

## **Chapter One**

### **Introduction**

#### **1.1. What is Medical Anthropology?**

Medical Anthropology is a subfield of anthropology that draws upon social, cultural, biological, and linguistic anthropology to better understand those factors which influence health and well being (broadly defined), the experience and distribution of illness, the prevention and treatment of sickness, healing processes, the social relations of therapy management, and the cultural importance and utilization of pluralistic medical systems. The discipline of medical anthropology draws upon many different theoretical approaches.

It is as attentive to popular health culture as bio-scientific epidemiology, and the social construction of knowledge and politics of science as scientific discovery and hypothesis testing. Medical anthropologists examine how the health of individuals, larger social formations, and the environment are affected by interrelationships between humans and other species; cultural norms and social institutions; micro and macro politics; and forces of globalization as each of these affects local worlds.

Medical Anthropology examines how health and well-being are socially and culturally constituted in comparative and transnational contexts and the ways in which culture influences the experience of illness, the practice of medicine and the process of healing for the individual and community. It explores how the experiences and perceptions of the body, self or notion of the individual or person influence the illness experience. It is also concerned with how cultural values and practices dynamically shape and are themselves shaped by biomedical research and practice and non-Western medicines and healing traditions (Romanucci et.al, 1983).

Medical anthropology is the study of human health and disease, health care systems, and bio-cultural adaptation. The discipline draws upon the four fields of anthropology to analyze and compare the health of regional populations and of ethnic and cultural enclaves, both prehistoric and contemporary. Collaboration among paleopathologists, human biologists, ethnologists, and linguists has created a field that is autonomous from any single sub-discipline, with strong potential for integration of physical and Cultural anthropology. The field is also highly interdisciplinary, linking anthropology to

sociology, economics, and geography, as well as to medicine, nursing, public health, and other health professions.

Since the mid-1960s, medical anthropology has developed three major orientations. Medical ecology views populations as biological as well as cultural units and studies interactions among ecological systems, health, and human evolution. Ethno-medical analysis focuses on cultural systems of healing and the cognitive parameters of illness (Paul, 1955; Polgar, 1962).

Applied medical anthropology deals with intervention, prevention, and policy issues and analyses the socioeconomic forces and power differentials that influence access to care. In this triad, cultural anthropology is most closely allied with ethno-medicine. In the formative years, some anthropologists favored identifying the field as "ethno-medicine," while others preferred "anthropology of health." The term "medical anthropology prevailed, however, coming to represent a diversified range of orientations.

## **1.2. History of Medical Anthropology**

George M. Foster and Barbara Gallatin Anderson (1978) trace the development of medical anthropology to four distinct sources: the interest of early physical anthropologists in human evolution and adaptation, ethnographic interest in primitive medicine, studies of psychiatric phenomena in the culture and personality school, and anthropological work in international health. William H. R. Rivers (1924), a physician, is considered the first ethnologist of non-Western medical practices. Early theoretical work by Forrest E. Clements (1932) and Erwin H. Ackerknecht (1942, 1946) also attempted to systematize primitive medical beliefs and practices. Paralleling theory development were early applications of anthropological principles to health problems. Since the 1940s anthropologists have helped health care providers understand cultural differences in health behaviours, as shown in Benjamin D. Paufs edited volume *Health, Culture and Community: Case Studies of Public Reactions to Health Programs* (1955), one of the first medical anthropology texts.

William Caudill (1953) was the first to identify the field, followed by review articles by Steven Polgar (1962) and by Norman Scotch (1963). Academics, applied scientists, and clinicians enthusiastically worked in the 1960s to organize the emerging social science in medicine movement at national meetings of the American Anthropological Association (AAA) and the Society for Applied Anthropology (SAA). Caudill, Polgar, and Scotch were among the most active, as were

Hazel Weidman, Arthur Rubel, Dorothea Leighton, Clifford Barnett, Marvin Opler, Marion Pearsall, Donald Kennedy, Benjamin Paul, and Charles Leslie.

The Group for Medical Anthropology (GMA), established in 1967 with Weidman as chair, affiliated with the SFAA in 1969. As the Society for Medical Anthropology (SMA), the organization became a formal section of the AAA in 1972, with Dorothea Leighton, a psychiatrist-anthropologist, serving as its first president. Membership grew from 657 in 1972 to 1,523 in 1993, including a few hundred Canadian and other international members, primarily Europeans. Next to North America, Great Britain has the largest number of medical anthropologists. Most of them are concerned more with political economy and clinical issues than with bio-cultural perspectives. Increasing numbers of medical anthropologists work in Australia, Latin America, the Philippines, and India.

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### **1.3. Scope of Medical Anthropology**

Currently, research in medical anthropology is one of the main growth areas in the field of anthropology as a whole and important processes of internal specialization are taking place. For this reason, any agenda is always debatable. In general, we may consider the following six basic fields:

- ✚ the development of systems of medical knowledge and medical care
- ✚ the patient-physician relationship
- ✚ the integration of alternative medical systems in culturally diverse environments
- ✚ the interaction of social, environmental and biological factors which influence health and illness both in the individual and the community as a whole
- ✚ the critical analysis of interaction between psychiatric services and migrant populations

✚ the impact of biomedicine and biomedical technologies in non-Western settings

Other subjects that have become central to the medical anthropology worldwide are violence and social suffering (Farmer, 1999) as well as other issues that involve physical and psychological harm and suffering that are not a result of illness. On the other hand, there are fields that intersect with medical anthropology in terms of research methodology and theoretical production, such as cultural psychiatry and transcultural psychiatry or ethnopsychiatry

Employment has been plentiful in medical anthropology. Especially from 1967 through the 1980s, departments of preventive medicine, social psychiatry, pediatrics, nursing, schools of public health, and the Public Health Service were employing social scientists, and training programs were also being established.

Several national and International university or educational institution establishes the course as well as training programs in medical anthropology especially public health, to prepare for work in a wide array of academic, clinical, government, and nongovernment positions..

Some careers in this field include: University Professor, Health Education Professional, Public Health Researcher, Epidemiologist, Medical Scientist, Health Care Administrator, Health Outreach Coordinator, Health and Social Policy Analyst, Health Care Consultant and Social Worker

#### **1.4. Major Area of Study for Medical Anthropologists**

These are:

1. Popular health culture and domestic health care practices
2. Local interpretations of bodily processes
3. Perceptions of risk, vulnerability and responsibility for illness and health care
4. Risk and protective dimensions of human behavior, cultural norms and social institutions
5. Preventative health and harm reduction practices
6. The experience of illness and the social relations of sickness
7. The range of factors driving health, nutrition and health care transitions
8. Ethnomedicine, pluralistic healing modalities, and healing processes
9. The social organization of clinical interactions
10. The cultural and historical conditions shaping medical practices and policies
11. Medical practices in the context of modernity, colonial, and post-colonial social formations
12. The use and interpretation of pharmaceuticals and forms of biotechnology

13. The commercialization and commodification of health and medicine
14. Disease distribution and health disparity
15. Differential use and availability of government and private health care resources
16. The political economy of health care provision.
17. The possibilities for a critically engaged yet clinically relevant application of anthropology

## 1.5. Summary

- ✚ The discipline of medical anthropology draws upon many different theoretical approaches.
- ✚ Medical Anthropology examines how health and well-being are socially and culturally constituted in comparative and transnational contexts
- ✚ Medical anthropology is the study of human health and disease, health care systems, and bio-cultural adaptation.
- ✚ Applied medical anthropology deals with intervention, prevention, and policy issues and analyses the socioeconomic forces and power differentials that influence access to care.
- ✚ George M. Foster and Barbara Gallatin Anderson (1978) trace the development of medical anthropology to four distinct sources
- ✚ William Caudill (1953) was the first to identify the field, followed by review articles by Steven Polgar (1962) and by Norman Scotch (1963).
- ✚ Anthropologists using an ecological perspective to understand disease patterns view human populations as biological as well as cultural entities
- ✚ Medical ecology, unlike other orientations, assumes that biomedical disease categories are universal.
- ✚ The ethnomedical perspective focuses on health beliefs and practices, cultural values, and social roles.
- ✚ The disease-illness distinction is important conceptually in the study of ethnomedicine.
- ✚ Cultural psychiatry is closely allied with ethnomedicine.
- ✚ Currently, research in medical anthropology is one of the main growth areas in the field of anthropology as a whole

## Chapter Two

### Theoretical Orientation of Medical Anthropology

#### 2.1. Medical Ecology

Anthropologists using an ecological perspective *to understand disease patterns view human populations as biological as well as cultural entities*. Taking a systems approach in research, culture is seen as one resource for responding to environmental problems, but genetic and physiological processes carry equal weight. *The evolution, demography, and epidemiology of humans are subject to ecological forces*, as are other species (McElroy and Patricia, 1989; Moore, et al.,1980).

*A key concept in medical ecology is "adaptation," the changes, modifications, and variations that increase the chances of survival, reproductive success, and general wellbeing in an environment.*

Alexander Alland, Jr. (1970), was one of the first to apply the concept of adaptation to medical anthropology. Humans adapt through genetic change, physiological responses (short-term or developmental), cultural knowledge and practices, and individual coping mechanisms. A basic premise is that *health is an inmeasure of environmental adaptation, and disease indicates disequilibrium*. A second premise is that *the evolution of disease parallels human biological and cultural evolution*. The risks faced by foraging peoples differ from those of agricultural groups and industrial societies, and the epidemiological profile of each subsistence type is a function of human relations with the environment and with other species in the ecosystem, especially food sources, domesticated animals, and pathogens.

*Medical ecology*, unlike other orientations, *assumes that biomedical disease categories are universal. Disease rates can be measured, compared through time and across geographic space, and correlated with changes in settlement patterns and subsistence*. The frequencies of hemoglobin types can be measured and mapped geographically in relation to the incidence of infectious diseases such as malaria. The impact of diseases of contact, such as malaria, smallpox, and tuberculosis, on the native populations of the New World can be studied historically.

In the field, *medical ecologists study subsistence patterns and nutrition; children's growth and development; pregnancy and birth rates; population size, density, and mobility; chronic and infectious disease; hazards and injury patterns; and demographic change over time*. Research on prehistoric populations analyses skeletal remains, house sites, settlement patterns, and ecology.

Medical ecology has usually studied isolated populations living in rigorous environments, such as high-altitude regions, the arctic, and tropical forests, such as the classic work of Napoleon A. Chagnon (1992) and James V. Neel (1977) on the Yanomamo, the work of A. T. Steegmann, Jr. (1983), on cold adaptation, and the long-term research in high-altitude regions of South America by Paul T. Baker and Michael A. Little (1976) and by R. Brooke Thomas (1973) and their respective colleagues and students (Clements, 1932; Foster and Barbara, 1978).

*Increased attention has been given since the 1980s by human biologists and medical ecologists to seasonality and health in agricultural populations, environmental and cultural regulation of fertility, migration and change in health status, and to work productivity in chronically undernourished and infected populations.* The urban ecology of health is a new focus as well, and there is increasing dialogue with political economy theorists with respect to developing a "political ecology of health."

### **2.1.2. Ethnomedicine**

*The ethnomedical perspective focuses on health beliefs and practices, cultural values, and social roles.* Originally limited to study of primitive or folk medicine, *ethnomedicine has come to mean the health maintenance system of any society. Health ethnographies encompass beliefs, knowledge, and values of specialists and lay people; the roles of healers, patients or clients, and family members; the implements, techniques, and pharmacopoeias of specialists; legal and economic aspects of health practices; and symbolic and interpersonal components of the experience of illness.*

*Pluralistic societies often encompass several ethnomedical systems.* Among these are cosmopolitan medicine, a dominant system in North America and in urban centers elsewhere, *which emphasizes empirical research, naturalistic explanations, technology and surgery, use of extraordinary intervention to preserve life, and hierarchical roles.*

*Humoral medicine*, derived from ancient Greek medicine, *emphasizes that health reflects balance among bodily humors and their intrinsic qualities. Disequilibrium derives from ingestion of inappropriate food and other substances, from change of climate, and from exposure to natural elements like air and water. Therapy involves restoring equilibrium through applying or ingesting remedies opposite to the state of the body.* Humoral medicine coexists with other systems in Latin America, the Middle East, Malaysia, Indonesia, and the Philippines.

*A key concept in ethnomedicine is "explanatory model," introduced by Arthur Kleinman (1980). Explanatory models (EMs) are notions about the causes of illness, diagnostic criteria, and treatment options. In a clinical encounter, the EMs held by practitioners, patients, and family often differs. The ensuing communication and negotiation of decisions for managing illness lead to the cultural "construction" of illness. To the extent that **disparity among EMs continues because of cultural, ethnic, or class differences, communication remains problematic.***

*The disease-illness distinction is important conceptually in the study of ethnomedicine. Disease, defined clinically as deviation from medical norms, is considered to be a Western biomedical category and not universal. Biomedical terms such as "hypertension" or "diabetes" may not correspond to diagnostic categories of a given ethnomedical system. **Illness, in contrast, is the experience of impairment or distress, as culturally defined and constructed.** Cause of the illness may also be located in social and spiritual realms, so that ethnomedical aetiology (causes of a disease or condition) may include sorcery, soul loss, and spirit intrusion.*

In addition to negotiation of the meaning of illness, management of illness and disability also occur in a social and cognitive matrix. Healing is often mediated by symbols and practices that induce conditioned neurophysiological and immune system responses. *The placebo effect of the healer's behavior and symbols to induce healing or to reduce stress is of central interest in ethnomedical studies.*

*Cultural psychiatry is closely allied with ethnomedicine. Many folk illnesses or "culture bound syndromes" (such as susto, arctic hysteria, or amok) appear to be psychogenic, although environmental stressors play a role in their onset. **These folk illnesses do not fit easily into Western diagnostic categories.***

*Ethnographic methods are primary in this orientation, and researchers usually do participant-observation, sometimes becoming apprentices of healers and midwives. Some elicit ethnosemantic data on disease categories, causes, and decision models in order to study underlying cognition. Interviews and life histories allow in-depth analysis of the lives of healers and patients, and medical discourse analysis is a specialized linguistic technique that studies the negotiation of meaning and power. Some specialists collect and analyze pharmacologic items; others study the history of medical practices. **Although traditionally researchers have worked in folk societies, increasing numbers are studying pluralistic societies,** such as Margaret Lock (1980). **Attention has***



*been given since the mid-1980s to integrating ethnomedicine and ethnoecology, as in studies of indigenous people's knowledge of medicinal plants.* There is also strong interest in clinical applications of ethnomedical treatments (Chagnon, 1992).

### **2.1.3. Applied Medical Anthropology**

Theories of the cultural patterning of health behavior can be applied in any arena. Following the pioneering examples set by Margaret Clark, George Foster, and Perttl Pelto, *anthropologists work*, for example, *in clinics serving multicultural populations, in maternal and child health programs, on surveys of community responses to environmental hazards, on program planning and evaluation in psychiatric hospitals, on AIDS prevention projects, and on the reintegration of people with traumatic brain injury to community life.* The populations served are often people on the margins of mainstream society-refugees, native peoples, rural elderly, drug addicts, people with disabilities, ethnic minorities. *The difference between basic and applied research is that applied medical anthropologists deliberately become advocates for the community and attempt to do research that is useful and ethical.*

While some applied research is a theoretical, others employ explicit theoretical frameworks. One notable framework is the political economy of health, also called critical medical anthropology. Influenced by Marxist theory and dependency theory, this approach analyses the impact of global economic systems, particularly capitalism, on local and national health. *Political economists* such as Soheir Morsy, Hans Baer, Lynn Morgan, and Merrill Singer argue that *change programs should not be attempted unless one also studies the social production of illness and poverty within the larger dynamics of class interactions, colonialism, or world economic systems* (Hill, 1991).

Critical clinical medical anthropology is an adjunct of political economy. *This approach analyses biomedical practice and the differentials in power and authoritative knowledge of practitioner and patient.* Clinical anthropology has been influenced by Michel Foucault's writings on the historical production of medical knowledge and the notion that the body can become an arena in which social control issues are played out. Usually focused on medical communication, the approach has been used particularly in relation to women's reproductive health and has developed a controversial literature on the lexicalization of women's bodies through the work of Brigitte Jordan, Emily Martin, Rayna Rapp, and others.

Applied anthropology methods are eclectic, ranging from qualitative to highly quantitative. *Ethnographers have developed rapid assessment techniques to document community health needs during brief field trips.* Others trained in public health, epidemiology, nursing, or medicine may do clinical or laboratory procedures or work with vital statistics. In quantitative approaches, rigorous attention is paid to sampling issues and sophisticated statistical analysis, and informed consent procedures are followed. As Carole E. Hill (1991) points out, many medical anthropologists are now working outside academia and combining standard anthropological skills with technical planning and evaluation skills.

## **2.2. Approaches to Medical Anthropology**

### **2.2.1. The Interpretive Approach in Medical Anthropology**

The interpretive approach, which emerged with Arthur Kleinman's foundational work (1980), departs from an epistemological stand that differs from earlier approaches such as the ecological and cognitive. The concept of explanatory models of illness proposed by Kleinman (1978:187) to elicit what he referred to as the 'native's point of view', introduced a radical change of perspective in the understanding of the relation between the cultural domain and the domain of disease. Kleinman's explanatory model also pertains to the domain of disease. He argued that *disease is not an entity but an explanatory model*. Disease, in this perspective, belongs to culture in particular to "the specialized culture of medicine. And culture is not only a means of representing disease but is essential to its very constitution as a human reality". Kleinman unveils the 'category fallacy' present in the currently dominant view of disease as belonging to the order of nature and asserts: "it is the mistaken belief that our categories belong to nature and that disease as we know is natural and therefore above or beyond (or deeper than) culture...".

This claim has been the basis for much of the theorising and empirical research in this interpretive tradition. For Good, understanding disease as an explanatory model "was not an idealist counter to biological reductionism, but a constructivist argument that sickness is constituted and only knowable through interpretive activities" (idem).

The interpretive activities according to Good involve interaction of biology, social practices and culturally constituted frames of meanings, through which "clinical realities" are constructed" (idem). According to Baer (1997), interpretive medical anthropology has verified how various biomedical subspecialties reach different conclusions about the same clinical episode. The interpretive tradition

examines the construction of interpretations in different social contexts. That is: “how meaning and interpretive practices interact with social, psychological, and physiological processes to produce distinctive forms of illness and illness trajectories” (Good 1994:54). Good’s work is part of this tradition. Together with Mary-Jo Delvecchio-Good, he conducted an analysis of semantic networks associated with ‘heart distress’ in Iran and America (Good 1977). Through this study, they achieved an understanding of how meanings and symbols attached to symptoms compress a reflection and, at the same time, both motivate experiences of illness and social relations.

Good’s semantic network analysis has “provided a means of systematically recording the domains of meaning associated with core symbols and symptoms in a medical lexicon. These are domains which reflect and provoke forms of experience and social relations, and which constitute illness as a ‘syndrome of meaning and experience’”(1994:54).

Within the interpretive theoretical orientation emerges the perspective of embodied experiences. The departure point of this perspective is that sickness is present in the human body as ‘traces of history and social relations’. From a phenomenological perspective these traces constitute ‘memoirs’ to interpret distress, illness and suffering (ibid:55). Efforts to achieve experience-near accounts have used the phenomenological approach to study the medium and structure of experience. Here, the body is conceived as “subject of knowledge and meaning and experience as prior to representation”.

The interpretive approach has been dealing with problems of adequately representing illness, suffering and experience in ethnographic accounts. It also deals with the problematic relation of experience to cultural forms such as narratives and the grounding of such experience in local moral worlds (Kleinman 1991). However, the main shortcoming of the interpretive approach has been its failure to provide a critical stance.

Critical views of the interpretive approach – which later resulted into the formulation of the ‘critical approach’ – pointed to a central flaw: the lack of attention to the role of asymmetrical power relations in the construction of the same clinical realities which this perspective has contributed to disclose. Indeed, those realities constituted through interpretation and representational processes have largely been treated as consensual by the interpretive approach, while usually, in reality, they are not.

The interpretive perspective, Baer (1997) asserted, lacks attention to societal structural determinations of the experience and its interpretations. This problem was also found in Good’s account, Baer maintains that:

The role of political economy (e.g., class relations) in shaping the formative activities through which illness is constituted, made the object of knowledge, and embedded in experience, for example, is largely ignored in Good's account (ibid:25).

Hence illness from the perspective of the interpretive approach provides a better understanding of illness as an inter-subjectively interpreted experience. However critical views of the interpretive approach point to its over emphasising illness individual experiences as well as to its lack of attention to the role of societal forces and structural determinations. Economic migration to Chile from neighbouring countries, responds to global economic trends and changing economic/social structures forcing people to search for low skilled jobs beyond the national frontiers. Consequently, related problems such as structural forms of exclusion and societal discrimination against migrants in Chile ought to be understood in the light of the analysis of the political economy of health, an approach to be discussed next.

### **2.2.2. Political Economy of Health Approach**

Concerned with the macro societal determinants impacting health, the political economy of health approach places its attention on the economic and political structures lying at the base of the social production of morbidity or the rate of disease incidence in a population group.

Morgan defines the political economy of health approach as a “macro-analytic, critical, and historical perspective for analysing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of stratified social, political, and economic relations within the world economic system”(Morgan 1984:132).

Although concerned with a variety of economic systems, centrally, the political economy of health addresses the process of development and expansion of the capitalist world-system and the way biomedicine operates within this context. Both systems, capitalism and biomedicine, are seen as having concomitant logics: “The profit making orientation caused biomedicine to evolve into a capital-intensive endeavour heavily oriented to high technology, the massive use of drugs, and the concentration of services in medical complexes” (Baer 1997:28). This perspective takes into account the economic and political interests involved in administration and provision of health services under the capitalist system.

Indeed, the expansion of the capitalist system is recognised by the political economy of health approach as the most significant, transcending contemporary process and increasingly shaping and

reshaping social life. Moreover macro-economic transformations create economic and social exclusion of large social groups, manifested in their marginal access to economic and social resources, security, housing and health.

In this particular case of study, the economic migration of Peruvian workers into Chile is a consequence of the expansion of capitalism and the emergence of new forms of labour such as labour provided by transnational migrant workers. Such workers' increasing vulnerability is the result of the weakening of the laws and structures that protect workers' well-being (e.g. labour legislation, social security provisions) and new labour-flexible schemes in tune with the changing needs of the capitalist system for expansion. These factors have increased the precarious work/economic conditions of migrant workers and ultimately impact upon their health.

Although very influential, the perspective of political economy of health showed some shortcomings when used within the anthropological analysis. Its emphasis on societal macro forces has resulted in a tendency to “depersonalise the subject matter and the content of medical anthropology by focusing on the analysis of social system and *things*, and by neglecting the particular, the subjective content of illness, suffering and healing as lived events and experiences” (ibid:32).

Not only particular and subjective experiences need to be addressed but also, the different identities existing among worker groups must be considered when scrutinizing the way in which a subordinated position impacts their health. These differences often become visible along lines of gender, ethnicity and national identities.

In general, factors that impact upon migrant workers' health are forms of exclusion and societal discrimination which should be understood in the light of political economy of health. This, as stated before, is because this phenomenon responds to global economic trends and changing economic/social structures. While this is true, recently, the possibility to apprehend empirically and conceptually the world system or global perspective has been debated by anthropologists.

Moore (2004) for instance, discusses how the world system has become an elusive dimension when anthropologists call for its examination in concrete terms. Although Moore does not discard the global perspective, she defines it as a concept-metaphor; as “a space of theoretical abstraction and processes, experiences and connections in the world, important not only to social scientists but now part of most people imagined and experienced worlds” (2004:71).

As Moore points out, one of the problems anthropologists face when dealing with the global perspective is that often the processes, experiences and connections encompassing it “do not involve face-to-face interactions, and are extended over space and time; flows of capital and financial transactions” (ibid:75). As a general consensus in the social sciences, the global perspective exists in contra-distinction and interrelation with the local perspective. However, for the anthropologic inquiry, it represents a less debatable scale of analysis.

This general critic also encompasses anthropological efforts to analyse illness and health from the perspective of political economy and led to the development of a new middle range theoretical approach. The development of a middle ground perspective has been expressed by Lindenbaum (2005) as follows:

Anthropological theories, once split between models of change based either on political– economic determinism or on changing beliefs and cultural values, have given away to an emphasis on an approach that brings the two sides together. Attention now focuses on the productive middle ground, on the analysis of material forces as well as economic and political factors in relation to cultural and subjective orientations (2005:752).

In summary, from an anthropological stand, shortcomings of the political economy of health specifically are divided into three areas. Its emphasis focuses upon the overarching social system. It pays little attention to individual-subjective experiences.

And it does not take culture into account. Acknowledgement of these gaps contributed to the development of the critical approach in medical anthropology; middle ground approach that is discussed next.

### **2.2.3. The Critical Approach in Medical Anthropology**

The critical approach in medical anthropology emerged as a distinctive theoretical conceptualization, mainly for two reasons. Firstly, as a criticism against the interpretive approach, and secondly, as an attempt to redirect the analysis of the medical anthropology towards broader societal and economic dimensions, much in the line proposed by the political economy of health.

Indeed, what of late is called the critical approach in medical anthropology was introduced by Soheir Morsy in 1979 in a paper titled “The missing link in medical anthropology: the political economy of health” (Morsy 1979). This was an early effort to bring the analysis of political economy of health into the anthropological perspective.

This theoretical endeavour aimed to overcome the inherent shortcomings of the one sided and macro perspective of the political economy of health.

Ten years later, Morsy (1990) gave an account of the developments of the critical medical anthropology, stressing its particularities and differences with the political economy of health.

The critical medical anthropology retained emphasis on the connection of health related issues with the economic order and social forces. However, this concern has gone beyond merely focusing upon 'grand' and modern capitalist orders to address the nature of health-related issues in indigenous and pre-capitalist societies, as well as socialist oriented-state societies.

The emphasis on individuals and the place culture has come to signify within the critical analysis, had not been present either in political economy of health. The focus on linkages between individual actions and social/structural determination is based upon the understanding of individual actions as "culturally informed interactions between social actors and political economic relationships as dialectically related" (Morsy 1990:22).

The centrality of culture is also manifested in the relation with 'the Other' seen as "different but connected; a product of a particular history that is itself intertwined with a larger set of economic, political, social and cultural process" (idem). Culture is seen in the critical approach as a system of symbols of an institutional order. The interpretation of these symbols, Morsy argues, involves simultaneous consideration of the political context where these symbols are inscribed. Culture is, therefore, understood in connection with issues of "power, control, resistance and defiance surrounding health, sickness, and healing" (ibid:23).

The critical approach also distinguishes itself from conventional medical anthropological studies as its analysis goes beyond the classic depiction of ethnomedical conceptions as historically free conceptions. The critical approach sees them both – ethnomedical and biomedical constructs – as historically situated social products.

The perspective of the local – as discussed before, more in tune with the anthropological view – has been a relevant and productive field of the critical analysis.

Empirically less problematic, in a critical account, the local is usually contextualized within the broader political setting an often situated within an imaginary global paradigm.

The priority to the local context becomes especially important when conducting ethnography. Indeed, Lindenbaum has acknowledged the development of a critical ethnographic engagement with concepts

of 'health' and 'human rights'. Such commitment has been embraced by the critical approach since it "provides a powerful entry point for understanding and confronting inequalities at home and abroad".

The value of the local has been also demonstrated by the critical approach in terms of creative powers of its analysis, reformulation and resistance. Agency and resistance are key concepts of the critical approach. In the critical analysis, recognizing the powerful role of economic and social forces "does not imply that individuals are passive or impersonal objects but rather, they respond to the material conditions they face in light of the possibility created by the existing configuration of social relations"(Baer, 1997:32).

Particularly important is the attention the critical approach pays to the agency of those whose experiences have been alienated by dominant biomedical discourse. Within the critical approach, the term 'resistance' has served to bring attention to cultural forms and activities which resist the increasing medicalisation of lives (Good 1994).

Studies in the critical approach have also emphasized the need to maintain close attention to sufferers' experience which is not seen as isolated from the social and economic forces which determine this same experience. "...Sufferer experience is a social product, one that is constructed and reconstructed in the action arena between socially constituted categories of meaning and the political-economic forces that shape the context of daily life" (Baer 1997:187).

In summary, as a middle ground perspective, the critical approach departs from the political economy of health approach to address shortcomings as well as critical views of the interpretive approach. As a result, the critical approach developed a more encompassing understanding of illness. Indeed, the epistemological stand of the critical approach holds an interpretive understanding of illness, but its analysis goes beyond that framework. It points to power relations and social interactions in which illness experiences are embedded. These dimensions are also central to my own analysis.

A pivotal element of the problem under study is the connection between macro societal determinations and an individual's subjective experiences. This is a connection to which the critical approach also adheres. The critical approach also addresses the importance of understanding the experience of the sufferer in social contexts which is a central dimension of my own problem.

In the next section I discuss the social suffering approach, which not only focuses on illness but also includes in its analysis, various forms of human suffering. This includes emotional suffering and sees these various forms as embedded in broader societal relations. In this approach, illnesses as well as



other forms of human suffering are seen as a consequence of existent structural inequality and various other forms of violence.

Hence, in this approach, migrants' emotional distress is placed within the framework of various forms of suffering which results from structural, economic and political violence.

#### **2.2.4. The Social Suffering Approach**

A call to explore the ways in which social relations and ideologies encourage diverse experiences of suffering was articulated by various authors in the field. Kleinman (1991, 1997) and Farmer (1989, 1990) have explored the ways in which structural violence and social suffering construct the social relations of everyday life. According to them, social suffering is understood as resulting from “what political, economic, and institutional power does to people and, reciprocally, from how these forms of power themselves influence responses to social problems”. However, suffering in this approach is a more all-encompassing concept. It can also take the form of grieving, frustration, desperation, impotence, desolation as well as other forms of human suffering.

Perspectives on social suffering interrogate aspects of human experience that are usually considered separately, and bring together conditions that simultaneously involve health, welfare, legal, moral and religious issues. This approach necessarily challenges dichotomized approaches to the mental and physical, or the individual and the collective. It highlights, instead, the interconnections needed to grasp the political economic and social origin of illness as well as other forms of human suffering. As Kleinman asserted “we put in that category of social suffering every different kind of human problem that creates pain, distress, and other trials for people to undergo and endure. We do not, for example, separate illness from political violence or from other forms of misery...”. This approach provides for a grouping of human problems which highlight the issue this study deals with. That is, how suffering derived from exclusion and discrimination is transformed into emotional distress, or through its embodiment, transformed into a physical experience.

Causes of suffering, as collectively rooted, make it a social experience which Kleinman defines as “the often close linkage of personal problems with societal problems. It reveals, too, the interpersonal grounds of suffering: in other words suffering is a social experience”.

Three themes are highlighted within the perspective of social suffering; the cultural representation of suffering; suffering as social – and changing – experience as well as the political and professional processes placed in motion to respond to suffering

Firstly, cultural representations of suffering refer to “– images, prototypical tales, metaphors, models – can be (and frequently are) appropriated in the popular culture or by particular social institutions for political and moral purposes”). In that sense it is possible to affirm that suffering has social and political use. Furthermore, collective suffering is a core component of the global political economy. Kleinman point out how in the modern, capitalist and interconnected world there is even a market for suffering.

For instance, “victimhood becomes commodified”, and global media campaigns are a case in point. The cultural representations of suffering shape different modes of suffering which, in turn, are authorised by a moral community and its institutions.

Secondly, the cultural representation of suffering shapes it as a form of social experience. As a social experience, suffering is understood in at least two ways:1) as collective modes of experience which shape individual perceptions and expression. Modes are visible in “collective patterns of how to undergo troubles and they are taught and learned, sometimes openly, often indirectly,” and (2) as social interactions that enter into an illness experience (idem).

Relationships and interactions are visible in the involvement of the social milieu in individual suffering. This means taking part in the experience of suffering. Suffering, the authors assert, although grounded in the human condition, may also undergo changes. These changes result from its connection with the moral symbolic system, with the political economy. Therefore, suffering is subject to societal transformations. Social experiences are viewed in the perspective of its transformation which, in turn, they impact upon the way individuals experience suffering “...Changing societal practices,” Kleinman says, “transform individual lives and ways of being-in-the-world” (1997:xii). What is ultimately transformed is the way in which individuals experience suffering.

Thirdly, political and professional processes powerfully shape the responses to the many types of social suffering. In other words, institutional efforts directed toward managing and regulating suffering take on the form of medicalisation and public policies as well as programs tailored to respond to social suffering. According to Kleinman, these processes involve both authorized and contested appropriations of collective suffering. Appropriation refers to the representation on behalf of the victims assumed by leaders, organizations or institutional agents.

## Chapter Three

### Health Behavior and Lifestyles: Their Impacts on Health

#### 3.1. Health Behavior

Before discussing the behavior of people who feel sick and in need of medical treatment, we will examine the behavior of healthy people who try to remain that way. This is an important area of investigation in medical sociology, because health-oriented behavior does not pertain just to those activities concerned with recovering from disease or injury. It also involves the kinds of things that healthy people do to stay healthy. Living a healthy lifestyle and maintaining one's own health in the process has become an increasingly important component of life for many people. Consequently, medical sociologists divide health-oriented behavior into two general categories: health behavior and illness behavior.

Illness behavior is the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it (Kasl and Cobb 1966). Health behavior, in contrast, is defined as the activity undertaken by individuals for the purpose of maintaining or enhancing their health, preventing health problems, or achieving a positive body image (Cockerham 2000a). This definition of health behavior does not limit participation to healthy people trying to stay healthy (Kasl and Cobb 1966). Instead, it includes people in good health, as well as the physically handicapped and persons with chronic illnesses such as diabetes and heart disease, who seek to control or contain their affliction through diet, exercise, and other forms of health behavior. It also includes persons whose primary motivation in regard to health behavior is their desire to look and feel good and for whom being healthy is secondary. For example, we know from past studies of business corporations that the health goals of some people are focused on enhancing their bodily appearance and physical condition to appear attractive and successful (Conrad 1994; Kotarba and Bentley 1988). For most other people, however, their health behavior is primarily intended to prolong their lives and maintain their health (Goldstein 1992). Yet regardless of the underlying motivation, it is clear that health-promoting behavior and lifestyles are spreading in advanced societies (Cockerham *et al.* 1988a; Conrad 1988a, 1988b, 1994; Goldstein 1992).

In this chapter we will review the research pertaining to 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. The first part of the discussion will focus on the health lifestyles that people pursue on their own, more or less independently of the medical profession. The second part will review the health behavior of people that places them in direct contact with medical doctors and other health professionals, for preventive care intended to maintain their health and reduce the risk of illness.

### **3.2. 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 at health spas. For most people, healthy 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) (1986), significant improvements in health in the nineteenth century were brought about by what might be called "engineering methods"-the building of safe water supplies and sewers and the production of cheap food for urban areas through the use of mechanized agriculture. These methods continue to improve the health of people in underdeveloped areas of the world. 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 "postmedical 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 (1986:117) 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."

While the provision and financing of medical care remains a critically important health policy issue today, 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. Robert Crawford (1984) helps us to understand why this is the case. 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.

### **3.2.1. Max Weber's Views on Lifestyle**

Before discussing health lifestyles, it is useful to review the work of German sociologist Max Weber (1864-1920). Weber is one of the most influential sociological theorists of all time, and his views on lifestyles in general help place the concept of a "healthy lifestyle" in perspective. Weber's notion of lifestyles appears in his discussion of status groups in his classic work *Economy and Society* (1978), originally published in 1922. Karl Marx had earlier suggested that a person's social class position is determined exclusively by his or her degree of access to a society's means of production. In other words, Marx claimed that one's location in a class structure results strictly from how much of society's goods and services that person is able to command. However, in Weber's view, Marx's concept of class is not the whole story in determining someone's social rank; rather, status (prestige) and power (political influence) are also important. Weber focused primarily on the difference between class and status in his analysis. He pointed out that while class was an objective dimension of social life signified by how much money and property a person has, status was subjective in that it consists of the amount of esteem a person is accorded by other people. Typically, a person's occupation, income, and level of education are the basis of such esteem.

A status group refers to people who share similar material circumstances, prestige, education, and political influence. Moreover, members of the same status group share a similar lifestyle. In fact, a particular lifestyle is what distinguishes one status group from another. People with high socioeconomic status clearly lead a different style of life than those at the bottom of society and those somewhere in the middle. Weber also made the pertinent observation that lifestyles are not based upon what one produces, but upon what one consumes. That is, one's lifestyle is a reflection of the types and amounts of goods and services one uses or consumes. Thus, for Weber, the difference between status groups does not lie in their relationship to the means of production as suggested by Marx, but in their relationship to the means of consumption.

This view applies to health lifestyles because when someone pursues a healthy style of life, that person is attempting to produce good health according to his or her degree of motivation, effort, and capabilities. Yet the aim of this activity, as Weber's insight suggests, is ultimately one of consumption. People attempt to maintain or enhance their health in order to use it for some purpose, such as a longer life, work, sexual attractiveness, or enhanced enjoyment of their physical being. A. d'Houtaud and Mark Field (1984) found in a study in France, that health was conceptualized as something to be cultivated for increased vitality and enjoyment of life among the upper and middle classes, and for the ability to continue to work among lower-class persons. The lower class viewed health largely as a means to an end (work), while persons with higher socioeconomic status regarded health as an end in itself (vitality and enjoyment). In both situations, health was something that was to be consumed, not simply produced. Furthermore, in producing a healthy lifestyle, the individual often *consumes* various goods and services, such as athletic clothing and equipment, healthy food and drink, vitamins, possibly sport club memberships, vacations for rest and relaxation, and the like.

Crawford (1984) suggests that health has indeed become a metaphor for consumption. That is, good health is a form of release in that it provides a person with the freedom to consume in order to satisfy personal needs. Furthermore, Crawford claims that the abundance of news and commentary in the media on lifestyles and health has reduced complacency about staying healthy. He notes that the media has declared health and fitness activity to be a lifestyle in itself. An important response to this situation is the virtual flood of commercial products in American society, to help the individual "manufacture" health. Crawford (1984:76), "the complex ideologies of health are picked up,

magnified, and given commodity form by the image-makers." Commercial products associated with fitness not only produce profits, but also reinforce the general idea that health and fitness constitute a practical goal to be achieved through the use of these products.

Weber did not ignore the socioeconomic conditions necessary for a specific lifestyle. Weber deliberately used three distinct terms to express his view of lifestyles: "*Lebensstil*" (lifestyle), "*Lebensfuhrung*" (life conduct), and "*Lebenschancen*" (life chances). *Life conduct* and *life chances* are the two components of *lifestyle* (Abel and Cockerham 1993; Cockerham, Abel, and Luschen 1993). *Lebensfuhrung*, or life conduct, refers to the choices that people have in the lifestyles they wish to adopt, but the potential for realizing these choices is influenced by their *Lebenschancen*, or life chances. Ralf Dahrendorf (1979:73) notes that Weber is ambiguous about what he really means by life chances, but the best interpretation he found is that life chances are the "probability of finding satisfaction for interests, wants, and needs." For Weber, the notion of life chances therefore refers to the probability of acquiring a particular lifestyle, which means the person must have the financial resources, status, rights, and social relationships that support the chosen lifestyle. One's life chances are shaped by one's socioeconomic circumstances.

Of course, the life chances that enhance participation in a healthy lifestyle are greatest among upper and middle socioeconomic groups who have the best resources to support their lifestyle choices. Yet it was Weber's contention that lifestyles frequently spread beyond the groups in which they originate (Bendix, 1960). A good example is the spread of the Protestant ethic (a lifestyle emphasizing thrift, effort, and the value of work as a good in itself) into the general culture of Western society. One result is that, in the modern world, the Protestant ethic is no longer distinctive to Protestants, nor the West. While lifestyles set people apart, Weber suggests that lifestyles can also spread across society. And there is evidence that health lifestyles, emphasizing exercise, sports, a healthy diet, avoidance of unhealthy practices such as smoking and so on, which had their origin in the upper middle class-are beginning to spread across class boundaries in Western society (Featherstone 1987). Most people try to do at least something (even if it is just eating sensibly, get enough sleep, or relax) to protect their health (Harris and Guten 1979).

Weber's ideas about lifestyles are important for several reasons. First, his work led to the development of the concept "socioeconomic status," or SES in sociology, as the most accurate reflection of a person's social class position. The location of a person in the social hierarchy of society

is determined not by income alone, but typically by a combination of three indicators: income, education, and occupational status. Second, lifestyle is a reflection of a person's status in society, and lifestyles are based on what people consume, rather than what they produce. Third, lifestyles are based upon choices, but these choices are dependent upon the individual's potential for realizing them. And this potential is usually determined by the person's socioeconomic circumstances. Fourth, although particular lifestyles characterize particular socioeconomic groups, some lifestyles spread across class boundaries and gain influence in the wider society.

Therefore, when it comes to health lifestyles, Weber's work suggests that, while such lifestyles are oriented toward producing health, the aim of the activity is ultimately toward its consumption as people try to be healthy so they can use their health to live longer, enjoy life, be able to keep on working, and so forth. Furthermore, while health lifestyles seem to be most characteristic of the upper and middle classes, the potential exists for them to spread across social boundaries. The quality of participation may differ significantly, but the level of participation in advanced societies may be spreading nonetheless. Regardless of one's particular socioeconomic position, an important feature of modern society appears to be the tendency for many people to adopt a healthy lifestyle within the limits of their circumstances and opportunities.

Of all the socioeconomic groups, however, the poor are especially disadvantaged in relation to positive health lifestyles. As K. A. Wickrama and associates (1999:260) explain, "socially disadvantaged individuals have less access to health information and resources; they have less control over sleeping hours, and food choices; and they are more likely to live in a social environment where unhealthy eating, smoking and heavy drinking are normality, making the formation of risky lifestyles more probable." Among the behavioral practices affecting health, for example, smoking cigarettes and cigars has the largest number of adverse consequences (Wray *et al.* 1998). Heart disease, stroke, atherosclerosis, and respiratory diseases, along with lung, throat, and other cancers, are all directly associated with smoking. The poor show the highest proportion of smokers followed (in descending order) by the near poor, middle-income groups, and high-income groups. About twice the proportion of poor persons smoke compared to persons with high incomes.

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 habitus operated to align individual aspirations and expectations with the objective probabilities for realizing them, typical of people in the same social class. 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.

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.

### **3.2.2. Theory on Health Lifestyles**

Drawing upon the theoretical perspectives of Weber and Bourdieu, the author (Cockerham 2005) has formulated an initial 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 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 (Backett and Davison 1995; Luschen *et al.* 1995). Exercise, however, tends to decline with age. 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 (Cockerham 200S; Grzywacz and Marks 2001; Marang-van de Mheen, Smith and Hart *et al.* 1999; Roos *et al.* 1998; Wickrama *et al.* 1999). 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 (Karlsen and Nazroo 2002; Robert and House 2000; Smaje 2000). Social class also exercises a powerful influence on age and gender, since adults on the higher rungs of the social ladder have more effective health lifestyles, regardless of how old they are or whether they are male or female (Cockerham 200S).

The next category is collectivities. 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 (Idler 1995; Musick 1996; Musick, House, and Williams 2004). 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, indoor plumbing, 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 (1990) 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.

Class circumstances and the other structural variables provide the social context for socialization and experience. Whereas primary socialization is the imposition of society's norms and values on the individual usually by family members and secondary socialization results from later (adult) training,

experience is the learned outcome of day-to-day activities that occurs through social interaction and the practical exercise of agency. Agency is a term in sociology, referring to the process by which people critically evaluates and chooses their course of action. Experience provides the essential basis for agency's practical and evaluative dimensions to evolve over time. Socialization and experience provide the capacity to make life choices. As previously noted, the term "life choices" was introduced by Weber and refers to the self-direction of one's behavior.

The structural categories comprise a person's life chances. Life chances represent structure in a Weberian context. Weber's thesis is that a person's life chances are socially determined and an individual's social structure is the arrangement of those chances. Choices and chances interact to determine a person's health lifestyle, as life chances either enable or constrain the choices made. The interaction between life choices and life chances produces dispositions toward particular forms of action. These dispositions constitute a "habitus" as suggested by Bourdieu. As noted, the habitus serves as a cognitive map or set of perceptions that routinely guides and evaluates a person's choices and options. The dispositions toward action provided by the habitus tend to be compatible with the behavioral guidelines set by the wider society. Therefore, usual and practical modes of behaving-not unpredictable novelty-typically occur.

Dispositions produce practices (action). The practices may be either positive or negative, but nonetheless comprise a person's overall pattern of health lifestyles. Action or inaction, with respect to a particular health practice, leads to its reproduction, modification, or nullification by the habitus through a feedback process. This is consistent with Bourdieu's assertion that when dispositions are acted upon they tend to reproduce or modify the habitus from which they are derived. Overall, this theory is an initial representation of the health lifestyle phenomenon and is intended to display how social structures influence individual participation in such lifestyles.

### **3.2.3. Health Lifestyles in Western Society**

Health professionals and the mass media have spread the message that healthy people need to avoid certain behaviors and adopt others as part of their daily routine, if they want to maximize their life expectancy and remain healthy as long as possible. These statements are supported by ample evidence that a lack of exercise, diets high in fat and cholesterol, stress, smoking, obesity, alcohol and drug abuse, and exposure to chemical pollutants cause serious health problems and early deaths (Greenland *et al.* 2003; Khot *et al.* 2003; I. Lee, Hsieh, and Paffenbarger 1995). It is also well known

that lifestyles involving unprotected and promiscuous sexuality and intravenous drug use increase the risk of AIDS, while smoking is linked to lung cancer, alcoholism to cirrhosis of the liver, and high-fat diets to atherosclerosis and heart disease.

On the positive side, there is evidence that pursuing a healthy lifestyle can enhance one's health and life expectancy. Exercise has been found to reduce the risk of dying from heart disease (I. Lee *et al.* 1995), as have reductions in cholesterol levels, blood pressure, and cigarette smoking (Greenland *et al.* 2003; Khot *et al.* 2003). In other research, an extensive ten-year survey of the health lifestyles of nearly 7,000 adults in Alameda County, California, identified seven good health practices: (1) seven to eight hours a night of sleep; (2) eating breakfast every day; (3) seldom if ever eating snacks; (4) controlling one's weight; (5) exercising; (6) limiting alcohol consumption; and (7) never having smoked cigarettes (Berkman and Breslow 1983). People reporting six or seven of these health practices were found to have better health and longer lives than people reporting fewer than four of them.

Such developments suggest that health lifestyles should be important for many people. Health lifestyles also should be more common in advanced societies where people have greater choices in their selection of lifestyles and a better opportunity to be healthy than in developing nations with relatively low standards of living and fewer health options. This appears to be the case as shown in research conducted in the United States and Western Europe.

*The United States and Germany.* Earlier research (Cockerham, Kunz, and Lueschen 1988a, 1988b; Cockerham *et al.* 1986b; Liischen, Cockerham, and Kunz 1987, 1989) compared the health lifestyles of Americans living in Illinois to Germans in Northrhine-Westphalia and found a distinct lack of difference between social classes in health behavior. Although the quality of participation varied, healthy lifestyles appeared widely accepted and practiced.

One study (Cockerham *et al.* 1988a) examined whether there were significant differences between people with comprehensive health care benefits provided by their government (Germans) and those generally lacking such coverage (Americans) in regard to participating in health lifestyles. Germany has an extensive system of national health insurance that covers 93 percent of the total population (the wealthiest are excluded and required to obtain private health insurance), while in the United States only some 20 percent of the population at the time—the aged and the poor—had government-sponsored health insurance through Medicare and Medicaid. The study sought to determine whether

Americans, who do not have the security of a national health insurance program, worked harder to stay healthy than Germans, who have their health care costs covered by a national health plan. The data showed a general lack of difference between Americans and Germans, as well as between social strata in the two countries, with respect to participation in health lifestyles. The more paternalistic German system of health insurance coverage did not appear to undermine personal incentives to stay physically fit in comparison to the American system, where people are more on their own in obtaining health insurance and covering their costs for health care.

These studies would suggest that—at least in the United States and Germany—health lifestyles are spreading across class boundaries in a manner, similar to that suggested by Weber (1958) for the Protestant ethic. This observation does not mean that everyone is trying to live in a healthy manner, but many people are, and they include persons in all social strata. However, the quality of participation is likely to be severely affected by class position and that position in the case of lower social strata can preclude or undermine health lifestyle practices.

### **3.3. Preventive Care**

As noted earlier in this chapter, healthy lifestyles generally take place outside of the formal health care delivery system, as people pursue their everyday lives in their usual social environment. However, an important facet of health behavior includes contact by healthy people with physicians and other health personnel for preventive care. Preventive care refers to routine physical examinations, immunizations, prenatal care, dental checkups, screening for heart disease and cancer, and other services intended to ensure good health and prevent disease—or minimize the effects of illness if it occurs.

#### **3.3.1. Preventive Care and the Poor**

While there is evidence that participation in health lifestyles that do not involve contact with physicians and other health personnel can spread across social class boundaries, there is other evidence showing that the poor remain least likely to use preventive care (Snead and Cockerham 2002). Low-income women receive less prenatal care, low-income children are significantly more likely to have never had a routine physical examination, and other measures like dental care, breast examinations, and childhood immunizations are considerably less common among the poor (Wilkinson 1996). The reason for this situation is that many low-income persons do not have a regular source of medical care, health facilities may not be near at hand, and costs not covered by

health insurance may have to be paid out of the individual's own pocket-and this factor can be a significant barrier in visiting the doctor when one feels well. Moreover, for people without any health insurance, going to the doctor for preventive care may be an unaffordable luxury.

The underutilization of preventive care among the poor is common, not just in the United States but also in several European countries where the lower class has been found to use preventive medical and dental services significantly less frequently (Lahelma 2005; Macintyre 1989). Consequently, it can be argued that preventive care is a behavior pattern most characteristic of the upper and middle classes in advanced societies. When explanations are sought for the significant disparity in health and life expectancy between the affluent and the poor in the world today, the conditions of living associated with poverty and the lack of preventive care among the lower classes are major factors.

### **3.3.2. The Health Belief Model**

One of the most influential social-psychological approaches designed to account for the ways in which healthy people seek to avoid illness, is the health belief model of Irwin Rosenstock (1966) and his colleagues (M. Becker 1974). The health belief model is derived to a great extent from the theories of psychologist Kurt Lewin, who suggested that people exist in a life space composed of regions with both positive and negative valences (values). An illness would be a negative valence and would have the effect of pushing a person away from that region, unless doing so would cause the person to enter a region of even greater negative valence (for example, risking disease might be less negative than failing at an important task). While people are pushed away from regions with negative valences, they are attracted toward regions of positive valences. Thus, a person's behavior might be viewed as the result of seeking regions that offer the most attractive values.

Within this framework, human behavior is seen as being dependent upon two primary variables: (1) the value placed by a person upon a particular outcome, and (2) the person's belief that a given action will result in that outcome. Accordingly, the health belief model suggests that preventive action taken by an individual to avoid disease "X" is due to that particular individual's perception that he or she is personally susceptible and that the occurrence of the disease would have at least some severe personal implications.

Although not directly indicated, the assumption in this model is that by taking a particular action, susceptibility would be reduced, or if the disease occurred, severity would be reduced. The perception of the threat posed by disease "X," however, is affected by modifying factors. These factors are

demographic, sociopsychological, and structural variables that can influence both perception and the corresponding cues necessary to instigate action. Action cues are required, says Rosenstock, because while an individual may perceive that a given action will be effective in reducing the threat of disease, that action may not be taken if it is further defined as too expensive, too unpleasant or painful, too inconvenient, or perhaps too traumatic.

So despite recognition that action is necessary and the presence of energy to take that action, a person may still not be sufficiently motivated to do so. The likelihood of action also involves a weighing of the perceived benefits to action contrasted to the perceived barriers. Therefore, Rosenstock believed that a stimulus in the form of an action cue was required to "trigger" the appropriate behavior. Such a stimulus could be either internal (perception of bodily states) or external (interpersonal interaction, mass media communication, or personal knowledge of someone affected by the health problem).

The health belief model has been employed successfully in several studies of (preventive) health behavior, such as dietary compliance (M. Becker *et al.* 1977) and ethnic differences in managing hypertension (c. Brown and Segal 1996). Help-seeking behavior was observed to be based upon the value of the perceived outcome (avoidance of personal vulnerability) and the expectation that preventive action would result in that outcome. For example, in the Becker *et al.* (1977) study, 182 pairs of mothers and their obese children were divided into three groups, while the children participated in a weight reduction program. The groups consisted of: (1) a high-fear group (shown alarming material about the potentially unfavorable consequences of being fat in later life), (2) a low-fear group (shown similar but less threatening information), and (3) a control group (shown no additional information). Children in the control group did not lose weight. Children in the low-fear group lost some weight initially but also tended to put some of it back on. The high-fear group lost the most weight and did not put any of it back on. The intervention of a fear-arousal cue in the high-fear group had a marked effect on the mothers' notions of the perceived susceptibility, seriousness, and benefits of compliance for their children.

Unfortunately, the usefulness of the health belief model is limited in that it has been applied mostly to preventive situations in which the behavior studied is voluntary. Obviously, however, many people who seek health services are motivated to take action only by the appearance of clear and definite symptoms.

Nevertheless, the health belief model has demonstrated considerable utility in the study of health behavior. The merit of the model is that even when an individual recognizes personal susceptibility, he or she may not take action *unless* the individual also perceives that being ill will result in serious difficulty. Thus, the individual's subjective assessment of the health situation becomes the critical variable in the utilization of health services. In fact, a person's subjective assessment may be more important than an objective medical diagnosis. David Mechanic (1972) has noted that the difficulty in preventive medicine is that commonsense approaches do not necessarily match clinical approaches, and common sense often determines whether health services are sought. Furthermore, if a patient subjectively feels well, physicians may be faced with the additional problem of motivating the patient to continue to follow medical advice.

### **3.4. The Connection between Social Environment and Health**

#### ***Definition of 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). But 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. As one young adult woman in a British study puts it:

Health is having loads of whump. You feel good, you look good, nothing really bothers you, life is wonderful, you seem to feel like doing more. (Blaxter 2004:52).

Thomas McKeown (1979) supports the WHO definition when he points out that we know from personal experience that feelings of well-being are more than the perceived absence of disease and disability. Many influences-social, religious, economic, personal and medical contribute to such feelings. The role of medicine in this situation is the prevention of illness and premature death, as well as the care of the sick and disabled. Thus, McKeown concludes that medicine's task is not to create happiness, but to remove a major source of unhappiness-disease and disability-from people's lives.

However, most studies suggest that laypersons 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. Good health is clearly a prerequisite for the adequate functioning of any individual or society. If our health is sound, we can engage in numerous types of activities. But if we are ill, distressed, or injured, we face the curtailment of our usual round of daily life, and we may also become so preoccupied with our state of health that other pursuits are of secondary importance or even meaningless. Therefore, as Rene Dubos (1981) explains, health can be defined as the ability to function. This does not mean that healthy people are free from all health problems, but means that they can function to the point that they can do what they want to do. Ultimately, suggests Dubos, biological success in all of its manifestations is a measure of fitness.

Social factors also are important in influencing the manner in which societies organize their resources to cope with health hazards and deliver medical care to the population at large. Individuals and societies tend to respond to health problems in a manner consistent with their culture, norms, and values. As Donald Light (Light and Schuller 1986:9) explains, "medical care and health services are acts of political philosophy." Thus, social and political values influence the choices made, institutions formed, and levels of funding provided for health. It is no accident that the United States has its distinct form of health care delivery and other nations have their own approaches. Health is not simply a matter of biology, but involves a number of factors that are social, cultural, political, and economic in nature.

Throughout history, human beings have been interested in and deeply concerned with the effects of the social environment on the health of individuals and the groups to which they belong. Today it is clear that social factors play a critically important role in health, as the greatest threats to the health and well-being of individuals stem largely from unhealthy lifestyles and high-risk behavior. Sociology's interest in medicine as a unique system of human social behavior and medicine's recognition that sociology can help health practitioners to better understand their patients and provide improved forms of health care, have begun to bring about a convergence of mutual interest between the two disciplines.

Attempts to understand the relationship between social behavior and health have their origin in history. Dubos (1969) suggested that 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 pervade 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, some 4,000 to 5,000 years ago, 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 (Porter 1997).

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. Little is known of Hippocrates, who lived around 400 B.C., not even whether he actually authored the collection of books that bears his name. Nevertheless, the writings attributed to him have provided a number of principles underlying modern medical practice. 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. In his classic treatise, *On Airs, Waters, and Places*, 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 ailment. 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 1977:131).

A few physicians, such as Paracelsus, a famous Swiss doctor who lived in the early sixteenth century, did show interest in understanding more than the physical functioning of the body. Paracelsus demonstrated that specific diseases common among miners were related to their work conditions. But Paracelsus was an exception, and few systematic measures were employed to either research or cope with the effects of adverse social situations on health until the late eighteenth and early nineteenth centuries.

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 in both Europe and North America 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 European 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.

The transition from acute to chronic diseases meant that physicians were increasingly called upon to deal with the health problems of the "whole person," which extend well beyond singular causes of disease such as a germ. Contemporary medical doctors are required to treat health disorders more aptly described as "problems in living," dysfunctions that involve multiple factors of causation, not all of them biological in origin. Social and psychological factors not only influence whether or not a person becomes sick, but also the form, duration, and intensity of the symptoms. Consequently,

modern medicine is increasingly required to develop insights into the behaviors characteristic of the people it treats.

Also, it is not uncommon for an individual suffering from a chronic disease to feel perfectly normal, even when irreversible damage to organs and tissues is occurring. Because of the irremediable damage done to the body by a chronic disease, patients may be required to permanently change their style of living. As Anselm Strauss (1975), one of the pioneers in medical sociology, pointed out several years ago, health practitioners need to know how patients with chronic disorders control their symptoms, adjust to changes in their physical condition, and live their lives. This is in addition to all else that physicians need to know about the behavior and lifestyles of individuals that influence whether they are likely to develop chronic disorders in the first place.

According to **Porter**, it is not only radical thinkers who appealed for a new "wholism" in medical practice, but many of the most respected figures in medicine were insistent that treating the body as a mechanical model would not produce true health. Porter (1997:634) 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, supplant laboratory medicine preoccupied with minute investigation of lesions but indifferent as to how they got there.

At this time in history, it is clear that social behavior and social conditions play a critically important role in causing disease. Negative health lifestyles involving poor diets, lack of exercise, smoking, alcohol and drug abuse, stress, and exposure to sexually transmitted diseases like AIDS can lead to sickness, disability, and death. Positive health lifestyles-the reverse of the above-help lessen the extent of chronic health problems, better control these problems when they appear, or allow the individual to avoid them until the onset of old age. However, adverse social conditions, such as poverty, also promote health problems and reduce life expectancy. Several studies report, for example, that the poor are more likely to engage in practices that induce ill health and less likely to engage in practices that forestall illness-inducing situations (Grzywacz and Marks 2001; Robert and House 2000; Pampel and Rogers 2004).

The poor are exposed to more violence in their daily lives and find themselves in situations where stress, inadequate diets and housing, and less opportunity for quality health care are common. They may also live in areas where industries pollute the environment with cancer-causing agents or other chemicals causing skin and respiratory disorders. They may have greater exposure to communicable diseases because of crowded living conditions, parasites, insects, and vermin. To be poor by definition means to have less of the good things in life. It also means the possibility of having more of the bad things and, with respect to health problems; this seems to be the case. The poor have the highest rates of disease and disability, including heart disease, of any socioeconomic group (Link and Phelan 1995, 2000; Phelan et al. 2004).

The need to understand the impact of lifestyles and social conditions on health has become increasingly important in preventing or coping with modern health disorders. This situation has promoted a closer association between medicine and the behavioral sciences of sociology, anthropology, and psychology. Medical sociologists are increasingly familiar figures, not only in medical schools, but also in schools of nursing, dentistry, pharmacy, and public health, as well as in the wards and clinics of teaching hospitals. Medical sociologists now routinely hold joint teaching and research appointments between sociology departments and departments in various health-related educational institutions or are employed full time in those institutions.

There are obvious differences in patterns of health and illness across societies, over time, and within particular society types. There has historically been a long-term decline in mortality within [industrialized](#) societies, and on average, life-expectancies are considerably higher in [developed](#), rather than developing or [undeveloped](#), societies. Patterns of global change in health care systems make it more urgent than ever to [research](#) and comprehend the sociology of health and illness. Continuous changes in economy, [therapy](#), [technology](#) and [insurance](#) can affect the way individual communities view and respond to the medical care available. These rapid fluctuations cause the issue of health and illness within social life to be very dynamic in definition. Advancing information is vital because as pattern evolves, the study of the sociology of health and illness constantly needs to be updated.

The Sociology of Health and Illness looks at three areas: the conceptualization, the study of measurement and social distribution, and the justification of patterns in health and illness. By looking at these things researchers can look at different diseases through a sociological lens. The prevalence and response to different diseases varies by culture. By looking at bad health, researchers can see if health affects different social regulations or controls. When measuring the distribution of health and

illness, it is useful to look at official statistics and community surveys. Official statistics make it possible to look at people who have been treated. It shows that they are both willing and able to use health services. It also sheds light on the infected person's view of their illness. On the other hand, community surveys look at people's rating of their health. Then looking at the relation of clinically defined illness and self reports find that as there is often a discrepancy.

### **Changing pattern of disease**

There are three characteristics of disease patterns in historical sequence.

Those are:

1. **Pre-agricultural disease patterns:** during this time people engage in hunting and gathering economic activity to sustain their live. Their health is affected by environmental hazardous and accidents as a result of natural factor. Infectious disease brought by pathogenic agent like germ and bacteria is relatively insignificant. The health problem during this time stem from natural environment and people relies more on religious institution to stay healthy.
2. **Disease in agricultural societies:** It is a period when human being started settled life. People collected together and establish dense community by settling around one area. This settlement led to overcrowdings of people which in turn led to poor sanitation. As a result disease brought by pathogenic agent like germs and bacteria and infectious disease like malaria started by unsanitary living conditions. A person relies on medical care to prevent themselves from such disease. E.g. malaria and cholera.
3. **Disease in modern industrial societies:** disease during this time is brought by unhealthy life style and risky behavior. Disease shift it's pattern from acute to chronic disease which affects all people equally those who leads typical unhealthy life style. A person responds to their illness by engaging in life style rather than entirely medicalization, because of different factor. They want to feel normal whenever irreversible damage occur to their body by adjusting themselves with their illness.

### **Summary**

Health behavior is the activity undertaken by a person who believes himself or herself to be healthy for the purpose of preventing health problems (Kasl and Cobb 1966). Health lifestyles, in turn, are ways of living that promote good health and longer life expectancy. Health lifestyles include contact

with physicians and other health personnel, but the majority of activities take place outside of formal health care delivery systems. These activities include a proper diet, weight control, exercise, rest and relaxation, and the avoidance of stress and alcohol and drug abuse.

Max Weber, one of the most important theorists in the history of sociological thought, analyzed the general role of lifestyles in society and found that, while particular socioeconomic status groups are characterized by their own lifestyles, some lifestyles spread across social boundaries. He also observed that lifestyles are based on what people consume, rather than what they produce. There is evidence from the United States and Germany, and to a lesser extent from Great Britain and France, that health lifestyles are spreading throughout the class structure of these societies-although the quality of participation in the lower classes is undoubtedly less than that of the classes above them. And, while health lifestyles help produce good health, the aim of such lifestyles is ultimately one of consumption as health is used to avoid disease, live longer, feel better, work, or have a pleasing physical appearance.

The work of Weber and Bourdieu contributes to a model of health lifestyles formulated by the author. This model shows how particular structural variables influence health lifestyle choices, with class circumstances depicted as an especially strong variable. Another important facet of health behavior is preventive care that involves contact by healthy people with health care providers. Preventive care consists of routine physical examinations, dental care, cancer and heart disease screening, immunizations, and the like intended to prevent or reduce the chance of illness or minimize its effects. Throughout the world, it appears that lower-class persons are significantly less likely to receive preventive care. The chapter concludes with a discussion of the health belief model, which is an influential approach to the study of health behavior.

## Chapter Four

### 4. Illness Behavior

#### 4.1. Illness Behavior and Self Care

##### 4.1.1. Illness behavior

Illness behavior, in comparison to health behavior, is the activity undertaken by a person who feels ill for the purpose of defining that illness and seeking relief from it (Kasl and Cobb 1966). As David Mechanic (1995:1208) explains: "Illness behavior refers to the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care." Some people recognize particular physical symptoms such as pain, a high fever, or nausea and seek out a physician for treatment. Others with similar symptoms may attempt self-medication or dismiss the symptoms as not needing attention.

We know that bodily changes-symptoms of illness that are disruptive, painful, and visible-are the basic determinants of medical help seeking, and this is especially the case if the discomfort is severe. But sometimes physical changes are not obvious, particularly in the early stages of chronic diseases. As Susan Gore (1989:311) explains, "the timing of the detection of diseases such as diabetes, heart disease, and cancer is determined by factors outside the disease process itself - social and psychological factors that shape the individual's response to the often subtle bodily changes that are experienced in daily living." Thus, subjective interpretations of feeling states become highly medically significant.

The focus of this chapter is on reviewing the social factors influencing the decisions of the ill to use professional medical services.

##### 4.1.2. 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), and 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. It essentially consists of a layperson's preventing, detecting, and treating his or her own health problems. 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. According to Alexander Segall and Jay Goldstein (1989:154), these factors include: (1) 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; (2) growing public dissatisfaction with medical care that is depersonalized; (3) recognition of the limits of modern medicine; (4) the increasing visibility of alternative healing practices; (5) heightened consciousness of the effects of lifestyles on health; and (6) a desire to exercise personal responsibility in health-related matters. More recent research indicates that access to the Internet, with its abundance of medical information, has also encouraged self-care (Stevenson *et al.* 2003). Thus, it would appear that self-care is becoming increasingly important and commonplace.

Yet self-care is not an action that is completely independent of the medical profession. People engage in self-care in a manner consistent with medical norms, values, and information. Often medical advice guides the actions taken (Stevenson *et al.* 2003). When laypersons lack knowledge, competence, or experience to proceed, or are simply more comfortable in allowing professionals to handle matters, they turn to doctors.

#### **4.2. The Effect of Socio-demographic Variables on health seeking behavior and the Utilization of Health Care Services**

Help-seeking "behavior often involves interaction between several variables acting in combination to influence specific outcomes in specific social situations. Nonetheless, attempts to isolate some socio-demographic variables have resulted in studies of such factors as age, sex, ethnicity, and socioeconomic status, explaining how they relate to the behavior of people seeking medical care.

##### **Sex**

The findings for age and sex have been consistent: Use of health services is greater for females than for males and is greatest for the elderly. As indicated in chapter 2 on the social demography of health, it is clear from existing data that females report a higher morbidity and, even after correcting for maternity, have a higher rate of hospital admissions (National Center for Health Statistics 2005;

Weiss and Lonnquist 2006). If extent of knowledge about the symptoms of an illness is considered, it also appears that women generally know more about health matters than men and take better care of themselves. In addition, the number of females in a household appears to be related to the number of physician visits for that household. That is, the larger the number of females in a particular household, the greater the demand for physicians.

Females exhibit a lifelong pattern of visiting doctors more often than do males. There are three peaks in the visitation pattern for females. Initially, there are high rates during childhood, followed by a decline until a second rise during the childbearing years. After age 35, there is once again a decline, but physician visits by females steadily increase after age 45. For males, there are high rates of visits during childhood, followed by comparatively low rates of physician visits until a gradual increase begins at age 45.

Pregnancy and associated conditions do result in especially high rates of visits to physicians for women between the ages of 15 and 45, but the woman's reproductive role accounts for less than 20 percent of all doctor visits. The higher visit rates by women are primarily the result of their greater number of ailments (Lorber 1997; Young 2004). More frequent utilization of physicians may have a substantial benefit for women in that they receive, on the average, earlier diagnosis and treatment for illness than men.

### **Age**

Perhaps it is obvious that people more than 65 years of age are in poorer health and are hospitalized more often than other age groups. It is also clear that elderly people are more likely to visit physicians than younger people. Since older people are more likely both to be physically disabled or ill, and to have public insurance (Medicare) coverage, they tend to visit doctors fairly often. Studies of the utilization of medical services by the aged indicate that such use is determined more by actual need than any other single factor (Cockerham 1997a).

### **Ethnicity**

Several early studies in medical sociology attempted to relate a person's utilization of health care services to his or her cultural background. One of the most systematic studies has been Edward A. Suchman's (1965a) investigation of the extent of the belief in and acceptance of modern medicine among several ethnic groups in New York City. Suchman sought to relate individual medical

orientations and behaviors to specific types of social relationships and their corresponding group structures. He believed the interplay of group relationships with an individual's personal orientation toward medicine affected his or her health-seeking behavior.

Suchman categorized people as belonging to either cosmopolitan or parochial groups. Persons in a parochial group were found to have close and exclusive relationships with family, friends, and members of their ethnic group and to display limited knowledge of disease, skepticism of medical care, and high dependency in illness. They were more likely than the cosmopolitan group to delay in seeking medical care and more likely to rely upon a "lay-referral system" in coping with their symptoms of illness. A lay-referral system consists of nonprofessionals-family members, friends, or neighbors-who assist individuals in interpreting their symptoms and in recommending a course of action. The concept of the lay-referral system originated with Eliot Freidson (1960), who described the process of seeking medical help as involving a group of potential consultants, beginning in the nuclear family and extending outward to more select, authoritative laypersons, until the "professional" practitioner is reached. Freidson suggests that when cultural definitions of illness contradict professional definitions, the referral process will often not lead to the professional practitioner. The highest degree of resistance to using medical services in a lay-referral structure was found in lower-class neighborhoods characterized by a strong ethnic identification and extended family relationships. The decision to seek out a physician is based, not just on professional standards of appropriate illness behavior, but also on lay norms and the two may be in conflict.

By contrast, the cosmopolitan group in Suchman's study demonstrated low ethnic exclusivity, less limited friendship systems, and fewer authoritarian family relationships. Additionally, they were more likely than the parochial group to know something about disease, to trust health professionals, and to be less dependent on others while sick.

As for ethnicity, its influence on physician utilization appears largely limited to its role in providing a cultural context for decision making within social networks. A variable that particularly confounds the effects of ethnicity on help seeking is socio-economic status. The higher an individual's socioeconomic position, the less ethnic the person often becomes (Hollingshead and Redlich 1958). In other words, middle-class Americans of European, African, Hispanic, Asian, and native-origin descent tend to reflect the same middle-class norms and values as part of their mutual participation in middle-class society. Included in this pattern are similar perspectives toward the utilization of health

services. This situation suggests that the direct effects of ethnicity on decision making concerning health care are largely confined to the lower class, as Suchman's (1965a) work indicated.

### **Socioeconomic Status**

Another major approach to the study of help-seeking behavior has been its correlation with socioeconomic status. Several years ago, it was generally believed that lower-class persons tended to under-utilize health services because of the financial cost and/or culture of poverty. The culture of poverty, as summarized by Thomas Rundall and John Wheeler (1979), is a phenomenon in which poverty, over time, influences the development of certain social and psychological traits among those trapped within it. These traits include dependence, fatalism, inability to delay gratification, and a lower value placed on health (being sick is not especially unusual). This, in turn, tends to reinforce the poor person's disadvantaged social position.

In 1968, however, the National Center found a changing pattern of physician utilization. It was now the middle-income group who had become the underutilizers. Highest rates of physician visits were either persons with the lowest level of income or the highest level. The higher rate for the low-income group was largely due to Medicaid and Medicare health insurance programs. Medicaid, administered at the state level, provides coverage intended to help pay the cost of health care for the poor. Medicare, a federal program, provides coverage for the elderly, who are overrepresented in the low-income group.

Between 1963 and 1970, as the effects of Medicaid and Medicare became evident, the use of physician services by low-income persons increased to the point where the significance of the relationship between income and utilization was greatly diminished. In fact, by 1970, it could be demonstrated that the poor had higher rates of physician use than any other income group. For example, according to data collected by Ronald Andersen and Odin Anderson (1979) for selected years between 1928 and 1974, the low-income group had the lowest rates of physician utilization from 1928 to 1931. The middle-income group ranked in the middle, and the high-income group had the highest number of visits. This pattern remained until 1970, when the low-income group emerged with the highest rates, followed by the high-income group and the middle-income group. The present pattern indicates the lowest income group visits physicians most often, followed by middle-income groups. The highest income group visits doctors the least.

Even though the poor are visiting doctors in greater numbers, this does not mean that they use the same sources of medical treatment in proportions equal to those of higher-income groups. Differences between income groups in regard to where they seek care are obvious and consistent. People with higher incomes are more likely than those with lower incomes to have received medical services in private doctors' offices and group practices or over the telephone. However, the reverse situation is true for other sources of care. People with lower incomes are more likely to contact hospital outpatient clinics or emergency rooms. Although people of all income groups use each source, a pattern emerges of a dual health care system—a "private" system with a greater proportion of the higher-income groups and a "public" system with a preponderance of lower-income groups. In the public system, the patient is likely to receive less quality medical care, spend longer amounts of time in waiting rooms, not have a personal physician, cope with more bureaucratic agencies, and return after treatment to a living situation that is less conducive to good health.

Furthermore, when actual *need* for health services is taken into account, low-income persons appear to use fewer services relative to their needs. Diana Dutton (1978) pointed out many years ago that statistics showing increased use of health services by the poor could be misleading. She argued that the poor have higher rates of disability due to illness and that the poor also tend to be more likely to seek symptomatic care. The non poor, in turn, are more likely to seek preventive care, which is aimed at keeping healthy people well, instead of waiting to seek help when symptoms appear. Thus, the poor appear to have more sickness and, despite the significant increase in use of services, still do not obtain as much health care as they actually need. Using data collected in Washington, D.C., Dutton tested three different explanations concerning why the poor would show lower use rates in relation to actual need than the non poor: (1) *financial coverage explanation*, (2) *the culture of poverty explanation*, and 3) *the systems barrier explanation*.

**The financial coverage explanation:** consists of the claim that the poor cannot afford to purchase the services they need—the cost is high, income is low, and insurance programs are inadequate. Dutton found this explanation to be weak. Public health insurance, notably Medicaid, had stimulated use of services by the poor to a much greater extent than private health insurance had done for the non poor. Unlike many private insurance plans, Medicaid paid for most physician services and thereby promoted physician utilization. Conversely, private insurance, with the exception of prepaid plans, had less impact on seeking physician services.

**The culture of poverty explanation:** is derived from the premise that attitudes and, characteristic of poor people, tend to retard use of services. For example, the poor may view society and professional medical practices as less than positive as a result of their life experiences. The poor also may be more willing to ignore illness or not define it as such because they must continue to function to meet the demands of survival. Dutton found the culture of poverty explanation to have some validity when combined with measures of income. As income decreased, belief in preventive checkups and professional health orientation also decreased, while degree of social alienation increased. "Of course," says Dutton (1978:359), "these differences may not reflect cultural variation so much as realistic adaptation to economic circumstances; preventive care may well be less important than paying the rent, and purchasing a thermometer may be viewed as an unaffordable luxury." Nevertheless, Dutton argues that attitudes related to the culture of poverty do play an important role in explaining differences in the use of health services between income groups, particularly the use of preventive care.

**The systems barrier explanation:** In Dutton's view, the strongest explanation for low use of services by the poor in relation to need was the systems barrier explanation. This explanation focused on organizational barriers inherent in the more "public" system of health care typically used by the poor, such as hospital outpatient clinics and emergency rooms. This type of barrier not only pertains to difficulty in locating and traveling to a particular source of care, but also includes the general atmosphere of the treatment setting, which in itself may be impersonal and alienating. For example, as Anselm Strauss (1970:14-15) observed:

The very massiveness of modern medical organization is itself a hindrance to health care for the poor. Large buildings and departments, specialization, division of labor, complexity, and bureaucracy lead to an impersonality and an overpowering and often grim atmosphere of hugeness. The poor, with their meager experience in organizational life, their insecurity in the middle class world, and their dependence on personal contacts, are especially vulnerable to this impersonalization.

Hospitals and clinics are organized for "getting work done" from the staff point of view; only infrequently are they set up to minimize the patient's confusion. He finds for himself and sometimes may even get lost when sent "just down the corridor." Patients are often sent for diagnostic tests from one service to another with no explanations, with inadequate directions, with brusque tones. This may

make them exceedingly anxious and affect their symptoms and diagnosis. After sitting for hours in waiting rooms, they become angry to find themselves passed over for latecomers-but nobody explains about emergencies or priorities. They complain they cannot find doctors they really like or trust.

. . . To the poor, professional procedures may seem senseless or even dangerous - especially when not explained - and professional manners impersonal or brutal, even when professionals are genuinely anxious to help.

Dutton (1978) found from her research that low-income patients in public health care systems confronted a lack of preventive examination (physicians had little time for counseling patients or providing preventive care), high charges for services, long waiting times, and relatively poor patient-physician relationships. Dutton's (1978:361-62) position was that this situation posed a highly significant barrier that discouraged low-income patients "from seeking care, *above and beyond* the deterrent effects of inadequate financial coverage and negative attitudes toward professional health care." Low utilization was therefore seen as a normal response to an unpleasant experience.

The majority of people in the Dutton study were black. Subsequent research by Rundall and Wheeler (1979), on the effect of income on use of preventive care, involved a sample of respondents in Michigan, who were mostly white. Dutton's findings were confirmed. There was no support for the financial coverage explanation. There was some support for the culture of poverty explanation in that the poor perceived themselves as relatively less susceptible to illness (they could tolerate unhealthy conditions) and therefore were less likely to seek preventive services. However, there was strong support for the systems barrier explanation. People with relatively high incomes were more likely to have a regular source of care, and those individuals with a regular source of care were more likely to use preventive services.

Having a regular source of care has been identified as an important variable in help-seeking behavior. This situation implies that the patient is relatively comfortable with the relationship and has some trust in the physician's skills at diagnosis and treatment. Low-income people receiving medical care in the public sector are less likely to have a personal physician and must be treated by whichever physician happens to be on duty in a hospital or clinic. If they have to maneuver between several clinics and public assistance agencies to obtain either treatment or authorization for treatment, low-income people are subject to even more fragmented pathways to health care.

In other research, the author and his colleagues (Cockerham *et al.* 1986a) found important differences between socioeconomic groups with respect to symptom perception, physician utilization, and sense of control over their health situation. Persons with higher socioeconomic status were more consumer-minded and expressed greater personal responsibility for their own health. The poor were less discriminating in deciding which symptoms warranted a doctor's attention. When ill, the poor reported they visited doctors more or less routinely, even for minor ailments, while the more affluent appeared more likely to engage in self-treatment or to recognize minor ailments as self-limiting and likely to disappear in a day or two without a physician's services. The poor also expressed a decreased sense of personal control over their health. Thus, the poor seemed to be relatively passive recipients of professional health services with a significantly greater likelihood of investing responsibility for their own health in the health care system than in themselves.

The culture of poverty tends to promote feelings of dependence and fatalism. Thus, the poor are especially disadvantaged when they interact with physicians as authority figures and are confronted with modern medical technology. The development of a large array of medical equipment and procedures has increasingly taken away the self-management of health from laypersons, but particularly from those at the bottom of society with their more limited levels of education and experience with technology. When direct collaboration with medical practitioners is required, the poor become even more dependent.

However, other better-educated persons have reacted to the professional dominance of physicians, with increased skepticism of physicians' service orientation and an emerging belief that physicians should not always be completely in charge of the physician-patient relationship (Crawford 1984). They have assumed more of a consumer position with regard to health care. That is, they are making decisions on their own about which steps are most appropriate for them in dealing with doctors and maintaining their health. In doing so, they are becoming less dependent on physicians and rejecting the traditional physician-patient relationship for one of provider-consumer.

This leads us to consider the influence of the culture of medicine. The culture of medicine does not promote equality among laypersons when direct physician-patient interaction is required, nor does it provide a context within which such an orientation can grow within the medical environment. Instead, physicians are portrayed as powerful individuals with the training and intellect to make life or death judgments and patients as completely dependent on those judgments. Consumerism and



equality are not promoted because of the physician's need to have leverage over the patient. In the medical view, leverage is needed because treatment may be painful and discomforting and the patient typically lacks the expertise to treat the disorder (Parsons 1951).

This situation suggests that the culture of medicine is particularly important in explaining the health and illness behavior of the poor. One consequence of the increased frequency of contact between the medical profession and the poor appears to be that medical values have spread to the lower class. Accepting responsibility and self-management for diet, exercise, smoking, and other health-advancing behavior is strongly encouraged by the mass media and the medical profession. Physicians actively promote and reinforce the practice of health-advancing behavior. But consumerism in dealing with doctors and the health care system are not similarly encouraged or reinforced.

The trend for the immediate future in the use of physician services seems to be one in which the more affluent and better educated are likely to be more discriminating in their use of doctors. They likely will take a consumer approach, shopping for the appropriate services, making their own decisions about their symptoms and what they mean, and dealing with physicians on a more equal basis than before. Conversely, the poor appear likely to continue seeing doctors more frequently than members of the other social strata, both because they have more illness and disability and because they have more of a tendency to invest responsibility for their problems in the health care delivery system itself. In doing so, they appear less likely to question the authority or judgments of doctors, while assuming doctors will alleviate their symptoms or cure them.

#### **4.3. Recognizing and Coping with Illness Symptom**

Several studies suggest that laypersons generally conceive of health as either the relative absence of the symptoms of illness, a feeling of physical and mental equilibrium or well-being, being able to carry out one's daily tasks, or some combination of the preceding (Blaxter 2004; Calnan 1987; Herzlich and Pierret 1987). Conversely, to be ill means the presence of symptoms, feeling bad and in a state of disequilibrium, and functional incapacitation (not being able to carry out one's usual activities).

Thus, what laypersons recognize as illness is in part deviance from a standard of normality established by common sense and everyday experience. David Mechanic and Edmund Volkart (1961) have suggested that a given illness manifests specific characteristics with regard to symptom recognition and the extent of danger. Illness recognition is determined by how common the

occurrence of the illness is in a given population and how familiar people are with its symptoms. Illness danger refers to the relative predictability of the outcome of the illness and the amount of threat or loss that is likely to result. When a particular symptom is easily recognizable and relatively devoid of danger, it is likely to be defined as a routine illness. When a symptom occurs infrequently, making identification more difficult, and is combined with an increasing perception of danger, there is likely to be a greater sense of concern.

Yet, as Mechanic (1978) has noted, recognition of a symptom, while certainly a necessary condition to motivate help-seeking behavior, is not in itself sufficient for a definition of illness. Some illnesses, such as appendicitis, may have obvious symptoms, while other illnesses, such as the early stages of cancer, may not. Also there are cases of persons who, despite symptoms, delay seeking health care. Cancer patients have been known to avoid cancer screening procedures because of their anxiety about learning the truth and being forced to confront what it means to have cancer. Therefore, the characteristics of illness recognition and illness danger can be significant influences on the manner in which people perceive a disease.

Mechanic (1978:268-69) suggests that whether a person will seek medical care is based on ten determinants: (1) visibility and recognition of symptoms; (2) the extent to which the symptoms are perceived as dangerous; (3) the extent to which symptoms disrupt family, work, and other social activities; (4) the frequency and persistence of symptoms; (5) amount of tolerance for the symptoms; (6) available information, knowledge, and cultural assumptions; (7) basic needs that lead to denial; (8) other needs competing with illness responses; (9) competing interpretations that can be given to the symptoms once they are recognized; and (10) availability of treatment resources, physical proximity, and psychological and financial costs of taking action.

In addition to describing these ten determinants of help-seeking behavior, Mechanic explains that they operate at two distinct levels: other-defined and self-defined. The other-defined level is, of course, the process by which other people attempt to define an individual's symptoms as illness and call those symptoms to the attention of that person. Self-defined is where the individual defines his or her own symptoms. The ten determinants and two levels of definition interact to influence a person to seek or not seek help for a health problem.

The central theme that forms a backdrop for Mechanic's general theory of help-seeking is that illness behavior is a culturally and socially learned response. A person responds to symptoms according to

his or her definition of the situation. This definition may be influenced by the definitions of others but is largely shaped by learning, socialization, and past experience, as mediated by a person's social and cultural background. The role of culture in shaping our understanding of illness and responses to it is profound (Quah 2005). This is seen in studies showing that the cultural beliefs of patients are important in coping with cancer (Remennick 1998). Marjorie Kagawa-Singer (1993), for example, found Anglo-American men had more difficulty coping with cancer than Japanese-American men who obtained greater social support and maintained the belief that they were healthy despite awareness of their condition. Even pain and the attempt to prove it exists as an objective condition within the body are grounded in cultural meanings and understandings about what pain is and how it should be dealt with (Kugelmann 1999; Radley 1994; Zborowski 1952; Zola 1966). As Alan Radley (1994) and Radley and Billig (1996) point out, a person's beliefs about health and illness are based upon that individual's understanding of the world one lives in and one's place in it. "This means," states Radley (1994:62), "That they draw upon a stock of knowledge about sickness, and about its bodily signs, that owes much to their cultural setting."

#### **4.4. Suchman stage of illness experience**

Suchman's (1968b) analysis of the stages of illness experience demonstrates how individuals draw upon their knowledge and experience of their bodily states to recognize symptoms of illness and 'do something about it in Western culture.

According to Suchman, when individuals perceive themselves becoming sick they can pass through as many as five different response stages, depending upon their interpretation of their particular illness experience. These stages, shown in Figure 6-1, are (1) the symptom experience, (2) the assumption of the sick role, (3) medical care contact, (4) the dependent-patient role, and (5) recovery and rehabilitation.

The illness experience begins with **the symptom stage**, in which the individual is confronted with a decision about whether "something is wrong." The decision of the person involved may be to deny the symptoms as not needing attention, to delay making a decision until the symptoms are more obvious, or to accept the symptoms as evidence of a health disorder. The person may also attempt to treat himself or herself through the application of folk medicine or self-medication.

If the decision is made to accept the symptom experience as indicative of an illness, the person is likely to enter Suchman's second stage of **the sick role**. Here the person is allowed to relinquish

normal social obligations provided permission is obtained from ill person's lay-referral system. The lay-referral system can grant the individual provisional permission to assume the sick role. "Official" permission to adopt the sick role, however, can come only from the physician, who acts as society's agent as the authority on illness. Thus, while lay remedies may continue, the individual is again faced with a decision to deny the illness and abandon the illness experience or accept the provisional sick role and perhaps seek medical treatment.

If professional assistance is sought, the person enters the third stage of **medical care contact**." At this stage, the person attempts to obtain legitimation of his or her sick role status and to negotiate the treatment procedure. The illness experience may be confirmed or denied by the physician. If there is a disagreement between physician and patient, the patient may go "shopping" for another physician's diagnosis that might prove more acceptable.

If both patient and physician agree that treatment is necessary, the person passes into the **dependent-patient stage**. Here the person undergoes the prescribed treatment, but still has the option either to terminate or to continue the treatment. Sometimes patients settle for the "secondary gain" of enjoying the privileges accorded to "a sick person, such as taking time off from work, and do not seriously try to get well. Or both patient and physician may cooperate to allow the patient to enter the fourth and final stage of **recovery and rehabilitation**. In this stage the patient is expected to relinquish the sick role and resume normal social roles. This may not happen, as in the case of a chronic illness or when the patient chooses to malingering in an illness experience, even though technically well.

Although an illness experience may not involve all of the stages described by Suchman and can be terminated at any particular stage through denial, the significance of Suchman's model is that each stage requires the sick person to take different kinds of decisions and actions. In evaluating the experience of illness, the sick person must interpret not only his or her symptoms but also what is necessary in terms of available resources, alternative behaviors, and the probability of success

## **Summary**

This chapter has reviewed the major theories and findings of medical sociology concerning the process of seeking medical care and the utilization of health care services. While there is no single theory or approach that has earned general consensus, the existing literature reveals the two most

important variables in health care utilization to be the perceived severity of symptoms and the ability to pay for the rendering of services.

Social-psychological models of help-seeking behavior have emphasized the importance of self-perception, as it relates to a person's understanding of a particular symptom. Especially important is whether the person perceives himself or herself as able to perform normal social roles. Studies concentrating on ethnicity as a factor have pointed to the role of the social network in influencing the perceptual process according to the network's own socio-cultural orientation. Although some patients, notably cancer patients, may delay seeing a doctor because they are fearful about having their perceptions confirmed, the generalization can be made that the more symptoms are perceived as representing a serious illness, the more likely it is that a person will seek professional services.

The ability to pay for health services has traditionally accounted for significant socioeconomic differences in health care utilization. Today it appears that public health insurance and social welfare monies have enabled the poor to visit physicians more frequently than the upper-income groups. However, whether increased physician visitation has resulted in a corresponding rise in the quality of health care provided to the poor remains to be determined. Then, too, the poor still reside in an environment of poverty that perpetuates their increased risk to health hazards. Among those persons without public health insurance-those covered by private health insurance plans that still leave considerable cost for the individual consumer, or those without any health insurance-the ability to pay remains an important obstacle to help-seeking behavior. This chapter also discussed the socio-demographic variables of age and sex, which were found to be consistent predictors of seeking medical care. Elderly persons and females generally report more illness than younger persons and males and tend to consult physicians more readily.

## **Chapter Five**

### **Anthropology and Epidemiology**

#### **5.1. The Subject Matter of Epidemiology**

In its strictest sense, epidemiology is the science of epidemics. However, present-day epidemiologists have broadened their field to include not only epidemic diseases, but also all other forms of disease and bodily injury such as cancer, heart disease, alcoholism, drug addiction, suicide, and automobile accidents.<sup>2</sup>

The primary focus of the epidemiologist is not on the individual, but on the health problems of social aggregates or large groups of people. The epidemiologist studies both the origin and distribution of health problems in a population, through the collection of data from many different sources. He or she then constructs a logical chain of inferences to explain the various factors in a society, or segment of a society that cause a particular health problem to exist. Epidemiology is one of the most important investigative techniques in the study of health and disease and is applied throughout the world to solve health problems.

The role of the epidemiologist can probably be best likened to that of a detective investigating the scene of a crime for clues. The epidemiologist usually begins by examining the sick person or persons and then extends the investigation to the setting where people first became ill and are likely to become ill again. What the epidemiologist is looking for is the common denominator or denominators that link all the victims of a health problem together so that the cause of the problem can be identified and eliminated or controlled.

Many sociologists working in the field of medicine are epidemiologists. Epidemiology is a discipline that has evolved relatively specialized methods for investigating health problems. Depending upon the particular health hazard being investigated, epidemiology draws upon the knowledge and techniques of several scientific fields. Besides sociologists, one will find physicians, public health workers, biologists, biochemists, , veterinarians, demographers, anthropologists, and perhaps even meteorologists (in studies of air pollution) involved in epidemiological work.

#### **5.2. The Development of Epidemiology**

As a method of measuring diseases in human aggregates, epidemiology has been a relatively recent development. As long as human beings lived as nomads or in widely scattered and isolated

communities, the danger from epidemics and infectious disease was relatively slight. However, once people began to crowd into primitive cities, with unsanitary living conditions and an abundance of rats and lice, the probabilities favoring the development of communicable diseases greatly increased. The crowded conditions of urban living also ensured that infectious diseases would spread more quickly and that disease-causing microorganisms would persist within the community for longer periods of time. In addition, the migration of peoples from one region of the world to another spread disease from geographic area to geographic area. Bubonic plague, for example, apparently reached Europe from China during the fourteenth century, cholera entered Great Britain by way of India in the seventeenth century, and Europeans brought smallpox to the western hemisphere during the exploration and settlement of the New World. History reveals numerous examples of explorers and travelers introducing the microorganisms of a dreaded disease to a community of unsuspecting people.

The bubonic plague, that ravaged Europe between 1340 and 1750, marks one of the worst epidemic afflictions in all human history. It is estimated that one-third of the population of Europe, about 20 million people, died during its greatest prevalence (Cantor 2001). During one month (September, 1665) in one city (London), approximately 30,000 people died from the plague. Describing conditions in the fourteenth century, historian Barbara Tuchman (1978:92) reports: "So lethal was the disease that cases were known of persons going to bed well and dying before they awoke, of doctors catching the illness at a bedside and dying before the patient." What made the disease especially frightening was that no one knew what caused it, how to prevent it, or how to cure it. Yet even though the pestilence affected the rich and poor alike, there was still a *social* difference in the death rates. The poor were much more likely to die from it than the rich. Tuchman (1978:98) says:

Flight was the chief recourse of those who could afford it or arrange it. The rich fled to their country places like Boccaccio's young patricians of Florence, who settled in a pastoral palace "removed on every side from the roads" with "wells of cool water and vaults of rare wine." The urban poor died in their burrows, "and only the stench of their bodies informed their neighbors of their death." That the poor were more heavily afflicted than the rich was clearly remarked at the time, in the north as ill the south. A Scottish chronicler, John of Fordum, stated flatly that the pest "attacked especially the meaner sort and common people-seldom the magnates." Simon de Covino of Montpellier made the same observation. He ascribed it to the misery and want and hard lives that made the poor more

susceptible, which was half the truth. Close contact and lack of sanitation was the unrecognized other half of it.

The cause of the plague was thought by many to be God's wrath upon sinners. However, the realization eventually came that diseases could be transmitted from person to person or between animals and people. The origin of the plague turned out to be the flea of the black rat, but the pneumonic plague, the most deadly form of the bubonic plague, was transmitted from person to person. What actually ended the plague in about 1750 was the appearance in cities of the aggressive brown rat. The brown rat tended to avoid humans, had fleas that were less effective carriers, and drove most of Europe's black rats out of urban areas. Another very important factor was the development of improved housing and sanitation.

Although the plague is popularly believed to be a disease of the middle Ages and no longer a major threat to the world's health, its pneumonic version resurfaced in western India in the city of Surat near Mumbai (formerly Bombay) in 1994. Some 6,000 persons were hospitalized and at least 55 died. Many people fled from the area in panic and some infected persons spread the disease to other locales. Curable if treated early by antibiotics, this modern-day outbreak of a supposedly vanquished disease is a sharp reminder of the relationship between health and social conditions.

Epidemics like the plague have existed for centuries, but the field of epidemiology did not develop as a form of systematic scientific investigation until the nineteenth century. It was not until 1854 that the work of John Snow established the foundation of modern epidemiology. Snow was an English physician who plotted the geographic location of all reported cholera cases in London. He then went out into the neighborhoods of these victims and inquired into their day-to-day behavior. He wanted to know what they ate, what they drank, where they went, and the nature of all their activities. Eventually Snow began to suspect that cholera was transmitted by water, since the common factor in the daily lives of the victims was getting their water from the Broad Street pump. At that time, London obtained drinking water from several water companies, and a few of these companies apparently were providing water contaminated with cholera bacteria. By closing down the pump on Broad Street, Snow was able to stop the epidemic. He not only established a mode of investigation but also demonstrated that research could lead to positive action and that social behavior and the physical environment were both important in the transmission of disease (Brown 2000).

At the time of Snow's research, the development of scientific medicine was well under way. The work of Louis Pasteur and his immediate followers, during the latter part of the nineteenth century,



revolutionized medical thought with the germ theory of disease stipulating that bacteria were the source of infection in the human body. The findings of Snow, Pasteur, and others provided the epidemiologist with a framework of analysis. Recognition that germs were causal agents of disease served as a precursor to scientific determination that people come into contact with a variety of causal agents. These agents include: (1) biological agents, such as bacteria, viruses, or insects; (2) nutritional agents, such as fats and carbohydrates as producers of cholesterol; (3) chemical agents, such as gases and toxic chemicals that pollute the air, water, and land; (4) physical agents, such as climate or vegetation; and (5) social agents, such as occupation, social class, location of residence, or lifestyle. What a person does, who a person is, and where a person lives can specify what health hazards are most likely to exist in that individual's life. The epidemiologist then identifies a particular host (person or group of persons or animals) most susceptible to these causal agents. Human hosts are examined in terms of characteristics that are both biological (age, sex, degree of immunity, and other physical attributes that promote resistance or susceptibility) and behavioral (habits, customs, and lifestyle). Next, the physical and social environment of the causal agent and the host is explored. The result is intended to be an identification of *what* is causing a group of people to become sick or suffer injury.

The term *social environment* in epidemiological research refers to actual living conditions, such as poverty or crowding, and also the norms, values, and attitudes that reflect a particular social and cultural context. Societies have socially prescribed patterns of behavior and living arrangements, as well as standards pertaining to the use of water, food and food handling, and household and personal hygiene. For example, the plague epidemic in Surat, India, in the mid-1990s, had its origin in unhealthy behavior and living standards. The social environment can cause sickness, so information about it can be used to identify the chain of transmission and assist in ascertaining the most effective means of treatment and prevention.

Since its inception in the 1850s, epidemiology has passed through three eras and is now entering a fourth (Susser and Susser 1996a). First was the sanitary era of the early nineteenth century, during which the focus of epidemiological work was largely on sewage and drainage systems, and the major preventive measure was the introduction of sanitation programs. Second was the infectious disease era that occurred between the late nineteenth and mid-twentieth centuries. The principal preventive approach was to break the chain of transmission between the agent and host. Third is the chronic disease era that took place in the second half of the twentieth century. Here the focus was on

controlling risk factors by modifying lifestyles (i.e., diet exercise), agents (i.e., guns, food), or the environment (i.e. pollution, passive smoking). According to Susser and Susser (1996b:674), the era of the twenty-first century is that of "eco-epidemiology." Preventive measures 3 scientists from many fields use their techniques to deal with problems at the molecular, social behavioral, population, and diseases remain the principal threat, but old infectious diseases with new ones like HIV / AIDS, the Marburg virus, and SARS.

### **5.3. Epidemiological Measures**

Several important analytic concepts assist the epidemiologist in describing the health problems of human groups. Two of the most commonly employed concepts are those of *incidence* and *prevalence*. Incidence refers to the number of *new* cases of a specific health disorder occurring within a given population during a stated period of time. The incidence of AIDS during a particular month would be the proportion of persons within a population who are reported as having developed the illness during the month in question. Prevalence, in contrast, would be the *total* number of cases of a specific health disorder that exist at any given time. Prevalence would include new cases, as well as all previously existing cases.

One way to distinguish between incidence and prevalence is to regard incidence as the rate at which new cases first appear, while prevalence is the rate at which all cases exist. To illustrate the difference between incidence and prevalence, consider that the incidence of influenza in a community might be low because no new cases had developed. Yet a measure of the disease's prevalence could be a larger figure because it would also represent all persons who are previously sick from the illness. For chronic health disorders such as cancer, cases initially reported in terms of incidence for a particular period may be reported later as prevalence because the duration of the disease has caused it to exist for a lengthy period of time. The cases are simply no longer new. Therefore, the use of data on disease determines whether an analysis should be one of incidence or prevalence. An epidemiologist would use cases denoting incidence if he or she were analyzing the outbreak of a health problem. Cases specifying prevalence would be used to study the overall extent of a specific disorder.

## **Chapter Six**

### **Traditional Medicine**

#### **6.1. Meaning of Traditional Medicine**

TM is a system of treatment modalities based on indigenous knowledge pertaining to healing (WHO, 2004). It is a group of health care practices and products with a long history of use. It frequently refers to medical knowledge developed by indigenous cultures that incorporates plant, animal, and mineral based medicines, spiritual therapies and manual techniques designed to treat illness or maintain wellbeing (WHO, 2003). TM tends to be practiced outside of allopathic medicine (also known as bio medicine, conventional or western medicine), which is the dominant systems of medicine in the developed world.

The world health organization (WHO) defines TM as “ the sum total of the knowledge, skills and practices based on the theories, beliefs and experiences indigenous to different cultures, whether explicable or not, used in the diagnosis, improvement or treatment of physical and mental illness” (WHO, 2000).

#### **6.2. Traditional Medical Practice**

TMP is defined as “ the sum total of all knowledges and practices, used in diagnosis, prevention and elimination of physical , mental or social or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation” (WHO, 2001). There are a number of traditional medical practices that reflect the diversity of Ethiopian cultures. Ethiopian traditional medicine is concerned not only with curing of diseases but also with the protection and promotion of human physical, spiritual, social mental, and material wellbeing. The many categories of traditional medical practices dealing with these different aspects of health include: spiritual healing, prevention as well as curative and surgical practices (Kebede, Binyam, and Yunis, 2006).

#### **Belief Systems**

TMP and belief systems about health, as well as aspects of living, evolved from religion. Health is not just the absence of disease, it is harmony with one self, including body, mind, and spirit, harmony with others, and harmony with one’s surroundings or environment. Therefore the concept of spirituality and religion are inseparable from one’s health. In Ethiopian TM, the issue of health is

seen as holistically and not separated into physical health and mental health. Spiritual wellbeing is also important. Health is seen as 'a gift of God' or 'the will of God' and many Ethiopians generally believe that their religion helps keep them healthy (Papadopoulos, Lay, and Gebrehiwot, 2002).

These perceptions are related to the belief that supernatural forces are involved in causing disease as well as in their treatment. For instance, while the devil is considered to be the cause of a number of illness, God is believed to provide the healing. The use of prayer as a therapy in the practice to a supernatural power has been around for a much longer time in the practice of Ethiopian traditional medicine.

### **6.3. Different Traditional Medical Practices and Belief Systems**

There are a number of traditional medical practices that reflect the diversity of Ethiopian cultures. Ethiopian traditional medicine is concerned not only with the curing of diseases but also with the protection and promotion of human physical, spiritual, mental, social and material well being. The many categories of traditional medical practices dealing with these different aspects of health includes, spiritual healing, prevention as well as curative and surgical practices (Kebede, 2005).

#### **Bone Setters (Woggeshas)**

Traditional bone setter (here after TBS) or the woggesha is an old practiced established more or less in all societies of the world. Up to 85% of patients with fractures present first to the TBS before coming to the hospital and therefore this mode of care delivery cannot be over looked in our country. The TBS practice is a highly specialized form of traditional medicine. It is usually passed from father to son but some outsiders also receive their training via apprenticeship (Omololu, Ogunlade, and Alonge, 2002).

Traditional practice considered to be related to surgery includes bone setting. The setting of bone is regarded as an important surgical procedure which requires a certain degree of skills and experience on the part of the healer. In most places, the healer involved in bone setting is the local woggesha. In many situation the woggesha practices his or her skills without aseptic conditions, with or without the application of medicines.

### **Herbalist (Kitel Betash or Yelimd Awaki)**

Herbalism is a traditional medical practice based on the use of plants and plant extracts. It is also known as medical herbalism. Medical herbalism is today a sophisticated systems of natural medicine using plant extracts and herbs to help treat physical and mental disorders. Herbalists use concentrated whole plant extracts, in the form of tinctures, infusions, salves, creams and pills, as part of a holistic treatment plan to address the underlying causes of your condition (Kennedy et al., 2009, Tapsell et al., 2006, Fabricant, 2001).

### **Drug Preparation**

The traditional herbalists prepare their drugs not only from herbs. They prepare the drugs from plants, minerals, and animal products. The traditional medicines come from the vegetables which comprises the leaves, flowers, seeds, barks, sap, and roots of a variety of plants. Also they get from the animals which is butters, fat, honey, skin and organs of many wild animals. Sometimes they also add and use salt and water to prepare their drugs. The healers gather the necessary inputs to prepare the drugs from their garden as well as from outside the town. They prepare the drug in the form of solid, liquid and powder and sometimes mixed with honey for different types of illness. It has been mentioned by the herbalist that they prepare the drugs either earlier in the absence of patients or at the moment based on the patient's problem.

## **6.4. Challenges of Traditional Medical Practices in the Study Area**

The main focus of the study, though, is to describe, assess and evaluate the existing challenges faced by traditional healers in treating peoples with different diseases in the study area.

### **Negative Outlook towards TMPS**

Practitioners of traditional medicines further revealed that they faced negative attitudes from community members. These challenges that faced traditional medical practitioners are, peoples who do not use the service catered by practitioners of traditional medicine have a negative outlook towards TMPS in the study area. Peoples in the study area consider the traditional medicine practice as witchcraft and they perceive their treatment as meaningless. They treat the traditional healers as evil believers and call their practice as an evil act.

### **Lack of Medical Plants**

Another theme emerged when analyzing the data was the lack of medical plants for treatment. The practitioners were asked if they do face challenges of lack of medical plants.

### **Financial Challenge**

+Traditional healers also faced financial challenge in their practice. The healers indicated finances are one of their main challenges in their practice because the lack of financial stability results in to poor services delivery to their clients. They added that the financial challenge is mainly caused by their clients who come to seek help without money to pay treatment. Their clients promise to pay later when they get money, but they have money and feelings better they do not come back to pay the treatment.