth century, have also reduced infant mortality. Similarly many of the diseases of ageing have been shown to have environmental/social causes. It has been calculated that up to 80% of all cancers are environmentally produced. Smoking diet exercise, etc, have all been implicated in ischemic heart disease which is highly correlated with age. All of these factors suggest that the biological decline of the body is not as fixed as it was assumed and it would appear that social factors play a part in the illnesses of ageing as much as biological.
- B. There is evidence that many of the so-called biological changes with ageing **are in fact culturally specific**. In other words, the biological changes known to accompany ageing in our societies are not found in other societies. For example, blood pressure is known to increase with age--in some people excessively, for example in urban areas so, producing hypertension; but in other societies there is no increase with age. Therefore, it is possible that many of the changes which have so far been accepted as inevitable are in fact the product of environmental conditions in our society.
- C. The final piece of evidence which suggests that ageing has a social component as well as a biological one is the specific way our culture treats old people. Several years ago there was a theory that elderly people gradually disengage from social life. In part, this was believed to be due to biological changes which prevented them from participating fully in usual activities, and in part because of their desire to leave the hurry and bustle of everyday life. In

retrospect this theory is now seen to be mistaken, and it is possible that many old people were **'disengaged' whether they wanted to or not.** As labeling theory suggests, treating old people as if they were disengaging is likely to produce the very phenomenon that it predicts. From appear that this forcible disengagement might have had damaging effects on their health. In the way it can be seen that it is not only the biological make-up, which then affect the social reaction to and treatment of old people and , in its turn, their illnesses.

5.3. Health Gender

Definition: *Gender relates to culturally appropriate behavior of men and women, whereas sex refers to biological differences.* ; There are two major gender differences in health statues in our society which seem to be contradictory.

1. The mortality experience of men is far worse than women, women living on average about seven years longer than men.
2. The morbidity of women seems to be higher than that of men. Measuring morbidity is difficult, but according to at least three measures, namely surveys of self-reported illness, data on using health services (which is probably an acceptable indicator given that availability of services is relatively constant in any compatriots between the sexes), and some morbidity a surveys, women have more illnesses than men.

Let us see some explanations about gender and health disparities

1. **Genetic explanation**:-it is a biological difference most of the time women face a problem like pregnancy related disease including cervical cancer and male infants is weaker but can live longer and suffer from problem associated with aging like;

---- Arthritics

----Testicular cancer

2. **Stress explanation**:-stress is a major cause of illness. Women which is employed they become stressed in both outside and house hold activities. Most of the time if they are lonely, isolated, poor rewarded they find triple shift double worker and fail for stress which leads to illness.
3. **Cultural behavioral explanation**:- this explained what men and women do most of the time. Men have risk taking behavior and they are neglected in terms of habit and diet. They chose not

to consult doctor they ignore their sickness most of the time less morbidity for women is examined in this explanation.

4. **Structural materialism**:-focus on structural factors role and responsibilities. Most women accept child care poor payment and condition more exposure to poverty and poor housing condition among single women and single mother for example as a house maid daily laborer which has less payment in constriction so women have more mortality rate than men.

In summary, women get ill but men died. How is this apparent contradiction to be explained? *First* it is important to stress that the explanation is likely to be a social one. There are some diseases which are linked to sex chromosome which are specific to biological sex differences, but most diseases occur in both men and women. Even a possible protective hormonal balance for women is challenged by the continuation of preferential survival after the menopause. In addition there is cross-cultural evidence of different patterns of disease between the sexes (in which it is the men who seem to get more illnesses and women who have shorter life expectancy) which also challenges the view that their diseases are biologically fixed. This leaves various possible explanations for the higher illness rate in women and higher mortality rate in men. One possibility of this contradiction is that the types of illnesses suffered by men and women are different. Diseases which cause death are different from the disease which causes non-fatal illnesses; men may have more of the former and women more of later. But why should this be so? Some of the apparent excess morbidity amongst women may be a product of a related lowered illness threshold and greater propensity to report illness either in health surveys or in terms of visiting the doctor.

Even so, it can be argued that this increased reporting of illness is itself part of the some problem, namely a greater awareness of poorer health. It has been argued that the disease which causes death, in particular heart disease and cancer, are closely linked with male lifestyle in our society. Men seem to be more competitive, aggressive and rushed: they therefore are more likely to indulge in health-harming activities-smoking, alcohol, bad diet, etc. -- as a coping response, and this, combined with the direct effect of these stressors, leads to a higher incidence of fatal disease. Women on the other hand have different sorts of stressors. Their traditional role is more passive and dependent, and their subsidiary social position often engenders low self-esteem. Taken together these aspects of women's social position may produce many minor illnesses, particularly psychiatric. If women had the same occupational and social environments as men –

which can be examined by comparing men and women in similar jobs and circumstances – then their rate of minor psychiatric disturbance is no worse than that of men. However it is not simply a question of having paid jobs if domestic responsibilities remain a major part of a women's role. Women in paid employment do seem to have better health, but only if over 40 years of age or without children; young mothers with fulltime work have worse health unless they have access to adequate resources to help cope with their multiple roles. Neither of these gender roles is fixed -- nor necessarily acceptable. Male life style which produces high mortality needs examining; women's life style which produces feelings of illness also needs addressing. In part the women's movement of the last few decades has played an important role in identifying gender differences, but it is not simply a case of female emancipation in the labor force, because if followed through this would produce female mortality rates to rival those of men. Some indication of the latter may be seen in the rising prevalence of smoking amongst women and the subsequent increase in heart diseases and lung cancer which beginning to make its appearance.

5.4. Race, Ethnicity and Health

Race

It is a color difference while ethnicity is cultural difference. There are some explanations about health disparities in health due to race.

Explanation

1. Genetic Argument

Focused on in biological disorder that is sickle cell anemia and blood disorder are causes of illness disparities due to genetically differences.

2. **Cultural explanations:** Includes such as diet, life style, beliefs and attitudes toward health care .Among Asian there are high rate of still birth and infant mortality than American.

3. Social class factors;-

Many ethnic is minorities are affected by mental health problem due to unemployment and worked in lower paid and highly hazardous work conditions. This leads high morbidity and mortality rate.

4. **Racism** – discriminatory social relationship based on racial identity racial minorities are concentrated in alienating and unrewarded jobs. They are paid less than they deserve and they become poor and unable to pay for health expenses’ and they live in less quality housing.

Ethnic minorities are highly attacked by abuse and unequal access for medical services in some ethnic groups. Organized medicine is both shaped by and shapes racism.

Ethnicity

Definition: *Ethnicity refers to the identification with a social group – membership of a collectivity – on the basis of shared values, beliefs, customs, traditions, language and lifestyles*

One of the ways in which erstwhile/former ‘racial’ groups have been able to fight for political recognition is through their ‘ethnic’ identity. Thus the argument is that race, grounded in a claimed biological reality, is in fact an ideological tool of oppression, while ‘ethnicity’, grounded in a political process of self-claiming and political mobilization is empowering. It has also become possible for members of ethnic groups to establish special cases of vulnerability for themselves in terms of disease, to appeal for resources and then health-care services. It is also true that this appeal to ethnicity challenges biological models of disease by drawing attention to the cultural and social aspects both of the causes of disease and of ways of dealing with disease.

For example, **Aboriginality in Australia, ‘Race’ and Disease** life expectancy at birth is nearly 15 years shorter for Aboriginal peoples. When they get sick Aborigines die at a greater rate than non-Aborigines, even of easily treated diseases. Poverty and ethnicity combine in aboriginality to produce chronic disease and early death.

5.5. Socio -economic status

Socioeconomic status typically consists of measures of income, occupational status or prestige, and level of education. Although interrelated, each of these measures reflects different dimensions of a person's position in the class structure of a society. In studies of health and illness, income reflects spending power, housing, diet, and medical care. Occupation measures status, responsibility, physical activity, and health risks associated with work. Education is indicative of a person's skills for acquiring positive social, psychological, and economic resources.

- **Socioeconomic status** - the higher a person's socioeconomic status is, the more likely he/she is to enjoy good health.
- **Education** - people with lower levels of education generally have a higher risk of experiencing poorer health. Their levels of stress will most likely be higher, compared to people with higher academic qualifications. A person with a high level of education will probably have greater self-esteem...
- **Job prospects and employment conditions** - if you have a job, statistics show you are more likely to enjoy better health than people who are unemployed. If you have some control over your working conditions your health will benefit too.

Explanations about health variations:-

1. Behavioral and cultural explanation

This explanation view that ill health condition is the result of un healthy life style such as the life style of working class which involves smoking, drinking and unbalanced diet.

2. The material explanations

This explanation mainly focuses on the availability of resources such as income to maintain once health condition and examines the occupational structure of poor which is risky.

In general, Good health= income +occupation+ education

5.6. Social Support

Social support refers to those aspects of social relationships that provide a sense of self-worth and offer resources in tackling life's troubles.

When exploring the links between social processes and health, it is often useful to distinguish between cause and context. A host of social factors can be associated with health and illness - marriage, social class, gender, ethnicity and age, to name but a few - but whether such variables can be shown to play a causal role in the occurrence of health and illness, or whether they act as important contexts in which, health and illness can be better understood is not always clear. In a wide-ranging review of social relationships and health, Berkman et al. (2000) argue that social support acts as a powerful mediating factor in a range of physical and mental health problems. The origin of the concept comes partly from Durkheim's emphasis' on the role of social integration (or the lack of it) in his study of suicide. Social integration can operate at a number of levels, from whole societies to local communities.

In the context of health research, social support is defined by Berkman et al. as having four dimensions. First, there are instrumental forms of support involving practical help in solving life's daily problems from helping with domestic chores to financial matters. Second, informational support relates to the 'provision of advice or information in the service of particular needs. Third, appraisal support is often likely to flow from the provision or sharing of information, and refers to the way in which decision-making is carried out and courses of action agreed upon. Finally, and perhaps most importantly, there is emotional support. A core component of social support involves being valued and loved. Berkman et al. argue that sources of self-esteem, through love and understanding are essential to health outcomes. Such support is likely to be the result of an intimate relationship though it may also come from wide circle of confidants and friend. Generally, evidence for the causal influence of social support on promoting good health has been adduced in a number of studies.

Chapter six

Health behavior and illness behavior

6.1 Health Behavior

Is any activity undertaken by an individual, regardless of actual or perceived health status, for the purpose of promoting, protecting or maintaining health, whether or not such behavior is objectively effective towards that end or not.

It is possible to argue that almost every behavior or activity by an individual has an impact on health status. In this context it is useful to distinguish between behaviors which are purposefully adopted to promote or protect health (as in the definition above), and those which may be adopted regardless of consequences to health. Health behaviors are distinguished from risk behaviors which are defined separately as behaviors associated with increased susceptibility to a specific cause of ill-health. Health behaviors and risk behaviors are often related in clusters in a more complex pattern of behaviors referred to as lifestyle. Some common health behaviors are exercising regularly, eating a balanced diet, and obtaining necessary inoculations. It also includes combination of knowledge, practices, and attitudes that together contribute to motivate the actions we take regarding health.

Gochman defined health behavior as "those personal attributes such as beliefs, expectations, motives, values, perceptions, and other cognitive elements; personality characteristics, including affective and emotional states and traits; and overt behavior patterns, actions, and habits that relate to health maintenance, to health restoration, and to health improvement."

Interestingly, this definition emphasizes the actions and the health of individuals. A public health perspective, in contrast, is concerned with individuals as part of a larger community. These perspectives are interrelated, as the behaviors of individuals determine many of the social conditions that affect all people's health.

Gochman's definition is consistent with the definitions of specific categories of overt health behavior containing three categories of health behavior:

1. **Preventive health behavior** involves any activity undertaken by individuals who believe themselves to be healthy for the purpose of preventing or detecting illness in a asymptomatic state. This can include self-protective behavior, which is an action intended to confer protection from potential harm, such as wearing a helmet when riding a bicycle, using seat belts, or wearing a condom during sexual activity. Self-protective behavior is also known as cautious behavior.
2. **Illness behavior** is any activity undertaken by individuals who perceive themselves to be ill for the purpose of defining their state of health, and discovering a suitable remedy.
3. **Sick-role behavior** involves any activity undertaken by those who consider themselves to be ill for the purpose of getting well. It includes receiving treatment from medical providers, generally involves a whole range of dependent behaviors, and leads to some degree of exemption from one's usual responsibilities.

6.2. Health Behavior and Lifestyles

The focus in medical sociology is not on the health behavior of an individual, but on the transformation of this behavior into its collective form-health lifestyles. Health lifestyles are collective patterns of health-related behavior based on choices from options available to people according to their life chances. A person's life chances are largely determined by his or her class position that either enables or constrains health lifestyle choices. The behaviors that are generated from these choices can have either positive or negative consequences on body and mind, but nonetheless form an overall pattern of health practices that constitute a lifestyle. Health lifestyles include contact with medical professionals for checkups and preventive care, but the majority of activities take place outside the health care delivery system. These activities typically consist of choices and practices, influenced by the individual's probabilities for realizing them, that range from brushing one's teeth and using automobile seat belts to relaxing. For most people, health lifestyles involve decisions about food, exercise, relaxation, personal hygiene, risk of accidents, coping with stress, smoking, alcohol and drug use, as well as having physical checkups. According to the World Health Organization (WHO) *the first 60 years of the twentieth century was the "medical era," in which the dominant approach to health was mass vaccination and the extensive use of antibiotics to combat infection. At present, however, WHO suggests that*

advanced societies are entering into a "post medical era" in which physical well-being is largely undermined by social and environmental factors.

These factors include certain types of individual behavior (smoking, overeating), failures of social organization (loneliness), economic factors (poverty), and the physical environment (pollution) that are not amenable to direct improvement by medicine. WHO concludes: "Whereas in the 'medical era' health policy has been concerned mainly with how medical care is to be provided and paid for, in the new 'post-medical' era it will focus on the attainment of good health and well-being."

Question: The role of health lifestyles as a means to improve the health of people in a post-medical situation is gaining in significance as the twenty first century begins. Why?

Roben Crawford (1984) helps us to understand why health lifestyles as a means to improve the health of people in a post-medical situation is gaining significance. First, as Crawford points out, there has been a growing recognition among the general public that the major disease patterns have changed from acute or infectious illnesses to chronic diseases-like heart disease, cancer, and diabetes-that medicine cannot cure. Second, numerous health problems, such as AIDS and cigarette-induced lung cancer, are caused by particular styles of living. Third, there has been a virtual campaign by the mass media and health care providers, emphasizing lifestyle change and individual responsibility for health. The result has been a growing awareness that medicine is no longer the automatic answer to dealing with all threats to one's health. Therefore, strategies on the part of individuals to adopt a-healthier lifestyle have gained in popularity. As Crawford explains when threats to health persist in the environment and medicine cannot provide a cure, self-control over the range of personal behaviors that affect health is the only remaining option. This means the person will be confronted with the decision to acquire or maintain a healthy lifestyle, or disregard the situation and perhaps be at greater risk for poor health.

6.3. Health Care Utilization Behavior

Health care utilization is the use of health services, whether it is clinical public health services or the services of medical care professionals. Health care utilization behavior is a continuum that ranges from using preventive services, such as getting immunizations or early detection and

screening tests, to elective surgery or involuntary hospitalization after an injury. Health care utilization is influenced by many different factors, and therefore the study of utilization behavior includes examining who uses medical services, when and why they use these services, and how satisfied they are with the services. Because health care utilization behaviors, like lifestyle behaviors, are quite complex, various factors need to be examined to understand them. A framework for understanding these factors that has been widely used is the model devised are health belief model and socio behavioral model.

6.3.1. Health Belief Model

The Health Belief Model (HBM) is a psychological model that attempts to explain and predict health behaviors. This is done by focusing on the attitudes and beliefs of individuals. It originally developed in the 1950s, and updated in the 1980s, it is based on the theory that a person's willingness to change their health behaviors is primarily due to the following factors.

- A. **Perceived Susceptibility:** People will not change their health behaviors unless they believe that they are at risk.
- B. **Perceived Severity:** The probability that a person will change his/her health behaviors to avoid a consequence depends on how serious he or she considers the consequence to be.
- C. **Perceived Benefits:** It's difficult to convince people to change a behavior if there isn't something in it for them.
- D. **Perceived Barriers:** One of the major reasons people doesn't change their health behaviors is that they think that doing so is going to be hard. Sometimes it's not just a matter of physical difficulty, but social difficulty as well. Changing your health behaviors can cost effort, money, and time.

The Health Belief Model, however, is realistic. It recognizes the fact that sometimes wanting to change a health behavior isn't enough to actually make someone do it, and incorporates two more elements into its estimations about what it actually takes to get an individual to make the leap. These two elements are *cues to action* and self efficacy.

6.3.2. Andersen's Socio-Behavioral Model of Health Service Utilization

The most common framework used to understand access to health care, health care seeking behavior and health care utilization is the behavioral model of health services use, also known as

the socio-behavioral model of the Andersen model that developed in the 1968 by Ronald Andersen (Andersen 1968 cited in Derose *et al.* 2011). According to Andersen (1973), socio-behavioral model considers an individual's use of health care services to be a function of three types of factors: First, predisposing factors represent the tendency to utilize health care services where an individual is more or less likely to use health care services based on demographics, position within the social structure, and values and beliefs of health services benefits. An individual who believes health care services are useful for treatment will likely utilize those services. Second, are the enabling factors, which include resources that found within the household and the community including health insurances. Family resources comprise economic status and the location of residence and community resources incorporate access to health care facilities and the availability of persons for financial support. Third are need-based factors, which include the perception of need for healthcare services, whether individual, social, or clinically evaluated perceptions of need. For example, need for acute and chronic illness.

6.4. Illness Behavior

Illness behavior refers to the way in which people define and interpret their symptoms and the actions they take in seeking help. One of the first sociologists to discuss illness as a social behavior was Talcott Parsons (1951). Parsons suggested that for illness not to disrupt society's ability to function efficiently and effectively, a specific 'sick role' was necessary. Within the sick role the patient has an obligation to seek and be receptive to medical advice and treatment and, in return, they will be identified as 'sick' and released from their usual duties within society. In turn, doctors are placed in a position of authority, with the expectation that they will provide appropriate health care.

6.5. Doctor- patient relationship and the sick role

It refers to the set of rights and obligations that surround illness and shape the behavior of doctors and patients.

The **sick role**, one of the most fundamental concepts in medical sociology, was first introduced by Talcott Parsons in a 1948 journal article but elaborated in his 1951 book, *The Social System*. Parsons emphasized that illness is not simply a biological or psychological condition, and it is not simply an unstructured state free of social norms and regulation. When one is ill, one does not simply exit normal social roles to enter a type of social vacuum; rather, one substitutes a new role—the sick role—for the relinquished, normal roles. The sick role is, “also a social role,

characterized by certain exemptions, rights, and obligations, and shaped by the society, groups, and cultural tradition to which the sick person belongs.” Parsons viewed sickness as a type of deviant behavior in that it is a violation of role expectations. Functionalist theorists (like Parsons) are concerned about the impact of deviant behavior upon society and parts of society. Sickness is assessed as being dysfunctional for the family because when one member is sick and relinquishes normal responsibilities, other members are required to pick up the slack—and may become overburdened in so doing. In addition, sickness is dysfunctional for society. The equilibrium that society maintains can be disrupted when individual members, due to sickness, fail to fulfill routine responsibilities. The “lure” of sickness—the attraction of escaping responsibilities—requires society to exercise some control over the sick person and the sick role to that disruption is minimized.

Sickness is acknowledged to be a special form of deviant behavior; however, it is not equivalent to other forms of deviance such as crime. Institutions (law and medicine) are created in society to deal with both behaviors, but while criminals are punished, the sick are provided with therapeutic care so that they become well and return to their normal roles.

Within the context of social control responsibilities of medicine, society allows two explicit behavioral exemptions for the sick person but also imposes two explicit behavioral requirements. The four exemptions are (sick roles)

- I. The sick person is temporarily excused from normal social roles. Depending on the nature and severity of the illness, a physician can legitimize the sick role status and permit the patient to forgo normal responsibilities. The physician’s endorsement is required so that society can maintain some control and prevent people from lingering in the sick role.
- II. The sick person is not held responsible for the illness. Society accepts that cure will require more than the best efforts of the patient and permits the patient to be “taken care of” by health care professionals and others. In order to be granted these role exemptions, however, the patient must be willing to accept the following two obligations:
- III. The sick person must want to get well. The previous two elements of the legitimized sick role are conditional on this requirement. The patient must not get so accustomed to the sick role or enjoy the lifting of responsibilities that motivation to get well is surrendered.

- IV. The sick person is expected to seek medical advice and cooperate with medical experts. This requirement introduces another means of social control. The patient who refuses to see a health care professional creates a suspicion that the illness is not legitimate. Such a refusal inevitably reduces the patience and sympathy of society and those surrounding the patient.

Criticisms of the Sick Role

Sociologists today are divided on the sick role's current value as an explanatory concept. The four main criticisms are briefly described below:

- a. The sick role does not account for the considerable variability in behavior among sick persons. Variation occurs not only by age, gender, and ethnicity, but also by the certainty and severity of prognosis.
- b. The sick role is applicable in describing patient experience with acute illness only and is less appropriate in describing persons with chronic illnesses who may not have easily recognizable symptoms and may not get well no matter how much they want to and how faithful they are in following the physician's instructions.
- c. The sick role does not adequately account for the variety of settings in which physicians and patients interact; it is most applicable to a physician-patient relationship that occurs in the physician's office.
- d. The sick role is more applicable to middle-class patients and middle-class values than it is for persons in lower socioeconomic groups. Not everyone can follow this pathway; for example, lower income persons have less freedom to curtail their normal responsibilities, especially their jobs, and thus have a more difficult time complying with the model.

6.6. The Medicalization of Deviance

While Parsons described the role of medicine as an instrument of social control, many believe that the powers of the medical institution have now expanded far beyond areas of genuine expertise. This has led to a **medicalization of deviance**, a concept that has two primary meanings. First, an increasing number of behaviors and conditions are being interpreted in medical terms, giving the medical profession increased powers in determining what is normal and desirable behavior; and second, medical practice is understood to be the proper mechanism for controlling, modifying, and eliminating these "undesirable" deviant behaviors. Bringing behaviors such as alcoholism, drug addiction, compulsive overeating, and compulsive gambling under a medical rubric introduces a "quality of therapeutic mercy into the way they are handled."

Demedicalization

Concern that the medical profession's powers of social control have become too extensive, a counter movement toward **demedicalization** is now underway. It includes such elements as the removal of certain behaviors (e.g., homosexuality) from the APA's list of mental disorders and the deinstitutionalization of mental health patients (mental patients who can survive on the outside and are not dangerous are mainstreamed into society. Ironically, both medicalization and demedicalization are occurring simultaneously in society.

6.6.1. The doctor as agent of social control

Talcott Parsons – The Sick Role – described the normative behavior a person typically adopts when feeling sick and “*being sick is a disturbance of the “normal” condition* – both biologically and socially Deviances(unable to function normal tasks) and Physician-Patient relationship must be like, *parent-child relationship since, for some, illness can foster a child- like state of dependence*, both child and sick person lack the capacity to perform the usual functions of the adult.

In this role of arbiter of social values, medicine therefore acts as an institution of social control and the doctor as an agent of social control. By constantly reaffirming the boundaries of social normality the doctor serves as a support for the maintenance of social order. This social control function is not unique to medicine: it has been, and still is, carried out by other occupational groups like the *Church and the law*.

E.g. there are obligations for patients to have approved evidence by doctors in order to exempt from social responsibility.

6.6.2. Models/ types/ of the doctor–patient relationship

Four prototypes of doctor-patient relationship

- A. **Paternalism:** Traditional form of doctor-patient relationship, doctor takes on role of parent, doctor is the expert and patient expected to cooperate, tightly controlled interviewing style aimed at reaching an organic diagnosis, passive patient and a dominant doctor, Focus is on care, rather than **autonomy**. Example, doctor says, “If I’ve told you once I told you 1,000 times, stop smoking!!”

B. Consumerism: We can simplify the complicated relationship with “buyer and seller” relationship, is it good or bad? What is your opinion? The patient can challenge to unilateral decision making by physicians in reaching diagnosis and working out treatment plans, reversing the very basic nature of the power relationship.

n **Mutuality:** The optimal doctor-patient relationship model, this model views neither the patient nor the physician as standing aside, each of participants brings strengths and resources to the relationship, based on the communication between doctors and patients. Patients need to define their problems in an open and full manner, the patient has right to seek care elsewhere when demands are not satisfactorily met. Physicians need to work with the patient to articulate the problem and refine the request, the physician’s right to withdraw services formally from a patient if he or she feels it is impossible to satisfy the patient’s demand.

C. Default: When patient and physician expectation are at odds, or when the need for change in the relationship cannot be negotiated, the relationship may come to a dysfunction standstill.

Note:- Doctor-patient relationship in the past were, **paternalism**, because physicians in the past were people who have higher social status, “doctor” is seen as a sacred occupation which saves people’s lives, the advices given by doctors are seen as paramount mandate , while, doctor-patient relationship at **present**, **Consumerism and mutuality**. Patients nowadays have higher education and better economic status, the concept of patient’s autonomy, the ability to question doctors.

6.7. The hospital as organization/institution

*The Concepts of organizations for David Sills (1962): “an organization consists of **a number of people, formally joined together and usually assigned specific functions for the purpose of achieving a stated goal.**”* In this definition people, formal organization, Specific function, stated goals are the main components. The hospital is a complex organization and an institute which provides health to people through complicated but specialized scientific equipments and team of trained staff educated in the problems of modern medical science. They are all coordinated together for the common goal of restoring and maintain good health

6.7.1. Functions of hospitals

A hospital is a health care institution with an organized medical and professional staff, and with permanent facilities that include in-patient beds. Provide medical, nursing and other health related services to patients.

- 1) **Preventive function:** it is an emerging secondary function for the hospital and concerned with health promotion. It is geared toward providing the preventive services through a community health center. It takes an active role to improve the health of the population
- 2) **Curative function:** it is the primary function of the hospital and concerned with providing patient care. It refers to any type of care given to the patients by the health team members e.g. physicians, nurses, dietitians.....Also includes health education to patients.
- 3) **Training function:** It is a secondary function and concerned with providing training and educational courses for the professional and technical personnel who provides health services (e.g. physicians, nurses, dentists, and therapist.)
- 4) **Research function:** It is a secondary function and concerned with conducting the health related researches that focus on the improvement of the health and/or prevention of diseases.

6.8. Ethno medicine and Modern medicine

It is the study of traditional medical practice where cross cultural health systems including categories, perceptions of illness and approach to prevention and healing are examined. Ethno medicine is a cultural interpretation of health, diseases and illness. Most of the practices include use of plants spirituality and the natural environment. These days; however, it includes perception of the body, culture and disability change in indigenous traditional healing systems due to globalization.

No.	Name of Medical System	Strength	Weakness
1	Traditional Or ethno-medicine	<ul style="list-style-type: none">✓ Effective in treating diseases of psychosocial origin✓ Easy access✓ Patients and curers share similar values✓ Cheap✓ Treatment of holistic persons✓ Treatment done under the context of personal, informal relationships✓ Serves large proportion of people in most developing societies	<ul style="list-style-type: none">✓ Lack of scientific standards✓ Hygiene problem✓ Lack of proper dosage✓ Inability to effectively deal with bacterial and viral diseases✓ Problem of risks of contracting other infections and adverse outcomes including death highly

		✓ Is a source in many instances for the modern medicine	
2	Scientific or modern medicine	<ul style="list-style-type: none">✓ Able to overcome many perennial health problems✓ Effective against bacterial, viral and others diseases✓ Scientific verifiability Less risk of unnecessary outcomes including death related to dosage, hygiene, etc✓ High achievements in promoting health, wellbeing, longevity, etc	<ul style="list-style-type: none">✓ Fails to deal with holistic person✓ Patient and practitioner do not have similar worldviews about health and disease Unequal authority relations✓ Highly impersonal and possibility of alienation and dehumanization Not easily accessible✓ Relatively costlier.

6.9. Self care

Self-care is the most common response to symptoms of illness by people throughout the world. Self-care includes taking preventive measures like: consuming vitamin supplements, self-treatment of symptoms (such as taking home remedies or over-the-counter drugs), managing chronic conditions (for instance, use of insulin by a diabetic). Self-care may involve consultation with health care providers and use of their services. As a way of acting in relation to one's health, self-care consists of both health and illness behavior.

What makes self-care distinctive is that it is a form of care that is self-initiated and self-managed (Segall and Goldstein 1989). In modern societies, a number of factors have promoted interest in self-care on the part of laypersons. What do you think? According to Alexander Segall and Jay Goldstein 1989:154), these factors include:

- ✓ the shift in disease patterns from acute to chronic illnesses and the accompanying need to displace medical intervention from an emphasis on cure to care;
- ✓ growing public dissatisfaction with medical care that is depersonalized;
- ✓ recognition of the limits of modern medicine;
- ✓ the increasing visibility of alternative healing practices;
- ✓ heightened consciousness of the effects of lifestyles on health; and
- ✓ A desire to exercise personal responsibility in health-related matters.
- ✓ Access to the Internet, with its abundance of medical information (Stevenson et al. 2003). Thus it would appear that self-care is becoming increasingly important and commonplace

Chapter- SEVEN

Urbanization and Health

7. 1. Introduction

Urbanization

Urbanization is the process of population concentration in urban areas. It involves the movement of people particularly from rural areas to urban areas. There are two simple measures of urbanization: 1. level of urbanization growth

$$\text{Level of urbanization} = \frac{\text{urban population}}{\text{Rural population}} = \text{ratio}$$

or

$$\text{Level of urbanization} = \frac{\text{urban population}}{\text{rural population}} \times 100 = \%$$

$$\text{Rate of urbanization} = \frac{\text{current year urban population} - \text{previous year population}}{\text{Previous year population}}$$

$$RU = \frac{\text{cyup} - \text{pyup}}{\text{Pyup}} \times 100$$

Sociologists see urbanization as resulting from three interrelated factors

1. Significant increase in the population of a given geographic area.
2. The corresponding increase in social density resulting from the population increase.
3. The increasing heterogeneity of people as more and more diverse people are drawn to the grown urban settlement. From these three factors arise a number of organizational consequences the most important of which is the social division of labor in economic activities.

Urbanism:

Urbanism refers to the cultural component associated with urbanization. It includes a range of beliefs, values and rules of behavior which are assumed to be associated with urbanization. Urbanism reflects the patterns of culture and social interaction resulting from the concentration of large population in a relatively small geographic area. It refers to an organization of society (community) in terms of a complex division of labor, high level of technology and social mobility.

Rural urban differences:

We can have at least eight characteristics in which the urban settlement varies from rural settlement

- 1) Occupation

- 2) Environment
- 3) Community size
- 4) Density of population
- 5) Heterogeneity and homogeneity
- 6) Social differentiation and stratification
- 7) Social mobility
- 8) System of interaction

Urban problems:

1. **Slums and squatter settlements;** slums are characterized by unsanitary housing condition that is deteriorated or degenerated due to lack of care. Squatting takes place mostly in marginal lands and steep slopes that are not good for development. Squatters occupy these areas and erect structures using plastics and old board to shelter themselves.

2. **Urbanization also has got many problems like anomie, depression, crime, substance abuse, suicide** and many other dirty and vice things. Counselors and psychiatrists became very important.

3. **The vulnerability to and dependence on modern technology.** If water supply or electricity gets crisis, the whole city will be disrupted in all ways of life. The same happen if fuel is not available for a short time.

4. **Water pollution-** fresh water is very scarce and polluted by modern technology like pesticides, mercury, lead etc.

5. **Air pollution is also another serious problem.** Air was Polluted by smokes of cars and industries. In some countries electrified traveling and bicycles are encouraged to minimize pollution.

6. **Solid and liquid wastes management-** there is an accumulation of waste materials which causes environmental pollution. Organic wastes can be recycled to produce fertilizer and other useful products. The problem is they are not recycled. sewer problem is also a serious problem polluting underground water.

7. **transportation-** there are too many vehicles and the goods are overcrowded. A large amount of urban land is used for parking. Parking shops are built in different parts of cities. In order to minimize congestion inner and outer ring roads are built. Different mechanisms like intersection traffic, zebra crossing, overpasses, underpasses, tube way systems, one way or two way streets are used. Adjusting working hours or separating schooling hours is also used.

8. **Another problem is finance**- revenue raised by municipalities is hardly enough to cover the cost of cities. A huge amount of investment is necessary to sustain city life. Municipalities need grants and compete for investment.

Ethiopian urbanization and urban centers

Starting from the ancient times, Ethiopian urbanization is characterized by roving capitals starting from the north towards the south. Axum_lalibela__gondar__shoa different scholars with different professional background have contributed articles on Ethiopian urbanization.

7.2. Urbanization and its effect on health

For the first time in history, more than 50% of the world's population lives in an urban area by 2050, 70% of the world's population will be living in towns and cities. By 2030, 6 out of every 10 people will be city dwellers, rising to 7 out of 10 people by 2050.

Many cities are currently burdened and will be confronted by a triple threat:

- ✓ Infectious diseases exacerbated by poor living conditions;
- ✓ Non communicable diseases – such as heart disease, cancers and diabetes – and conditions fuelled by tobacco use, unhealthy diets, physical inactivity, and harmful use of alcohol; and
- ✓ Accidents, injuries, road accidents, violence and crime.

These are the result a complex interaction of various determinants of health, including insufficient infrastructure and services that particularly impact the health of the poor and slum dwellers. Living and working conditions vary widely within and between cities across the world and are the “causes of the causes” of ill-health.

According to WHO, “A healthy city is one that is continually creating and improving the physical and social environments and expanding the community resources that enable people to mutually support each other in performing all the functions of life and in developing to their maximum potential.”

Health is valued universally as an essential prerequisite for a fulfilling and productive life.

WHO recommends the following five prerequisite and six priorities to promote urban life.

1. *Promote urban planning for healthy behaviors and safety*

2. *Improve urban living conditions*
3. *Ensure participatory urban governance*
4. *Build inclusive cities that are accessible and age-friendly*
5. *Make urban areas resilient to emergencies and disasters*

Six priority areas were o make a city healthier:

1. Healthy schools
2. Water supply
3. Health and hygiene education
4. .Garbage removal and disposal
5. Drainage and sanitation
6. Income generation
7. second workshop was held

7.3. Urban settings and health determinants

Question: - Why we interested about urban health and determinant of urban health?

The focus on urbanization and health is timely and highly relevant for the following reasons

- I. With the majority of the world's population now living in urban areas and this proportion expected to grow, urban health should become a major focus of global public health policy. Whilst urbanization and the growth of cities may be associated with increasing prosperity and good health at an aggregate level, urban population demonstrate the world's most obvious health disparities – in both low- and high-income countries. Rapid migration from rural areas as well as natural population growth are putting further pressure on limited resources in cities, especially in low-income countries.
- II. Much of the natural and migration growth in urban population is among the poor. More than one billion people – one third of the urban population – live in overcrowded and life-threatening conditions in urban slums and informal settlements. If cities fail to deliver on the perceived promise of economic opportunities for the poor, large concentrations of unemployed young people may threaten social stability, security and the health of communities as a consequence. In low-income countries, in particular, disparities will increase, as the combination of in-migration, natural growth and scarcity of resources results in cities being unable to provide the services needed by those who come to live in them.

- III. There is evidence that rapid, unplanned urbanization can have negative consequences for the health and safety of people.

In recent times, the growth of urban areas in low-income countries has been four times faster than the growth in high-income countries. This trend, For a growing proportion of the world's population, prospects for a better future are tied to living conditions in cities.

Cities concentrate people, opportunities, and services, including those for health and education. In a well known trend, cities house the most and the best hospitals and they attract the most talented doctors, nurses and other health care staff. When cities are planned, managed, and governed well, life flourishes and health outcomes surpass those seen in rural areas. But cities also concentrate risks and hazards for health. They magnify some long-standing threats to health and introduce others. When large numbers of people are linked together in space and connected by shared services, the consequences of adverse events – like contamination of the food or water supply, high levels of air or noise pollution, a chemical spill, a disease outbreak or a natural disaster – are vastly amplified. Given the current scale of urbanization, it comes as no surprise that cities themselves contribute to two global trends of direct concern to health: climate change and the rise of chronic diseases. According to the latest estimates, cities contribute directly to more than 60% of greenhouse gas emissions. They account for 75% of energy consumption and a similar proportion of all wastes. At the same time, city dwellers are especially vulnerable to the consequences of climate change, whether expressed as heat waves, water scarcity, increasing levels of air pollution, or rising sea levels in coastal areas. Cities also tend to promote unhealthy lifestyles, like “convenient” diets that depend on processed foods, sedentary behaviour, smoking, and the harmful use of alcohol and other substances. These lifestyle choices are directly linked to obesity and the rise of conditions like heart disease, stroke, some cancers, and diabetes. And these conditions are increasingly concentrated in the urban poor.

Perhaps most alarming, the growth of urban centers in the 21st century is being accompanied by a second, distinctly ominous trend. Poverty, which in previous centuries was greatest in scattered rural areas, is now heavily concentrated in cities. In many countries, urbanization has outpaced the ability of governments to build essential infrastructures and enact and enforce the legislation that make life in cities safe, rewarding, and healthy. Strongly linked to social unrest, mental

disorders, crime, violence, and outbreaks of disease associated with crowding and filth. These threats can easily spread beyond a single neighbourhood or district to endanger all citizens and taint a city's reputation.

Municipal authorities know what this means in terms of attracting tourists and new businesses and winning the next election. City dwellers know what this means in terms of social cohesion, safety, security, and the quality of life.

In addition, health inequities are an excellent social accountant. They are a reliable way to measure how well a city is meeting the needs of its residents. Poor health, including mental health, is one of the most visible and measurable expressions of urban harm. Health inequities can also be a rallying point for public demands for change that compel political leaders to take action.

Urban health matters and urban health governance matters most especially. For example, in developing countries, the best urban governance can help produce 75 years or more of life expectancy. With poor urban governance, life expectancy can be as low as 35 years. Good urban health governance helps ensure that opportunities and advantages are more evenly distributed, and that access to health care is fair and affordable. Abundant evidence has identified the root causes of urban health inequities and shown how they can be tackled.

“The world is rapidly urbanizing with significant changes in our living standards, lifestyles, social behavior and health,” says Dr Jacob Kumaresan, director of the World Health Organization's Centre for Health Development. “While urban living continues to offer many opportunities, including potential access to better health care, today's urban environments can concentrate health risks and introduce new hazards”.

Health challenges particularly evident in cities relate to water, environment, violence and injury, non communicable diseases (cardiovascular diseases, cancers, diabetes and chronic respiratory diseases), unhealthy diets and physical inactivity, harmful use of alcohol as well as the risks associated with disease outbreaks. City living and its increased pressures of mass marketing, availability of unhealthy food choices and accessibility to automation and transport all have an effect on lifestyle that directly affect health.

7.4. An Introduction to Ethiopia's Health

Ethiopia has a long history of disease, epidemics and famine, mainly due to poor sanitation, a lack of potable water (only 25% of rural population and 75% of the urban population have clean water), malnutrition, and uneven concentration of health services..

The main cause of many of Ethiopia's health problems is the relative isolation of large segments of the population from the modern sector. Additionally, widespread illiteracy prevents the dissemination of information on modern health practices. A shortage of trained personnel and insufficient funding also hampers the equitable distribution of health services. Moreover, most health institutions were concentrated in urban centers prior to 1974 and were concerned with curative rather than preventive medicine. Western medicine came to Ethiopia during the last quarter of the nineteenth century with the arrival of missionary doctors, nurses, and midwives. But there was little progress on measures to cope with the acute and endemic diseases that debilitated large segments of the population until the government established its Ministry of Public Health in 1948. In addition to establishing hospitals, health centers, and outpatient clinics, the government initiated programs to train Ethiopian health care personnel so that they could supplement the private institutions that existed in a few major urban centers. The few government campaigns that exhorted the people to cooperate in the fight against disease and unhealthy living conditions were mainly directed at the urban population.

By the mid-1970s, the number of modern medical facilities had increased relatively slowly-- particularly in rural areas, where at least 80 percent of the people still did not have access to techniques or services that would improve health conditions. In the absence of modern medical services, the rural population continued to rely on traditional folk medicine.

The major health problems of the country remain largely preventable communicable diseases and nutritional disorders. Despite major progresses have been made to improve the health status of the population in the last one and half decades, Ethiopia's population still face a high rate of morbidity and mortality and the health status remains relatively poor. Figures on vital health indicators from DHS 2005 show a life expectancy of 54 years (53.4 years for male and 55.4 for female), and an IMR of 77/1000. Under-five mortality rate has been reduced to 101/1000 in 2010 and more than 90% of child deaths are due to pneumonia, diarrhea, malaria, neonatal problems, malnutrition and HIV/AIDS, and often a combination of these conditions. These are very high levels, though there has been a gradual decline in these rates during the past 15 years. In terms of

women health, MMR\maternal mortality rate\ has declined to 590/100,000 though it still remains to be among the highest.

7.4.1. Health policy of Ethiopia

Health Policy, Plans and Strategies

The government of Ethiopia issued its health policy in 1993, which emphasizes the importance of achieving access to a basic package of quality primary health care services by all segments of the population, using the decentralized state of governance. The health policy stipulates that the health services should include preventive, promotive and curative components.

In order to achieve the goals of the health policy, a twenty-year health sector development strategy has been formulated, which is being implemented through a series of five-year plans. The implementation of the first health sector development program (HSDP) was launched in 1997, and now the second HSDP is under way. The main thrust of the HSDP implementation is based on sector-wide approach, encompassing the following eight components:

- Service delivery and quality of care
- Health facility rehabilitation and expansion
- Human resource development
- Pharmaceutical services
- Information, education and communication
- Health sector management and management of information systems
- Monitoring and evaluation
- Health care financing

7.4.2. Concepts of Primary Health Care

The term ‘**Primary Health Care**’ (PHC) is the name given to the essential healthcare that is universally accessible to individuals and is acceptable to them at a cost that the country and community can afford. Ethiopia is one of the countries in the world which has adopted PHC as a national strategy since 1976. This strategy focuses on fair access to health services by all people throughout the country, with special emphasis on prevention and the control of common diseases, self-reliance and community participation. In Ethiopia, this level of healthcare is free

for people living in rural areas. PHC focuses on disease prevention and health promotion. It is the type of healthcare delivery sometimes described as ‘by the people, of the people and for the people.’ It involves the community in the whole process of healthcare delivery and encourages them to maintain their own health.

A. Principles of Primary Health Care

The Primary Health Care policy has five principles that have been designed to work together and be implemented simultaneously to bring about a better health outcome for the entire population.

1. *Accessibility* (equal distribution): this is the first and most important key to PHC. Healthcare services must be equally shared by all the people of the community irrespective of their race, creed or economic status. This concept helps to shift the accessibility of healthcare from the cities to the rural areas where the most needy and vulnerable groups of the population live.
2. *Community participation*: this includes meaningful involvement of the community in planning, implementing and maintaining their health services. Through the involvement of the community, maximum utilization of local resources, such as manpower, money and materials, can be utilized to fulfill the goals of PHC.
3. *Health promotion*: involves all the important issues of health education, nutrition, sanitation, maternal and child health, and prevention and control of endemic diseases. Through health promotion individuals and families build an understanding of the determinants of health and develop skills to improve and maintain their health and wellbeing.
4. *Appropriate technology*: technology that is scientifically sound, adaptable to local needs, and acceptable to those who apply it and for whom it is used.
5. *Inter-sectoral collaboration*: to be able to improve the health of local people the PHC programme needs not only the health sector, but also the involvement of other sectors, like agriculture, education and housing.

B. Elements of Primary Health Care

1. Education on health problems and how to prevent and control them.

2. Development of effective food supply and proper nutrition.
3. Maternal and child healthcare, including family planning.
4. Adequate and safe water supply and basic sanitation.
5. Immunization against major infectious diseases.
6. Local endemic diseases control.
7. Appropriate treatment of common diseases and injuries.

C. Health Service Extension Programme

The Health Service Extension Programme, (HSEP) is an innovative, community-based programme that was first introduced in Ethiopia in 2003. This programme was launched after realizing that the basic health services were not reaching the majority of the population. The objective of HSEP is to improve equitable access to mainly preventive health services through community (*kebele*) based services. These services all have a strong focus on health promotion and preventive health activities, as well as increased community health involvement. The principle behind this programme is to transfer ownership and the responsibility of maintaining health to individual households. This programme has required a sustained political commitment from the government and continued investment that has led to the construction of over 14,000 Health Posts and the training of 30,000 female Health Extension Workers (two for each Health Post) and their deployment in each village.

The role of the Health Extension Workers and Practitioners is to work with the community and help them acquire the knowledge and skills that enables them to ensure their own health. PHC is the lowest tier of the health service. It is where most health services are delivered at village level. Health Extension Workers and Practitioners work at this level. It is available to every member of the community.

Components of Health Service Extension Programmes

The HSEP is an approach that brings healthcare down to the household level. It has been designed to provide a number of health packages which are categorized under four main topics: Disease Prevention, Family Health Service, Hygiene and Environmental Sanitation, and Health Education and Communication. These packages have been developed to tackle the main health

problems of the country, such as TB, HIV/AIDS, malaria, and maternal and child health, in order to be able to achieve the Millennium Development Goals which the country aspires to achieve by the year 2015 (the year 2008 in the Ethiopian calendar).

1. Disease Prevention and Control. Under this component the most dominant communicable diseases are addressed.

- TB, HIV/AIDS and other STI prevention and control.
- Malaria prevention and control.
- First aid and emergency measures.

2. Family Health Service.

- Maternal and child health.
- Family planning.
- Immunization.
- Adolescent reproductive health.
- Nutrition.

3. Hygiene and Environmental Sanitation.

- Excreta disposal.
- Solid and liquid waste disposal.
- Water supply and safety measures.
- Food hygiene and safety measures.
- Healthy home environment.
- Control of insects and rodents.
- Personal hygiene.

4. Health Education and Communication. This is part of all the packages.

7.5. Health care financing in Ethiopia

State of health care financing in Ethiopia over the years has been characterized by low government spending and minimal participation of the private sector. Health care expenditure in Ethiopia represented 6.2% of the total public budget, and 1.8% of GDP in 2000 and move to 5% in 2005 and only about 50% of the population has access to basic health services, and drug supplies are irregular in most of the available facilities (FMoH 2010; Wamai 2009).

Healthcare financing in Ethiopia has been depend on government expenditure, donors and high out of pocket user fees. For example in 1999/2000 the government and other public enterprises provides 31% of the financing, donors and NGOs 37%, households 31% and other private employers and funds about 1% (FMoH 2005; MOFED 2008). A study conducted by FMoH (2010) found out that out of pocket expenditures of households increase to 37% in 2010 due to low government spending on the health sector and high reliance on out of pocket expenditure. The government of Ethiopia planned a policy to promote the health condition of society and

underdevelopment of healthcare facilities. However, annual utilization per capita remains very low at only 0.36 (36%) for the national average as at 2004 (FMoH 2005) and out of pocket expenditure of households accounts 31% in 2000 (MOFED 2008).

One way to facilitate access and overcome unaffordable expenditure is through a health insurance mechanism, whereby risks are shared and financial inputs pooled through cross subsidizations within people who sick frequently and unable to afford for health care, and people who are healthy but pay premium for health insurances scheme (Ahuja and Jutting 2010).

7.5.1. Ethiopian Health Insurances

Most developing countries similar to Ethiopia implemented CBHI scheme for the propose of universal coverage and equity of health care access focusing mainly on risk pool resource mobilization, equitable access that promote utilization of health care and protects the poor and near poor from expensive out of pocket expenditures. Since the late 1990s, Community-Based Health Insurance schemes (CBHI) become alternative mechanism to address universal coverage mainly for informal sector population in developing countries (Jutting 2003; Ekman 2004; FMoH 2011; Anagaw 2015).

The low and falling health care utilization levels and health care seeking behavior, combined with rising poverty issues, a high burden of communicable diseases and the emerging chronic illness, poor health outcomes, and a decrease in international assistance raised awareness of the urgent need for increased health care financing in Ethiopia (CSA 2014). As of June 2011, as part of Ethiopian government health sector financing reform (HSFR) program, the Ethiopian Government launched a pilot community based health insurances scheme in 13 districts in the four main regions (Tigray, Amhara, Oromiya, and SNNPR) of the country in an attempt to increase access to health care and reduce household vulnerability to out-of-pocket health care expenditure (FMOH 2008; FMoH 2011).

The health insurance is classified into two types: **social health insurance and community based health insurance.**

Social health insurance caters for all employees in the country on the payroll of private and public institutions. It will be mandatory for taxpayers to take out the insurance. The costs will be covered by funds collected from individuals, employers and government subsidies, says the report. ***Community based health insurance*** deals with people that are not registered as taxpayers or informal sector, which often includes farmers. These people can choose whether they want to receive the service. According to the draft proposal, an agency to control the scheme is to be set up in the near future. Premiums for the health insurance scheme are calculated according to the income of members, but the ***benefits are the same for all***. According to the proposal, plastic surgery, teeth problems, and dialysis are among the identified treatments that are not going to be covered by the insurance.