11

STRENGTHENING HUMAN SECURITY THROUGH PUBLIC HEALTHCARE SERVICES

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Human Security

The concept of *security* is fluid and evolving. It's conceptual developed can be placed parallel along with the struggles and changing political, economic and military power regimes at the global level (Tadjbakhsh and Chenoy 2007). It was traditionally understood in terms of military power, and defense of state and territory from external attacks. Thus it concerned with the state and not the individuals. However, over the last few decades, the concept has moved beyond mere security of nation or state and focuses on the individuals and communities (Takemi et al. 2008).

The concept human security took shape in the 1990s. The Human Development Report 1994 for the first time gave a framework for the concept and linked it to 'freedom from fear and freedom from want' (p. 24). It defined human security from two aspects (1) 'safety from such chronic threats as hunger, disease and repression' and (2) as 'protection from sudden and hurtful disruption in the patterns of daily life- whether in homes in jobs or in

communities' (p.23). The report emphasized on universality, interdependence of components, prevention and people-centered as characteristics of human security. The main threats to human security are economic, food, health, environmental, personal, community and political.

Government of Canada as cited in Dorn (no date of publication, source: http://walterdorn.org/pub/23) defines human security as 'freedom from pervasive threats to people's rights, safety or life.' In its *human security agenda* the Canadian Foreign Ministry incorporated five theses as essential. They are (1) protection of civilians, (2) peace support operations, (3) conflict prevention, (4) governance and accountability, and (5) public safety. And according to Takasu, speaking on behalf of Government of Japan (2000) human security is 'the preservation and protection of the life and dignity of individual human beings.'

According to Kofi Annan (2001 as cited in Tadjbakhsh 2005) human security cannot be limited to purely military terms but has to be understood as a concept that encompasses 'economic development, social justice, environment protection, democraticization, disarmament, and respect for human rights and the rule of law.' The Commission on Human Security (2003) co-chaired by Oakta and Sen redefined human security to include protection of individuals and communities, freedom from fear, freedom from want, and freedom to love with dignity and freedom to take action on ones behalf. The Commission highlights as one of the priorities 'guaranteeing the availability and affordability of essential health care' as an essential component of human security (p. iv).

Academicians (Bajpai 2000; Hammerstad 2000; and others) lay strong emphasis on priority of individual to state, personal safety, and freedom from direct or indirect threats and violence in understanding human security. According to Chen (2000) human security is the ultimate aim and can

be achieved through other forms of security such as military, health, environment, livelihoods, economic etc. Thus human security in its broadest goes beyond absence of violent conflict and protection of state; and 'encompasses human rights, good governance, access to education and health care and ensuring that each individual has opportunities and choices to fulfil his or her own potential' (Commission on Human Security 2003 citing David Malcolmson). It is about ensuring basic needs such as food, shelter, education and health care for *satisfactory* and *dignified survival* of human kind.

Health and Human Security

Health is a global concern and is of universal interest (Clements 1932). It is one of the basic needs of human kind (Thomas 2000). Health, defined as a state of complete physical, mental and social well-being (WHO 1948) is central to human happiness. Good health enhances productive capacity to individuals thus leading to economic progress as people can earn and save more (WHO 2012). Human insecurity can arise from many sources and one of them is 'disease' and 'public health problems' (King and Murray (2001–12: 603). The authors further link human insecurity as can be arisen out of 'crime, military conflict, nonpeaceful transfers of governmental power, … acute environmental disasters (floods, droughts, earthquakes, weather storms, hazards from space, contamination) long-term environmental changes (global warming, ozone hole, water shortage, pollution) and economic crises' (ibid: 603).

Health security is about enabling individuals, families and communities to be able to care themselves during routine and emergency situations, it is about provisions of health care services that are accessible, affordable and of quality. It is about imparting knowledge and making resources available to the people for living healthy life

(National Health Security Strategy, US Department of Health). Health security is often understood as a state of feeling of well-being. It is a state of existence with quality and goodness engraved into it. It causes an individual to be happy and contented. As a concept it is popularly related to health. Thus, generally a person in a state of well-being is often referred to mean to a person of good health and who feel a sense of safety against diseases and illnesses.

There are various factors that affect this feeling of well-being among people. They can be related to physical, social, psychological, environment, and behavioral. It can be internal (within self) or external (environmental). Labonte (1998) provides a framework for understanding factors affecting health and well-being. According to his framework there two types of factors that affect health and well-being of person. They are (1) Protective factors and (2) Risk factors. These two factors are further divided into four sub-types each. Thus under

(1) *Protective* factors there are

(a) Healthy conditions and environments,

- Safe physical environment, supportive economic and social conditions, regular supply of nutritious food and water, restricted access to tobacco and drugs, healthy public policy and organizational practice, provision for meaningful, paid employment and provision of affordable housing.

(b) Psychosocial factors,

- Participation in civic activities and social engagement, strong social networks, feeling of trust, feeling of power and control over life decisions, supportive family structure and positive self-esteem.

(c) Effective health services

- Provision of preventive services, access to culturally appropriate health services, community participation in planning and delivery of health services.

(d) Healthy lifestyle.

- Decreased use of tobacco ad drugs, regular physical activity, balanced nutritional intake, positive mental health, safe sexual activity.

(2) Under the *Risk* factors there are

(a) Risk conditions

- Poverty, low social status, dangerous work, polluted environment, natural resource depletion, discrimination (age, sex, race, disability), steep power hierarchy (wealth, status, authority) within a community and work place.

(b) Psychosocial risk factors

- Isolation, lack of social support, poor social networks, low self-esteem, high self-blame, low perceived power, loss of meaning or purpose, abuse.

(c) Behavioral risk factors

- Smoking, poor nutritional intake, physical inactivity, substance abuse, poor hygiene, being overweight, unsafe sexual activity

(d) Physiological risk factors

- High blood pressure, high cholesterol, release of stress hormone, altered levels of biochemical markers, genetic factors.

The protective factors lead to improvement in quality of life and functional interdependence, while risk factors

lead to morbidity, mortality and disability. These factors together affect the well-being of an individual. This calls for an intervention in both factors in order to enhance health and well-being of individuals. While the protective factors have to be promoted, the risk factors have to the prevented.

One of the ways of enhancing this well-being among people is by provision of equitable, affordable, accessible and quality public healthcare services. Public health concerns with the health of the community and population as a whole. It involves efforts to achieve *'health and well-being of individuals, families and various groups of people'* (McMurray 2003: 13), by prevention of health risks and promotion of healthy life style and health seeking behaviour (WHO 2006: 9). Public health is a 'public good' and can be accessed by all, no matter who pays the cost (Ostrom and Ostrom 1971: 206).

Availability of a good health care service in a locality makes people feel a sense of safety and security related to health and well-being. The physical factors that make for health security among people include health infrastructures, availability of health personnel, and drugs. However, availability of health care services has to be accompanied by awareness and knowledge among the people for effective utilization. The effective utilization of these services leads to outcomes, which in turn leads to health and well being of the people. A sense of feeling of safety related to health and well being (health security) among people arises out this process.

Public health in India, is a subject of the state. Article 47 of the Constitution of India directs the state to 'raise the level of nutrition and the standard of living and to improve public health.' Though this article does not give right to health a constitutional status, the Judicial Interpretation of Article 21 of Indian Constitution on right to life has included 'right to health' fundamental right of an individual. This

has further emphasized the promotion of public health as a responsibility of the state. In short promotion of health security in Indian context is fundamentality the function of the state. It has responsibility to formulate policies, design programmes and implement them either on its own through the public health system or in collaboration with other stake holders. This study is carried in this context and attempts to capture the sense of health security that National Rural Health Mission (NRHM) has generated among the rural people in Chirang District of Assam.

Study Setting

The study is located in Ouguri Mini-Primary Health Center (MPHC) in Chirang District of Bodoland Territorial Council of Assam. An MPHC was constructed there, but was used as a military camp in the name of maintaining law and order during the All Bodo Students Union (ABSU) Movement (1987–1993). The health institution was destroyed by the public around 1989, because they felt that the military had created more problem then had actually maintained law and order. The Ouguri sector remained without public health service since then till May of 2009 when under National Rural Health Mission (NRHM) Programme the center was reopened in a house donated by the All Bodo Students Union (ABSU) of Ouguri unit. The process was facilitated by the District Community Mobilizer (DCM), NRHM, Assam. The MPHC today has two sub-centers under it, and caters to the population of 72 villages of the river locked land of Ouguri sector. As of 2011 August the MPHC was manned by two MBBS Doctors, one ANM, One Lab Technician cum Accountant and a helper. There are also two other ANMs posted in the two sub-centers attached to the MPHC. There are sixteen Accredited Social Health Activists (ASHAs) in the sector.

The area is rural and is categorized as difficult to reach

area within the NRHM programme implementation plan. During monsoon the area often becomes inaccessible due to floods. This make not only the regular supply of drugs difficult but often places a challenge to the doctors and nurses to go to the Health Center regularly. In such cases often there have been incidents where the ABSU along with the community people have taken up responsibility ensure the regular supply of drugs. This ensured continuation of health service to the people.

The demographic, development and health profile of Assam and Chirang are given in Table 4. From the table one sees there is not much of difference between the state and the Chirang as a distinct. While the state's average is better in institutional delivery than Chirang (34.3 and 29.5 percent), the performance of Chirang is better than the state's average in immunization with 51.3 percent and 50.9 percent respectively.

Table No 4: The demographic, development and health profile of Assam and Chirang

Sl. No.	Indicators	Assam	Chirang district where Ouguri MPHC is located
1.	Total Population (Census 2011 in millions)	311.67	0.4818
2.	Density (Census 2011)	397	244
3.	Decadal Growth (2001–11) in per cent	16.93	11.26
4.	Sex Ratio (Census 2011)	954	969
5.	Literacy Rate (Census 2011)	73.18	64.71

6.	Life Expectancy (UNDP, India 2011)	58.9	NA*
7.	Population below poverty line (%) (Planning Commission 2003)	36.09	NA*
8.	HDI (2011)	0.534 (29th rank among Indian states)	NA*
9.	Crude Birth Rate (SRS 2010)	23.2	NA*
10.	Crude Death Rate (SRS 2010)	8.2	NA*
11.	Health Institutions (2009–10)**	5557	102
12.	Health Personnel (2011)****	18472	300 (district office register)
13.	Institutional Delivery (DLHS-3) (%)	35.3	29.5
14.	Full Immunization (DLHS-3) (%)	50.9	51.3
15.	Maternal Mortality Ratio (MMR) (Annual Survey Assam 2010–11)	381	NA*
16.	Infant mortality Rate (IMR) (SRS 2010)	58	NA*
17.	Total Fertility Rate (TFR) (SRS 2008)	2.6	NA*

Table 1: Demographic, Development and Health profile of Assam with reference to Chirang. *NA refers to Not

Available till 2011. **Health Institutions includes PHC, CHC, DH, SDH, MPHC and SCs as in NRHM report 2009–10. ***Health Personnel (medical and administrative) includes both regular and contractual under NRHM.

National Rural Health Mission

National Rural Health Mission popularly known as NRHM, recognizes the importance of health for economic and social development and for improvement in the quality of the life of the people. It envisages on providing and improving 'equitable, affordable, accountable and effective primary health care' to the rural people especially women and children (NRHM Mission Document 2005–12). The programme aims improving maternal and child health, prevention of communicable and non-communicable diseases, population stabilization, revitalization of local health traditions and msinstream AYUSH (Ayurveda, Yoga and Naturopathy, Unani, Siddha and Homeopathy), and promotion of healthy life style. The policy document of the programme provides for flexible administration for efficiency and effectiveness in health care. It also provides a space for *'necessary architectural correction in basic health care service delivery system'* [as in original] (NRHM Mission Document 2005–12: p. 1)

The programme was launched in April 2005 for a period of seven years that is till 2012. It is implemented in eighteen states of India, including all the states of the Northeast region. The programme gives the Northeast states a status for 'special focus' based on low health indicators as compared to other states of India. It is within this framework of NRHM that this study is carried out.

Methodology

The study is qualitative in approach and attempts to capture the sense of feeling of health security among the

people of the study area. It used an interview guide as a tool for collection of first hand information from the subject of study. It tried to capture the feeling of well-being among the service utilizers in relation to presence and availability of medical personnel, availability of drugs and the presence of health infrastructure and facilities. Interviews were conducted with the health personnel (two doctors, three ANMs and the Lab Technician) to capture their feeling of being able to cater to the health care needs of the people. Also ASHAs were interviewed with an intention to capture their experiences on the attitude and behavior of service utilizers. The study also analyses the NRHM policy document and its role in promotion of health security through its provision of flexibility in health programme and activities implementation.

Theoretical sampling method was adopted in the study and purposive sampling technique was used for selecting the samples. The principles of divergence and saturation were observed. The process of interviewing let to saturation point in each category of following number of sample distribution- three medical personnel, five ASHAs, six pregnant women, seven non-pregnant women of whom three had crossed the reproductive age (but whose husbands were still alive), four never married women and five men (married) and three men (not married) were interviewed. Thus in all there were thirty three interviews that were carried out. (See the distribution of interviews by category in Figure 1). Also one Focused Group Discussion was carried out with the Health personnel.

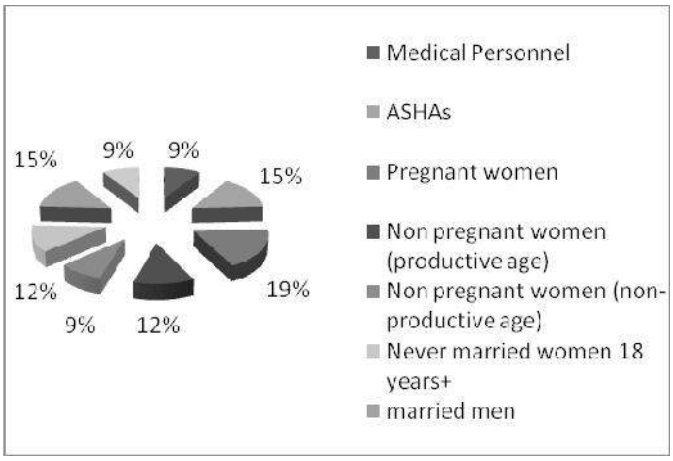

Figure No 2: Distribution of Respondents in Percentage

Data analysis and Findings

The interviews were analyzed thematically. The themes that emerged were feeling of satisfaction and a feeling of sense of health security (by thirty non-medical respondents) that a health institution was finally opened and functional in the area. They also expressed some degree of satisfaction about the availability of the drugs and the infrastructure setup of the health institution. People in general experienced a feeling of safety and assurance of health because of the presence of MBBS and ANMs in the health institution. The findings are further explained below.

All six pregnant women expressed high level of satisfaction about the health services given them at the MPHC. For example, one woman said 'now that the health center is I feel a more sense of safety than during my first pregnancy.' Another pregnant lady said 'after consultation with the doctor I feel a sense of relief, because I was getting some pain in my stomach last week.' And yet another pregnant lady said 'now I do not need to go far away to get checked up, because I know that this health center is good and the medicines effective.'

The ASHAs felt that the health institution has created a feeling of sense of safety among the people from disease and illness. All of them said that people generally now speak of going to the Ouguri MPHC rather than to some pharmacy or *ojha* (village doctor).

The non-pregnant women (within the reproductive age and still married) utilized the family planning kit provided by the public health system extensively. They used it because they felt that it was 'effective and safe.' Three of the women shared their previous experiences of having to get emergency pills from a distance of about six kilometers away. And how they feel 'safe' now that a 'sister' (referring to the ANM) is here to cater to their demand. This category also expressed a high level of sense of safety and a sense of less fear of having unwanted pregnancy.

The non-pregnant women (beyond of reproductive age an still married) did not much bother to use the services provided by the MPHC. They felt that their felt needs like treatment for 'body pain', 'joints pain', 'gastric', and 'giddiness' were not effectively met. So their degree of feeling of health assurance by the service of MPHC was low.

The never married women of reproductive age accessed the MPHC services for minor ailments. Their responses were similar to as that of non-pregnant women who had crossed their reproductive age. This attitude according to the ASHAs was because of the moral values that the society upholds of not having sexual interactions outside marriage. So they might not have felt the sense of need for utilization of services from the MPHC.

The category of married men also experienced a sense of high level of health security. This was to a large extend because their partners were 'able to access family planning packages easier that what was earlier.' Three of the respondents expressed that they felt 'a sense of more safety

and security unlike in the previous years' when their wives were pregnant and there were no health institutions nearby.

The category belonging to unmarried men experienced a low level of health security as was the case with never married women. They felt that the MPHC should was too interested in women *'hinjaofwrnisw'* (of women) health and left out men. They also felt that public health service in rural areas is good as far as immunization is concerned but not in other areas.

The health personnel category felt not sure of themselves of being able to ensure health security to the people. They expressed stress and inability to meet all the demands of the people. During both personal interview and Focused Group Discussion (FGD) they expressed their inability to serve too large an area of 72 villages. They felt that in order to insure health security of the people there was immediate need for improvement of the MPHC and posting of more doctors and nurses. In the course of FGD one of the medical personnel said that she feels scared the health may break down if he has to cater to so large a population. This she termed as 'paradox of health care promotion in rural setting.' She feels that her health is at risk while she is trying to contribute towards health security of the people through her practice.

It was observed that there was a difference in the level on feeling of sense of safety based on income level. The respondents who had higher level of income spoke of accessing health care service from private health care provider. On the other hand those from lower socio-economic status spoke of public health care service as being equally good as private providers. The people in the lower level of income used also stronger qualifying terms in speaking of their sense of security related to health arising out of public health. Terms such as 'confidence', 'very happy with', 'effective', 'got alright' etc were used by them. While

those of upper socio-economic class spoke of public health care services in milder forms as 'good', 'it is ok', and like 'will use it in case there is no other option.'

All the respondents (utilizer category) expressed a feeling of higher sense of health security when advised by an allopathic doctor than an allopath or a homeopath. This was found across respondents.

With regard to the health infrastructure all the respondents felt that there was need of urgent improvement and reconstruction of a full and functional health center in the area. However, all expressed a sense of satisfaction with the present availability of five beds for emergency purpose in the within the present setup.

Majority of the respondents (85 per cent) expressed a feeling of a sense of safety because they knew that there were Doctors and Nurses available in the health center regularly during the service hours. The people also felt a sense of assurance because the doctors were qualified persons with MBBS degree and nurses ANM. The respondent however, expressed a lower sense of satisfaction with availability of drugs in the health center in comparison to their sense of satisfaction with the medical personnel.

Critical analysis of finding

The public health service provided to the people in through Ouguri MPHC has enhanced the feeling of sense of health security among them. It is also observed that the section of respondent that felt most safe and experienced the sense of health security were the women especially those who are pregnant and those who are in the reproductive age. This can be attributed to the provision of Maternal and Child Health (MCH) services within the NRHM framework to the public. The MCH service includes Antenatal Care, (ANC) Postnatal Care (PNC), and Immunization of children. This high feeling of sense of health security among this

group of respondent also is related to the service provided for family planning by the MPHC.

Labonte's framework (1998) on health and well-being as determined by *protective and risk* factors seems to explain the effect of reopening of health institution (Ouguri MPHC) in the area to a large extend. The reopening of the health center has definitely catered to the health care need of the people as was evident from the interviews with the people, and also from the register maintained by the MPHC. It has to some extend contributed to improvement in the *quality of life* of the people, since it provides services at an affordable rate (the MPHC Rs. 5/- as registration charge). All available medicines are given free of cost (public good). So the people are able to save money and use it for other purpose. For example, three of the respondents said that they were able to spend the money that could have been used for ANC in a private hospital for construction of toilets. Eleven of the respondents said that they stopped spending money for family planning drugs as the health center provided it for free. Thus the reopening of the MPHC has strengthened the *protective* factors- by providing (1) safe physical infrastructure for health care, regular supply of drugs at affordable rate; (2) provision of opportunities for participation of people in health care through ASHAs, and involvement of local people leading to the feeling of empowerment among the people; (3) provision of preventive and promotive health services which are which are appropriate and demanded by the people; (4) promotion of health behaviors though seeking health care services from appropriate sources, and discouragement of habits related to use of tobacco and promotion of healthy diet and safe sex practices.

The risk factors in this study were observed to be simultaneously addressed along with the strengthening process of the protective factors. There seems to be an inverse

relationship between the two factors- that is the strengthening of protective factors led to alleviation and reduction of risk factors. Thus provision of health care service at an *affordable* cost reduced the degree of effect on the expenditure of the people in the area of health. The presence of health center, medical personnel and drugs in the center reduced a sense of isolation among people, and enhanced their sense of self-esteem that they too had a health center which careered to their basic health care needs. The MPHC engages extensively in generation of awareness on health seeking behavior both through Information Education and Communication (IEC) of Behavorial Change Communication (BCC) materials and techniques. This has created awareness on importance of health behavior among the people, and some changes have been seen in reduction on sale of tobacco and cigarettes especially to school going children. The health center also has provides consultations and refers patients with physiological risk factors for further treatment in the higher curative level of stage both within public or private providers.

Conclusion

The study finds provision of health care services to the people leads to strengthening of feeling of human security from health perspective. The study has also been able to point out the feeling of health security among people depends on the kind of services that are given them by the service provider. Thus the category of people who felt that the services catered to their demands expressed a higher level of feeling of sense of safety and security in this study. The study also finds people expressed a sense of feeing of safety by the mere fact that there was a health center in their locality and the medical personnel and drugs were available there. This shows that psychosocial factors of feeling of being neglected and isolated tends to reduce by

the mere fact of physical presence of health facilities. The study has also generated a hypothesis that sense of security among the health utilizers is determined by the type of services the providers give.

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