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**A review of health seeking behaviour:
problems and prospects**

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Summary

This review of health seeking behaviour outlines the main approaches within the field, and summarises some of the key findings from recent work around the probes. However, it also suggests that health seeking behaviour is a somewhat over-utilised and under-theorised tool. Although it remains a valid tool for rapid appraisal of a particular issue at a particular time, it is of little use as it stands to explore the wider relationship between populations and health systems development. If we wish to move the debate into new and more fruitful arenas, this review reaches the conclusion that we need to develop a tool for understanding *how populations engage with health systems*, rather than using *health seeking behaviour* as a tool for *describing how individuals engage with services*. This opens up into the broader arena of community organisation, social capital and citizenship; of political and non-political pressure points on the system. The paper suggests one way in which we might start to frame the debate in the context of this programme of work, using **social capital** and **reflexive communities** as key theoretical and analytical concepts.

1 Understanding health seeking behaviour

Health promotion programmes worldwide have long been premised on the idea that providing knowledge about causes of ill health and choices available, will go a long way towards promoting a change in individual behaviour, towards more beneficial health seeking behaviour. However, there is growing recognition, in both developed and developing countries, that providing education and knowledge at the individual level is not sufficient in itself to promote a change in behaviour. An abundance of descriptive studies on health seeking behaviour, highlighting similar and unique factors, demonstrate the complexity of influences on an individual's behaviour at a given time and place. However, they focus almost exclusively on the individual as a purposive and decisive agent, and elsewhere there is a growing concern that factors promoting 'good' health seeking behaviours are not rooted solely in the individual, they also have a more dynamic, collective, interactive element. Academics have therefore started to explore the way in which the local dynamics of communities have an influence over the well-being of the inhabitants.

This reflects a growing interest across the social sciences in the contested concept of *social capital*. Attempts are now being made to develop this, as yet under-utilised idea, to incorporate knowledge about health seeking behaviour into health service delivery strategies in a way which is sensitive to the local dynamics of the community. This may be an extremely positive development. The whole area of knowledge around health seeking behaviour is rendered of little value if not incorporated into management and system developments. The fact that health seeking behaviour is 'not even mentioned' in widely used medical textbooks (Steen and Mazonde, 1999), perhaps reflects that many health seeking behaviour studies are presented in a manner which delivers no effective route forward. This results in an unfortunate loss for medical practice and health systems development programmes, as proper understanding of health seeking behaviour could reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts.

This paper draws mainly on evidence from our partner countries, to review the situation. It suggests what may usefully be learnt from studies to date, and begins to explore how we might make studies of health seeking behaviour more useful from a health systems development perspective. As part of this, it begins to explore some of the growing body of literature around local social development, participation and citizenship. This is usually divorced from the sort of one-on-one understanding of actual acts of health seeking behaviour, but the paper highlights a few key studies that begin to make more explicit the importance of the links between the *health seeking behaviour of the individual* and *wider theoretical models of the local dynamics of health systems and social participation*. In this review of the literature I work towards an understanding of how this more collective, situational, experiential understanding can be developed in a practical way through this research programme.

Thus, it is suggested that although the debate is largely stagnant at present, it is possible to make progress by turning the old favourite of health seeking behaviour into something more dynamic, useful and applicable in health systems development. By the introduction of social capital, a potential way in which to develop the agenda around health seeking behaviour is suggested. I begin by outlining the current picture,

firstly drawing from the literature around health seeking behaviour in general, and secondly by highlighting some key issues relevant to the probes.

1.1 Health seeking behaviours: two approaches

Researchers have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to their health. There has been a plethora of studies addressing particular aspects of this debate, carried out in many different countries. For the sake of this paper they can simplistically be divided into two types, which roughly correspond with a division identified by Tipping and Segall (1995). Firstly there are studies which emphasise the ‘end point’ (utilisation of the formal system, or *health care seeking behaviour*); secondly, there are those which emphasise the ‘process’ (illness response, or *health seeking behaviour*).

Health care seeking behaviours: utilisation of the system

There is often a tendency for studies to focus specifically on the act of seeking ‘health care’ as defined officially in a particular context. Although data are also gathered on self care, visits to more traditional healers and unofficial medical channels, these are often seen largely as something which should be prevented, with the emphasis on encouraging people to opt first for the official channels (Ahmed, et al, 2001).

These studies demonstrate that the decision to engage with a particular medical channel is influenced by a variety of socio-economic variables, sex, age, the social status of women, the type of illness, access to services and perceived quality of the service (Tipping and Segall, 1995). In mapping out the factors behind such patterns, there are two broad trends. Firstly there are studies which categorise the types of *barriers* or *determinants* which lie between patients and services. In this approach, there are as many categorisations and variations in terminology as there are studies, but they tend to fall under the divisions of geographical, social, economic, cultural and organisational factors (see **Table 1**).

| Author | Geographical | Social | Economic | Cultural | Organisational |
|-----------------|---------------|-----------------------------------|----------|----------|-----------------|
| Kloos (1990) | Geographical | Socio-economic | | Cultural | |
| Yesudian (1988) | | Demographic | Economic | Cultural | Organisational |
| Leslie (1989) | | User factors | | | Service factors |
| Anderson (1995) | Environmental | Predisposing and enabling factors | | | Health system |

Table 1: an illustration of categorisation of health care seeking factors across studies

These categorisations can be further broken down to illustrate the types of measures frequently used. These are grouped under reoccurring determinants in **Table 2**, and placed into key spheres of influence: informal, infrastructure and formal.

| Category | Determinant | Details | Sphere |
|----------------|------------------------------|--|---|
| Cultural | Status of women | Elements of patriarchy | 'Cultural propriety' |
| Social | Age and sex | | |
| Socioeconomic | Household resources | Education level Maternal occupation Marital status Economic status | <i>informal</i> |
| Economic | Costs of care | Treatment Travel Time | Physical |
| | Type and severity of illness | | |
| Geographical | Distance and physical access | | <i>infrastructure</i> |
| Organisational | Perceived quality | Standard of drugs Standard of equipment Competence of staff Attitudes of staff Interpersonal process | Technical Staffing Interpersonal <i>formal</i> |

Table 2: Breaking down determinants of health care seeking behaviour

Secondly, there are studies that attempt to categorise the type of *processes* or *pathways* at work. Bedri (2001) develops a pathways to care model in her exploration of abnormal vaginal discharge in Sudan. She identifies five stages where decisions are made, and delay may be introduced, towards adoption of 'modern care'. There are four 'sub pathways' that women may follow, from seeking modern medical care immediately, to complete denial and ignoring of symptoms. This approach offers an opportunity to identify key junctions where there may be a delay in seeking competent care, and is therefore of potential practical relevance for policy development. For example, in order to optimise the pathways taken by women, Bedri suggests husbands should be involved in health education programmes about vaginal discharge, and women should be enabled to conduct home vaginal swabs. Bedri's study is particularly interesting as it compares health care seeking behaviour around vaginal discharge and malaria, revealing, perhaps not surprisingly, that women follow quite different pathways for different conditions, relating predominantly to the role of the husband, social networks and cultural customs. This clearly has implications for health systems development.

The view is often that the desired health care seeking behaviour is for an individual to respond to an illness episode by seeking first and foremost help from a trained allopathic doctor, in a formally recognised health care setting. Yet a consistent finding in many studies is that, for some illnesses, people will chose traditional healers, village homeopaths, or untrained allopathic doctors above formally trained practitioners or government health facilities (Ahmed et al, 2001). There are variations witnessed, and apart from differences according to type of illness, gender is a recurring theme. For example, Yamasaki-Nakagawa et al (2001) found women in Nepal were more likely than men to seek help from traditional healers first. The scale

of this may be reflected in findings from a recent study by Rahman (2000) in rural Bangladesh, where 86% of women received health care from non-qualified health care providers. This has implications for diagnosis, and women have been found to have significantly longer delays to diagnosis than men (Needham et al, 2001; Yamasaki-Nakagawa et al, 2001).

Despite the ongoing evidence that people do choose traditional and folk medicine or providers in a variety of contexts which have potentially profound impacts on health, few studies recommend ways to build bridges to enable individual preferences to be incorporated into a more responsive health care system. For example, Ahmed et al (2001, 98) conclude: “efforts should be made to raise community awareness regarding...the importance of seeking care from trained personnel and the availability of services”. Nonetheless there is now growing recognition of the need to be more sensitive to the realities of health care seeking behaviour. For example, in Bangladesh there is a large and growing sector of non-qualified allopathic providers engaged in the traffic of modern pharmaceuticals. They provide an accessible means of reaching Western medicines to a wider range of the population, yet lack formal medical training. There is therefore the accompanying problem of bad, unregulated prescriptive practices. Incorporating these unqualified providers into more formal training may therefore be beneficial (Ahmed et al, 2000). Uzma et al (1999) also suggest incorporating unqualified TBAs into training programmes for maternal health in order to improve the health status of women. Thus increasingly health care seeking behaviour studies are coming to the conclusion that traditional and unqualified practitioners need to be recognised as ‘the main providers of care’ (Rahman, 2000) in relation to some health problems in developing countries.

In acknowledgement of the fact that untrained non-Western practitioners remain a strong favourite, Outwater et al (2001) interviewed traditional healers about their knowledge and relationship with ‘modern’ medicine, and explored in far more depth the preferences of women who attended traditional healers and unofficial sources of health care. Through this they recognised, as have others (Moses et al, 1994) that some groups appear to ‘wander’ between practitioners rather than seek care through one avenue or provider. Similarly, Rahman (2000) found that different facilities will be frequented for different needs, according to a complex interplay of factors, sometimes regardless of the intended purpose of those facilities.

Thus there is growing acknowledgement that health care seeking behaviours and local knowledges need to be taken seriously in programmes and interventions to promote health in a variety of contexts (Price, 2001; Runganga, Sundby and Aggleton, 2001). With this broader appreciation of behaviour, some have suggested the need to improve integration of private sector providers with public care (Needham et al, 2001). Calls have been made for explicit recognition of the potential to combine the two worlds by involving unofficial providers in official training and service provision (Green, 1994; Outwater et al, 2001). However, Ahmed et al concede that whilst extending training to such providers may enhance their services, training in itself will not change practice. For this, managerial and regulatory intervention is needed. Thus the provision of medical services alone in efforts to reduce health inequalities is inadequate (Ahmed et al, 2000). Clearly any research interest in health care seeking behaviour, focusing on end point utilisation, needs to address the complex nature of the process involved, cognisant of the fact that the particular ‘end point’ uncovered

may be multi-faceted and not correspond to the preferred end points of service providers.

Health seeking behaviours: the process of illness response

The second body of work, rooted especially in psychology, looks at health seeking behaviours more generally; drawing out the factors which enable or prevent people from making 'healthy choices', in either their lifestyle behaviours or their use of medical care and treatment. Thus whilst in the former literature health care seeking behaviour is conceptualised as a 'sequence of remedial actions' taken to rectify 'perceived ill-health' (Ahmed et al, 2000), in the second approach the latter part of the definition, responding specifically to *perceived ill-health*, may be dropped, as a wider perspective on affirmative, health promoting behaviours is adopted. A number of 'social cognition models' (Conner and Norman, 1996a) have been developed in this tradition, to predict possible behaviour patterns. These are based on a mixture of demographic, social, emotional and cognitive factors, perceived symptoms, access to care and personality (Conner and Norman, 1996b). The underlying assumption is that behaviour is best understood in terms of an individual's perception of their social environment.

A number of genres of model exist, and variations have been developed around them. One of the most widely applied is the 'health belief model'. Sheeran and Abraham (1996) categorise the range of behaviours that have been examined using health belief models into three broad areas: preventive health behaviours, sick role behaviours and clinic use. In this type of model, individual beliefs offer the link between socialisation and behaviour. One of the earliest examples was Hochbaum's (1958) study of the uptake of screening for TB, where he discovered that a belief that sufferers could be asymptomatic was linked to screening uptake. Health belief models focus on two elements: 'threat perception' and 'behavioural evaluation' (Sheeran and Abraham, 1996). Threat perception depends upon perceived susceptibility to illness and anticipated severity; behavioural evaluation consists of beliefs concerning the benefits of a particular behaviour and the barriers to it. 'Cues to action' and general 'health motivation' have also been included (Becker et al, 1977). The health belief model has been criticised for portraying individuals as asocial economic decision makers, and its application to major contemporary health issues, such as sexual behaviour, have failed to offer any insights (Sheeran and Abraham, 1996).

A second genre of model is linked to the general assumption that those who believe they have control over their health are more likely to engage in health promoting behaviours (Normand and Bennett, 1996). The 'health locus of control' construct is therefore utilised to assess the relationship between an individual's actions and experience from previous outcomes. The most popular of these is 'the multidimensional health locus of control measure' (Wallston, 1992). However, this approach to social cognition models has been criticised for taking too narrow an approach to health and because the amount of variance explained is low (Norman and Bennett, 1996). Other approaches, including 'protection motivation theory' and 'theory of planned behaviour' have equally met with mixed reception (Boer and Seydel, 1996; Conner and Sparks, 1996). **Figure 1** represents a visual summary of the approach of social cognition models.

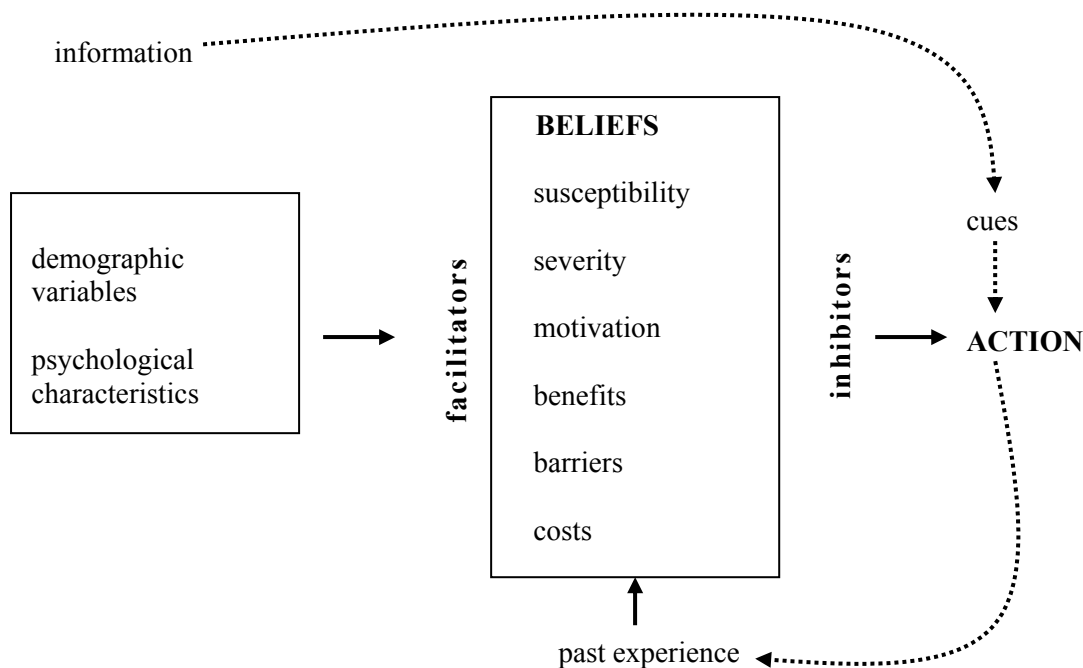


Figure 1: Predicting health behaviour with social cognition models (adapted from Sheeran and Abraham, 1996).

These models, attempting to predict health behaviour through a variety of means, are predicated on two assumptions central to classic health promotion: health is influenced by behaviour; behaviour is modifiable (Conner and Norman, 1996b). The downfall of these models is that most view the individual as a *rational decision maker, systematically reviewing* available information and forming *behaviour intentions* from this. They do not allow any understanding of *how* people make decisions, or a description of the *way* in which people make decisions. Fazio (1990) proposes an alternative to this ‘deliberative processing model’ in the form of a ‘spontaneous processing model’ which takes greater account of the unpredictable nature of the actual process of decision making. However, the central problem remains that these models focus *on the individual* and the centrality of *cognitive processes* (‘I know, therefore I act’). This loses the sense that we are all rooted in social contexts that affect, in a far more complex manner, the way we process and act on information.

Reflexive communities

MacPhail and Campbell (2001) begin to explore the neglected societal, normative and cultural contexts in which individual-level phenomena such as knowledge, attitudes and behaviour are negotiated or constructed. In their work on risk taking behaviour and sexuality amongst young South Africans, they criticise much previous work which focuses on the individual level, utilising a KABP model approach (knowledge-attitude-belief-practice), that assumes individual behaviour is built upon rational decision making based on knowledge. MacPhail and Campbell believe developed country research has a better track record of exploring this broader contextual picture, whilst work in developing countries tends not to acknowledge the poor relationship between knowledge and health seeking behaviour. This suggests we need to develop a

more critical approach to our conceptualisation of health seeking behaviour in developing countries.

When an individual makes a decision in relation to their health, they weigh up the potential risks or benefits of a particular behaviour. But they do so in a way that is mediated by their immediate practical environment, their social rootedness and their whole outlook on life more generally. Not all of this is immediately apparently relevant to an act of health seeking behaviour, but it *is* all nonetheless inherent to that act, and must therefore be acknowledged. Lash (2000) suggests that in order to understand the complexities of how people explore their relationship to particular decisions or actions, how and why they weigh up options as they do, we might think of '*reflexive communities*'. Reflexive communities reflect the particular ways of behaving, thinking and reaching decisions of individuals or groups, that in turn reflect the social construction of their position in wider society at a particular place and time. Acts within these reflexive communities do not rely solely on the processing of information and knowledge. They reflect something far more complex, emotional, social and practical.

Whilst 'information' is a central part of the process of reflexivity which we are at pains to understand, the notion of 'information' is 'too one-sidedly cognitive' (Lash and Urry, 1994). Lash and Urry suggest an individual's relationship with information must be seen also as possessing 'moral, affective, aesthetic, narrative and meaning dimensions' (222). Hence the availability of 'information' for individuals to make health seeking behaviour choices around is only a small part of the equation. There is a wider 'aesthetic reflexivity' which "means making choices about and/or innovating background assumptions and shared practices upon whose bases cognitive and normative reflection is founded" (Lash and Urry 1994. 316). In order to understand how people reach the decisions they do around their health seeking behaviour, we need to understand not only the information sources and how they are interpreted, but also the underlying, unspoken, unconscious feelings and assumptions which support that cognitive process and the journey taken during it. This reflects findings of previous studies on health seeking behaviours that confirm decisions around health seeking behaviour are underpinned by both rational cognitive processes and less easily identifiable affective-emotional processes (see for example Campbell's (1997) work on male identities and HIV). As Harvey (1996) stresses, the way people *perceive* risks and *experience* risk should be a matter for public policy.

If we adopted this sort of approach to health seeking behaviour, it would move beyond the traditional confines of social cognition models and health promotion assumptions, and may therefore be a more fruitful conceptual framework to use when exploring the decisions people make around health seeking behaviour. Lash and Urry (1994) claim all human existence is 'a movement towards death', but that individuals recognise there are ways of prolonging or hastening that movement. A whole host of factors come into play in this reflexive process, which we are only just beginning to understand in relation to health seeking behaviours.

Norman and Conner (1996) propose that social cognition models may in future be developed to incorporate other variables such as self identity ('I am a healthy eater'). I see this as a potentially promising development, as it would open up the field to including the role of 'reflexive communities' in decision making. Although work

around risk cultures and health has to date concentrated predominantly on contemporary Western society and large-scale environmental risks, a framework developed from such work could bring the idea and relevance of health seeking behaviour into a useful area for health service development in the context of the developing world, and is an idea worth exploring further.

If we aim to investigate the way in which people in particular places make decisions regarding their patterns of health seeking behaviour, we could fruitfully adopt a framework that highlights the way in which people identify ‘risks’ attached to particular behaviours. For some it may simply be a matter of cost, for others a particular lifestyle aesthetic or cultural code may underpin any decision they make in a seemingly less ‘rational’ or scientific manner. Thus we need to expose not just people’s perceptions, definitions and legitimations of risks in not seeking health care, but also the mutual constitution of implicit assumptions about behaviours and their translation into risks (Adam, Beck and van Loon 2000), or Lash’s ‘reflexive communities’.

It seems therefore that neither of the literatures outlined above adequately address either the *nature of how people reach the decisions they do* in the context of their daily, socially and culturally embedded lives, or the *complexity of health care systems*. Both approaches see health seeking behaviour as a one-off event, following a linear direction, filtered in different ways along its course. If we explore Lash’s reflexive communities we would begin to conceptualise health seeking behaviour much more as a state of being which ebbs and flows around daily life and is brought into sharp focus at particular points of crisis in time and space.

Thus it is my belief that we need to move the debate forwards into the messier terrain which remains unmapped around the dynamics of engaging in a complex and ongoing process that can not adequately be conceptualised by measuring dislocated actions aimed at a specific end point. As we are particularly interested in *health systems*, implications must be drawn out for service utilisation and system development, and this necessitates our lens encompass something far broader than the majority of health seeking behaviour studies. Broader both in terms of the channels which the individual may engage with (i.e. not purely official medical ones) and in terms of how we look at the influences on people’s behaviour in particular places. MacPhail and Campbell (2001) begin to explore this broader context of system and policy implications, as they suggest sexual health policy and practice for young South Africans is influenced by simplistic generalised views held by adults, thereby excluding the very groups they wish to target. It is these sorts of ideas that need to be teased out of work on health seeking behaviour more explicitly.

In order to do this there are two strands that need to be addressed: the hitherto neglected *collective, social* element of health seeking behaviour, and the *interaction of individuals and societies with health systems*. These two issues are explored in more detail below. Firstly, in order to provide a setting around this, I want to expand a little more on the conceptual framework that I am suggesting will bring into sharp focus these two elements (this follows in **Section 2**, after a brief review of health seeking behaviour in relation to the probes).

1.2 Health seeking behaviour and the probes: a review

Health seeking behaviour clearly varies for the same individuals or communities when faced with different illnesses. For example, Bedri (2001) highlights contrasting pathways to care for women when faced with abnormal vaginal discharge, as opposed to malaria. For the former, the woman is bound far more by rituals and obligations, such as shaving prior to examination, and being accompanied to a medical consultation by her husband. There have been a plethora of studies on women's health seeking behaviour in Bangladesh, some of which are cited in this paper, and alternative suggestions made for improvements to the health system in relation to particular conditions or services. But there have been less explicit attempts to address the social dimensions of health seeking behaviour, as demonstrated for example in the literature around HIV and sexual health, particularly in South Africa. Thus the probes in this programme offer us one way to draw out comparisons and differences across disease categories and see where we may wish to develop this strand of work in future.

Tuberculosis

TB represents a classic public health issue, as effective diagnosis, treatment and control are important for the whole of a society. Hence it is appropriate for the state to play a dominant role in provision of services for TB detection and treatment (Lönnroth et al, 2001). Nonetheless, studies of health seeking behaviour in relation to TB repeatedly demonstrate that patients do not always choose a public health care facility, they delay diagnosis and often do not complete the lengthy course of treatment necessary.

Steen and Mazonde (1999) found 95% of patients in Botswana visited a 'modern' health facility as a first step. However, after initiating modern treatment, 47% then went on to visit a traditional or faith healer as well. They emphasise the importance of social and cultural factors in contributing to the outcome of TB control. For these patients TB is seen as a 'European disease' that will respond well to Western medicine. Nonetheless a traditional healer is also consulted to explain the 'meaning' of the disease for that particular person:

“there is an increasing tendency to use modern medicine as a 'quick fix' solution, whereas traditional medicine is utilised for providing answers that may be asked about the meaning of the misfortune, and to deal with the 'real' causes of the illness” (Steen and Mazonde, 1999. 170).

Steen and Mazonde berate the fact that health seeking behaviour is 'not even mentioned' in widely used textbooks, despite the fact that proper understanding of health seeking behaviour can potentially reduce delay to diagnosis, improve treatment compliance and improve health education strategies. They suggest lessons can be learnt from work around HIV and AIDS, regarding in particular greater co-operation between traditional and modern medicine.

Similarly in Pronyk et al's (2001) study, they found TB patients in South Africa attended government facilities more readily than for some other conditions. 72% presented initially to a hospital or clinic, with only 15% presenting to a spiritual or traditional healer, and 13% to a private doctor. Nonetheless the authors recognised a

significant failure of official clinical services to diagnose symptomatic individuals. This added to the already substantial problem of late presentation, particularly amongst women.

The picture in the Philippines appears to be different. Here Auer et al (2000) suggest 'multiple health seeking' may account for delayed case finding. Only 29% of patients in their study presented first to a health centre, with 53% consulting a private doctor initially. They found 69% of patients had been told by a member of the household to seek medical advice for their symptoms, and that those who felt ostracised because of their TB delayed seeking medical help longer. The authors claim:

“effective health seeking and case finding are influenced by the health system, community, family, and other personal issues” (Auer et al, 2000. 648).

Indeed the health system appeared to play a large role in the health seeking behaviour of these patients. They chose private doctors over public facilities, as they believed their service to be more polite, more effective, more sympathetic and respectful of privacy.

Auer et al stress that in the case of TB, with its lengthy treatment period, the fostering of a good doctor-patient relationship is crucial. Information is also needed regarding the availability of free drugs. Many patients in their survey continued to purchase privately prescribed drugs and were unaware these were available free of charge at public facilities. This has a potential impact on treatment compliance. They also found fear did not necessarily motivate health seeking and in fact may delay seeking treatment, and recommend it should therefore not be overstated in health education messages.

Key issues from TB

A number of key issues arise from these studies which may be interesting to explore within the context of the partner countries:

- Late presentation and delayed diagnosis are key problems for TB, reflecting both individual and social factors, and system failures. Delay can be related to social stigma, gender, fear or 'multiple health seeking'.
- Culturally sensitive and situated understanding of health seeking behaviour may improve treatment compliance and shorten delay to diagnosis.
- Health education should be promoted at family and community level to improve awareness and avoid stigma.
- 'Multiple health seeking' should be recognised and incorporated into a wider co-ordination across the health system, with better co-operation between public and private providers in particular.
- The doctor-patient relationship may need particular attention in relation to TB due to the lengthy treatment period.

Maternal and child health

Maternal health and health seeking behaviour of mothers have a huge impact not only on the lives of women, but also on the lives of their children. Perhaps unsurprisingly therefore there is a substantial body of health seeking behaviour work directed specifically at women. This typically highlights the difficulty women face in many developing countries where they rely on the male head of household to secure access to medical treatment, financially and practically. They may also require support from the wider social network for childcare or household duties that must be undertaken

while they travel sometimes great distances for a medical consultation, often with long waiting times at the other end (Bedri, 2001; Manhart et al, 2000; Rahman, 2000). Thus we have a body of knowledge about the cultural, social and structural difficulties faced by women in a variety of contexts in relation to their health seeking behaviours.

Evans and Lambert suggest that too much emphasis has been placed on a biomedical definition of 'health' in many studies. Whilst this renders health to be little more than the absence of disease, they argue women have much more subtle interpretations of health which impact upon their health seeking behaviour. Thus their emphasis is to "situate women's health practices and understandings analytically within the specific political-economic and social context of their every day lives" (Evans and Lambert, 1997. 1793).

This is a concern reflected in studies across other probes (see for example Campbell, 1997).

Although accessibility is commonly suggested as a factor in health facility use, Bhatia and Cleland (2001) support the findings of many others, that women are quite happy to travel further to attend a private, more expensive service that is perceived to be of 'good quality'. Complex justifications are also seen for inappropriate use of treatment, over-dosage, under-dosage, stopping a course halfway through or selecting particular drugs from a lengthy prescription (Evans and Lambert, 1997; Manhart et al, 2000; Théra et al, 2000). The type of health care provider that is sought, or the health seeking behaviour adopted, also differs according to the type of disease. For example Goldman and Heuveline (2000) found mothers more likely to seek help for diarrhoeal disease than acute respiratory infections, despite the fact that both are leading causes of child mortality in developing countries. In another study, mothers in Uganda were found to be poor at recognising malaria in their children. They interpreted signs of malaria, notably fever, differently according to the general health of that particular child, and adopted varying health seeking behaviours accordingly. If the child was a finger-sucker, fever may have been put down to worms, or if the child had developed a fever following on from, or in conjunction with another illness, the mother was less likely to interpret it as malaria (Lubanga et al, 1997).

Although the focus is often on social and cultural restrictions on women, there are also other enabling and constraining factors. Wallman and Baker (1996) provide a detailed list of 'elements of livelihood' that are likely to affect women's capacity to obtain treatment: actual money income, potential money income, social status, social life, networks, autonomy and liability. These they argue will come into play after a woman has assessed how good, kind, shameful, private, feasible and appropriate options are, within the physical infrastructure of that area. The total resource base will vary in absolute size between women, in relative proportions, geographic scope and according to a particular illness episode. They use the model to study through a range of illness episodes over time, and begin to

"transform the respondent from a flat unit of enquiry into a person 'in the round', embedded, as real people are, in social relationships and economic obligations which constrain all the decisions they make" (Wallman and Baker, 1996. 678).

This allows a picture of the resources to build up as the actor experiences them, and claim the authors, is a crucial step towards understanding why and how people do what they do.

Bedri (2001) in her study of women's health seeking behaviour around abnormal vaginal discharge, highlighted the role of the husband and the availability of knowledgeable social contacts as key factors in securing an early diagnosis and use of health care services. She suggests women could be empowered by policy and health system developments that encourage the creation of 'expert social networks' and 'expert husbands' in order to ensure the necessary social infrastructure is in place to support women through their health care seeking process. Ahmed et al (2000) also suggest that efforts are needed to raise community awareness of the immediate and future benefits of improving women's health, and this also appeals more directly to existing social structures and an opportunity to strengthen them for beneficial health outcomes, rather than a further attempt to change behaviour of individuals.

Evans and Lambert (1997) adopt the word 'strategy' rather than 'behaviour', to reflect the complexity of the decision making processes that women face on a daily basis, weighing up social, economic, practical, cultural and personal factors, and not simply in response to one-off isolated illness events. This they argue suggests a purposeful action rather than an unreflecting, predetermined behaviour. This idea is salient across the study of health seeking behaviour and mirrors my own interest in theorising 'reflexive communities' to understand health seeking behaviour in a more meaningful way.

Thus, there is a lot of work on women and health seeking behaviour that simply portrays women as an unfortunate group caught up in the patriarchal cultures of their society. However, there are also a number of original and interesting studies that start to explore women as intentional individuals mediating the structures around them in order to fit their particular aims at that time, and to offer policy solutions to create a more enabling environment for these women to act within.

Key issues from maternal and child health

- The way in which women reach the decisions they do can have a profound effect on child morbidity and mortality and is therefore worthy of continued study.
- The approaches of Evans and Lambert, Wallman and Baker, and Bedri suggest there may be a more fruitful way of exploring women's embeddedness in health systems and social structures that is as yet under-developed in the literature.
- Bhatia and Cleland's paper demonstrates the direct relevance of understanding health seeking behaviour to the current debate around the introduction of public sector charges as a means of cost containment.

HIV/STIs

Some of the most interesting work around health seeking behaviour is carried out in relation to this probe. Because of the very 'social' nature of the spread of HIV, and the reflection of cultural beliefs around sexuality, virility and reproduction it is perhaps seen as an area where solutions will only be found through research that reflects this cultural and social element. Health education aimed at using condoms for safer sex, for example, will have minimal impact when directed at individual girls or women who have little or no control over their sexual encounters (MacPhail and Campbell, 2001). Campbell and Williams (1999) have therefore criticised management and policy approaches to HIV and AIDS that have been dominated by

biomedical and behavioural approaches, rather than seeing it as a wider social and developmental issue.

Research around sexual behaviour and health seeking behaviour is now beginning to move away from the realm of the private individual, interviewed retrospectively about illness episodes in their house, and into the reality of interaction in the social world. Campbell and Williams (1999) present a pathways model to HIV infection in the context of the Southern African mining industry. This flows through four stages to potential infection: Social factors (economic factors, gender dynamics, working conditions), Psychosocial mediators (self-efficacy, competing knowledges and beliefs, masculine identities), Behavioural pathways (poor condom use with multiple partners) and/or Physical pathways (other sexually transmitted diseases).

Such studies demonstrate clearly that decisions made around sexual behaviour are far more complex than traditional health promotion approaches would acknowledge.

“This is because – far from being a matter over which individuals exercise rational control as the KAP [knowledge-attitudes-practices] framework suggests – sexuality is shaped by a complex process of identity formation nested within the dynamic web of cultural, psychological and social factors” (Campbell, 1997. 280).

Campbell suggests changing behaviours will only be witnessed if individuals are allowed to refashion their identities as part of a collective process. At a group level people can then change their ‘recipes for living’ in an active rather than an individualised passive manner. I would suggest the same argument could be applied to any study of health seeking behaviour, not just one focused on behaviour in relation to STDs. Bedri’s (2001) policy suggestions around expert social networks similarly place the potential for changing women’s health seeking behaviour in the evolution of social structures rather than the individual.

Key issues from HIV/STIs probe

- The work around health seeking behaviour and HIV (expanded upon below) offers an original take on health seeking behaviour as a research concept. It may be interesting to expand such innovative explorations into health seeking behaviours more widely across the probes.
- Campbell and Williams offer the challenge of exploring the broader contextual factors within which health promotion programmes around HIV are implemented, and exploring why policy is reluctant to disengage with the biomedical, individualised model.

Diabetes Type 1

To date I have not found anything of direct relevance under this probe for the partner countries. However a number of general issues arise which are pertinent. Rapley and Fruin (1999) emphasise that conditions such as diabetes often require changes in lifestyle and approach to health behaviours, and the ease with which such changes occur depends on the person’s self-efficacy and expectations about outcomes. Clearly this is linked to health seeking behaviour. A paper on native and immigrant diabetes sufferers in Sweden reiterates the importance of self-efficacy in health related behaviours and compliance, as well as the cultural relativity of beliefs about health and illness (Hjelm et al, 1999). However, Miglani, Sood and Shah (2000) suggest that

physicians usually neglect the social or psychological issues associated with diabetes during consultations with diabetic patients.

Stenström and Andersson (2000) also raise the interesting point that patients with weaker beliefs in health care professionals may be more likely to engage in risky behaviours in relation to their diabetic status. Thus this doctor-patient dynamic is yet again raised as an important issue.

Key issues from diabetes probe

- Perhaps the lack of material suggests there is more work needed in this area?
- The doctor-patient dynamic can potentially be used to promote 'good' health seeking behaviour and compliance with treatment, and is an issue reflected across the probes.

These very brief reviews demonstrate the relevance of an understanding of health seeking behaviour across many sections of the programme. The rest of the paper provides a more detailed exploration of how health seeking behaviour itself could be usefully expanded as a tool and utilised in research on health systems development.

2 Introducing a framework for analysis

In order to move our interest in health seeking behaviour beyond the narrow confines laid out so far, it is necessary to locate it within the wider development and health system literature. Rather than using health seeking behaviour to understand how an individual responds to an illness situation, I am interested in finding out what it can tell us about the wider dynamics of health systems and engagement or disengagement with them. The difficulty in moving the debate from the individual to the social embeddedness of that individual's behaviour, is that social phenomena are so all-pervasive, yet often vaguely defined (Narayan, 1999). One way in which authors have attempted to untangle and analyse the way in which social forces interact in the development process is through the lens of social capital (Woolcock, 1998). This section of the paper therefore introduces social capital as one potentially useful area to provide a guiding framework allowing us to locate issues of collectivity and health systems dynamics. This, it is suggested, enables a more useful understanding of the potential use of health seeking behaviour as a conceptual and empirical tool.

2.1 Social capital and health

The idea that social capital may be a useful construct in developing our understanding of healthy communities is taking hold (Gillies, 1998; Leeder, 1998). Social capital has been variously defined as the social resources (Loury, 1997), norms and networks (Putnam, 1995) or processes and conditions (Kreuter, 1999) within society that allow for the development of human and material capital. It is believed that social capital is created and used through civic participation and has been suggested this process can be enhanced by the right policy interventions (Adler and Kwon, 2001). Social capital can exist in two distinct ways within social structures. There is *bonding* social capital which links members of a particular group, and there is *bridging* or *cross-cutting* social capital which links across groups (Gittell and Vidal, 1998; Narayan, 1999).

Cross-cutting ties are those ties that bring different groups, with unequal access to power, resources and influence, together in a way which helps those with less power to benefit from that tie, either directly or indirectly. The importance of bridging social capital is highlighted by examples of bonding social capital which undeniably serve to exclude certain groups from the benefit of internal membership. For example, the operation of criminal gangs or the Mafia provide strong support for members, but have a negative effect on outsiders. Or membership of a particular group, for example a mother's group, may provide internal social capital, but without cross-cutting ties to other groups brings little extra 'power' through that bond.

There is widespread interest in utilising social capital to understand the social processes behind health inequalities (Baum, 1999; Gillies, 1998), and it has begun to enter the health seeking behaviour literature (Alam, 2000; Campbell and Mzaidume, 2001). Although there is strong criticism that social capital remains poorly theorised and is yet to be constructed as a robust social concept (Brown, 1999), the general direction of the debate is logical in that it builds upon the well established idea that health inequalities are related in some way to other social, economic and cultural inequalities (Kawachi et al, 1997; Kawachi and Kennedy, 1997).

There have been numerous interpretations of, and attempts to operationalise, the concept of social capital across a range of fields. The health and health care literature tends to focus on the role of social capital in sustaining or generating healthy lay communities (Morrow, 2001; Narayan and Pritchett, 1997); the concept is seen as residing in, and measurable through, *sense of community*, *engagement* in health promoting activity and general *community well-being* as represented by the presence of specific amenities. In this context social capital is seen as a new framework for thinking about the broader determinants of health and how to influence them through community based approaches (Gillies, 1998).

Another literature, rooted in sociological and organisational theory, explores the role of social capital in supporting institutional success at local, national or international levels (MacKian, 2002), and it is perhaps in this literature that we should be most interested. The structures of co-operation which are witnessed in association with successful corporate enterprise are explored within a social capital framework; from the study of regional networks (Romo and Schwartz, 1995), micro enterprises (Honig, 1998), right down to the attributes of particular employees (Gabbay and Zuckerman, 1998). Here social capital is utilised to explore the nature of those interactions which appear to sustain and accelerate system development. Thus there have also been attempts to understand social capital as a theoretical framework for organisational research (Adler and Kwon, 2001). As we are primarily interested in how health systems may better serve the needs of the poor and excluded, and the health seeking behaviour literature suggests it is often the system itself which serves to limit an individual's capacity to engage with it, this approach would seem particularly apposite.

Across studies, regardless of the substantive issue of interest through which the effects are being conceptualised, social capital is understood to lie at the interface of social networks and relations. It is seen as the product of social interaction processes manifested as the accumulated knowledge and identity resources drawn on by 'communities-of-common-purpose' (Faulk and Kilpatrick, 2000). Although it is

currently proving difficult to reach agreement on how to define precisely the processes behind the construction and use of social capital, the constituent elements or definitive outcomes, this should not preclude us from using social capital as a 'work in progress'. It would seem safe to suggest that there exist a set of processes that we can broadly equate with active social capital. They generate unity, commonality of purpose, but also exclusions, and can ultimately be beneficial to health system development.

Social capital and health seeking behaviour

Social capital actually serves an extremely useful purpose in the area of health seeking behaviour as it provides a means of shifting the focus from individuals to social groups, and the social embeddedness of the actions of individuals. In relation to the health of individuals there is growing evidence that high levels of social capital in themselves may have a positive effect on health. The point to stress is that this sort of benefit is an attribute of social structures, and therefore *cannot be read off the individual alone* as most health seeking behaviour studies attempt to do. There is also evidence to suggest that participation in community projects has a potential spin-off effect, engendering more active health seeking behaviour in other contexts (Brown and Ashman, 1996). The very act of participation in a health promotional community project also means health-related knowledge, traditionally the preserve of experts, is placed in the hands of ordinary people (Campbell and Mzaidume, 2001). Thus again we see social capital also has implications for the operation of health systems.

It is my belief, although there has been much description of the contextual nature of an individual's health seeking behaviour, this wider perception of the importance of social context has not been acknowledged explicitly. Furthermore, whilst much emphasis is placed on cultural norms, social conventions and expectations, little has been done to translate this into a contextual picture of how the structural preconditions of the health care system reinforce or contribute to the related set of problems. Social capital offers us a lens through which to do this. It would also allow us to explore how social capital may act as an enabling resource to improve the effectiveness of other inputs and engender a more participatory system for a wider range of users.

2.2 Social capital and development

Narayan (1999) claims the current development paradigm focuses exclusively on reforming the state or markets to help countries prosper. He suggests interventions aimed at economic prosperity must also take account of the underlying social organisation of a community or country, and believes an acknowledgement of the role of social capital is one way to do this. Dhesi however claims there *is* growing recognition of the role of social capital in development,

“A broad consensus is emerging that development initiatives should take into account the role of social capital, that is, shared knowledge, understandings, values, norms, traits, and social networks to ensure the intended results” (Dhesi, 2000. 201).

Morris (1998) also suggests there has been a recent shift to focus on human and social capital in development studies, with growing recognition that far more people rely on informal social capital than formal institutions. This may seem particularly apposite in a health systems context.

As a means of assessing the application of this, Narayan introduces a framework of analysis for development, exploring the key relationship between social structures and governance. He believes both formal and informal structures and institutions need to be operating effectively to promote development. On the formal side he says institutions of the state vary from being 'well-functioning' to 'ineffective'. On the informal, he measures social structures according to the level of 'cross-cutting ties' in existence. In Narayan's model, cross-cutting ties between informal groups open up economic opportunities to excluded groups, and build social cohesion, a critical part of social stability and economic welfare. The state plays an important role in supporting the informal institutions which allow the development of cross-cutting ties, in particular by helping to provide physical and social space in which these ties can emerge (Narayan, 1999). The model presents four quadrants according to the functioning of the state and level of cross-cutting ties, or 'social capital'. It permits a structured examination of how different combinations along the two dimensions affect social and economic performance. By placing individual communities or countries in each quadrant it is possible to start to explore how long-term economic development might be secured, and where most effort is required to initiate change and improvement.

In health systems development there is growing recognition of the importance of a social dimension to health improvement, and Campbell and Mzaidume (2001) note a 'paradigm drift' within health promotion, involving a shift away from traditional educational approaches towards a community development approach involving local people in interventions. Indeed they claim the success of health promotional interventions are now partly assessed on their ability to mobilise existing sources of social capital and encourage the development of new ones.

Thus it is possible to adapt Narayan's development model to provide an analytical framework more specifically for health systems development (**Figure 2**). Here there are also two axes of influence across which the infrastructure supporting social capital may exist: formal structural provisions (the policy framework, ministry organisation, public and private facilities and providers), and informal institutions with potential health impacts, such as traditional healers and a range of social networks. The cross-cutting ties in this model are composed of a range of social factors potentially contributing to wellbeing, including for example the position of women in society, community cohesion and civic engagement. (By referring back to **Table 2** we can see that these elements, informal, formal and infrastructure, have routinely been examined in health seeking behaviour studies, but have not routinely been theorised in such a way).

By placing socially rooted studies of health seeking behaviour into such a framework we will begin to see the value of understanding health seeking behaviour not as something that resides in the individual, but as a reflection of wider societal processes and something that is related to the health system. Rather than concentrating on the individual as the potential source of solutions, this shifts the gaze onto the wider contextual setting. Thus health seeking behaviour studies which are either facility or household based miss the opportunity of capturing the wider community picture, which could be all important in understanding why, when and how people use health system facilities.

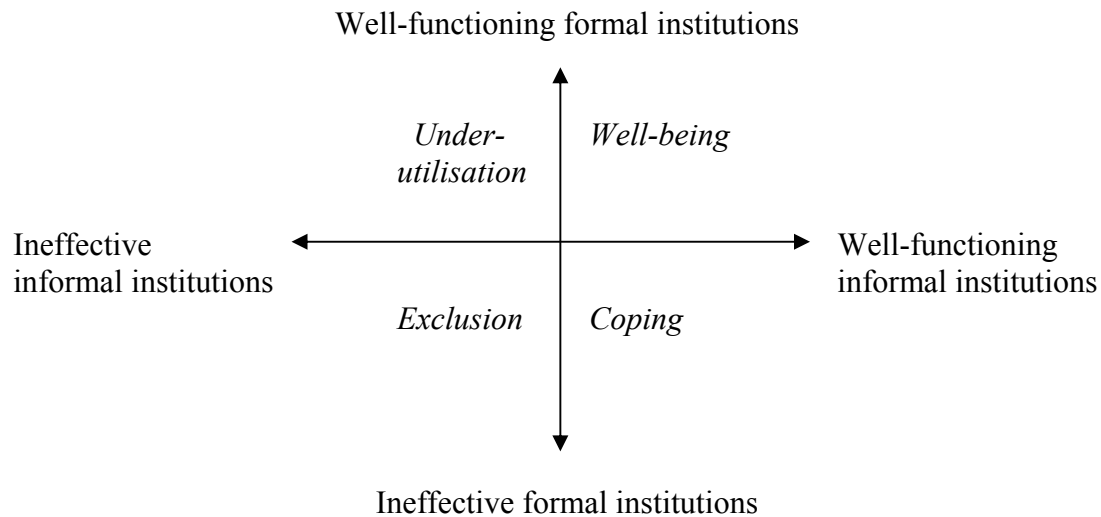


Figure 2: relationship between formal and informal institutions (adapted from Narayan, 1999)

There are now growing attempts to foster community participation in local health systems, to encourage better health seeking behaviour *and* develop management structures. However ideological and theoretical differences about the nature of participation abound, and there remains a lack of clarity over mechanisms for inclusion. There is a lack of detailed comparative analysis of just what forms civic organisations might take to have the greatest benefit for both the health of the system and the health of individuals. As Campbell and Mzaidume (2001) suggest, although the trend towards mobilising existing community resources in health promotion strategies makes theoretical and political sense, the reality of translating it into practice is fraught with difficulties. This is especially true where existing community networks are structured around unequal and exploitative relations.

Thus the effect of introducing new opportunities for participation may not always be entirely beneficial to health and it is therefore imperative to paint the wider picture beyond the bonding social capital that may occur through participation in a particular way. For example, Ahmed, Chowdhury and Bhuiya (2001) assessed the effects of micro-credit schemes, aimed specifically at women in Bangladesh. They claim that development programmes concerned with material improvement of participants, and in this example the projection of women into non-traditional roles, fail to address the effect on physical and emotional well-being of participants. Here material capital was being directly enhanced through the provision of collateral-free loans, human capital was developed through skills training, and social capital was engendered through group formation. However, there was little effect demonstrated on women's emotional well-being, with some evidence that involvement in micro-credit schemes to enhance the socio-economic standing of these women, promoted emotional stress and potential ill-health as a result. This reiterates findings of other studies, where people are asked to rank elements of well-being - income often appears as a surprisingly low priority, in comparison to health, family life, respect and social values (Chambers, 1997).

Although the concept of social capital had taken hold in the discourse of development agencies (Campbell and Mzaidume, 2001), we have yet to see a systematic analysis and evaluation of strategies applied in a comparative setting. This programme offers an ideal opportunity to address this in the context of health system development, and the framework outlined above offers an opportunity to address the urgent need to draw together and theorise existing scattered, and rather descriptive knowledge around health seeking behaviour. It could provide an opportunity to conduct a systematic analysis of interventions aimed at changing health seeking behaviour and promoting increased usage of health care services, and begin to outline where future interventions may need to lie in order to address the two dimensions of development - formal system development and informal social development.

Resituating health seeking behaviour: from the individual to the collective

How might our two key themes, the neglected collective element of health seeking behaviour and the interaction of people and health systems, be understood in this framework? By locating our understanding of health seeking behaviour within this framework already we begin to see that the over-riding emphasis on the individual has been misplaced. It would be more rewarding to explore the inter-relationships of individuals within containing social systems, cultural norms and system constraints, and understand resulting behaviour as a product of these inter-relations rather than something intrinsic to the individual. Despite the fact that repeated studies of health seeking behaviour amongst individuals throw up social factors as being central to that behaviour, these problems are recast, and attempts to address them are focused on the individual. The way in which the research is actually conducted is also predominantly rooted in the individual in their immediate home environment (Tipping and Segall, 1995).

MacPhail and Campbell (2001) begin to break away from this. They used focus groups to tap into the socially-negotiated nature of sexuality for young people in South Africa, playing down the role of individual decision making. MacPhail and Campbell's work begins to explore the sorts of reflexive communities these young people inhabited and the influence of these on decisions, or forced choices, made around sexual behaviour. They demonstrate far more insight can be gained by exploring social issues related to health behaviours, *within a social context*, than by talking to individuals in their homes and asking them to talk about specific acts of illness response. This shifts the emphasis then from individual behaviour, to recognising the force for control, the potential driving force behind change, lies not in the individual, but within surrounding structures and relations. In the view of social capital theorists, it is these wider structures, not the individual, that are the source of an individual's advantage or disadvantage (Portes, 1998), and it is therefore these that are of greatest interest. This emphasises the relational nature of health seeking behaviour, and would seem a more logical approach to adopt.

Authors such as Campbell and Mzaidume (2001) and Alam (2000) are now presenting the concept of social capital as a useful starting point for conceptualising those features of 'community' most likely to contribute to health promotion goals. Similar work is often conducted in health related behaviours in a developed world context. We can begin to map this approach onto the ideas of Lash and Urry around reflexive communities, in order to explore how we might move the tool of health seeking behaviour into a more fruitful arena for work around health systems development.

The framework could be used to explore the relative positions of the ‘reflexive communities’ particular groups or individuals inhabit, and help to understand how guided improvements could be brought about to include a wider range of participants in meaningful ways. Here the emphasis would not be on the knowledge of an individual that might affect their health seeking behaviour, but their engagement with other structures around them. There has so far been little synthesis of knowledge and understanding around structural influences on health seeking behaviour, conceptualising it as a socio-structural phenomenon, rather than one that resides in the individual. This removes health seeking behaviour from the locus of control of the individual and places it within the enabling and constraining framework of the social system and health care structures, and renders the tool far more useful in helping to understand utilisation of services within these systems.

Hence we see there is a complex relationship between health seeking behaviour, the health of the individual, the material, human and social capital of a community, and the health system. It is not always a straightforward one. Thus we may want to explore the possibility of changing systems to influence opportunities for social, rather than individual change, very much like Bedri begins to suggest in relation to vaginal discharge.

Health seeking behaviour in the context of health systems

A framework of social capital places the emphasis on social structures, interactions and systems, and allows us to explore the implications of findings on individual health seeking behaviour more meaningfully. As a framework it can also be useful for understanding health systems; firstly in exploring the way in which health systems operate themselves, the social capital *within* participating organisations, and secondly in terms of the relationship between local health systems and the population, *the interface*. Both of these can be addressed through the model outlined above. Within a health systems development context, the above framework can therefore help to understand what ties might exist across groups in order to help them benefit from knowledge, services or infrastructure they have so far been excluded from. Services can then be developed in a way that targets directly these links. For example, the success of the family welfare clinic in Rahman’s study of Bangladesh was largely a reflection of the way in which the service was embedded in existing ties between women, by virtue of its physical location. (However, Rahman also found physical decentralisation of services in itself was not a recipe for increased utilisation). The embedded nature of traditional doctors and birth attendants in the existing social fabric and reflexive communities also clearly plays a huge role in women opting to use these for delivery in favour of trained public service doctors.

The framework would also enable us to visualise where formal institutions may need to nurture informal networks, or highlight those who lack the benefit of being embedded in supportive networks. Women are an extremely good example of this. They also highlight the importance of both bridging and bonding social capital to the individual and the efficient functioning of the system. Problems highlighted by authors such as Rahman (2000) and Bedri (2001) suggest women’s health status and health seeking behaviour clearly reflects the need for bridging capital and supportive formal institutional structures to enable that. In many situations they are limited in choice by their position in society, in the household and in the community. Health services that use their formal structures to support a more accessible way of engaging

women in social networks, and are more responsive to their own institutional barriers to participation, would enable a greater proportion to benefit from health services they are currently not utilising. But this must be done in a way that is cognisant of, and sensitive to, the position of women in society. Otherwise there may be negative knock-on effects on the wellbeing of these women, as the study of women involved in micro-credit schemes in Bangladesh demonstrates.

Dhesi (2000) also stresses the important role of structural conditions in promoting the scope of trust, and hence the development of social capital. There are many examples in the health seeking behaviour literature where structural elements within the system are highlighted for their unintended impact. For example, the practice reported by Rahman (2000) and others, of public doctors running private clinics alongside their public role, where they can charge patients they have referred from the public system, may have the effect of undermining trust in the wider system. Thus both formal structural arrangements and the informal traditional discourses they are mapped onto must be taken into account, and Narayan stresses: “[t]o design the right policy intervention, it is vital to understand the nature of a society’s formal and informal institutions” (1999. 37). In order to understand those formal and informal institutions in relation to health and health seeking behaviour, we may want to explore how formal institutions have attempted to develop mechanisms for the inclusion of those previously excluded. How they have attempted to promote changes in values and norms in local informal institutions and communities; or create wider opportunities for involvement in formal institutions of health care, encouraging social connectivity across groups, between the excluded and the powerful. In particular it would be interesting to explore spaces and places for the production and consumption of social capital, and the influence of these on the reflexive communities affected by them.

3 Conclusion

“To begin to picture the resources and constraints...*the way the actor experiences them*, is to take a crucial step towards understanding why and how people do what they do” (Wallman and Baker, 1996.678. Italics in original).

Health seeking behaviour is not just a one off isolated event. It is part and parcel of a person’s, a family’s or a community’s identity, which is the result of an evolving mix of social, personal, cultural and experiential factors. The process of responding to ‘illness’ or seeking care involves multiple steps (Uzma et al, 1999), and can rarely be translated into a simple one off choice or act, or be explained by a single model of health seeking behaviour. Rahman (2000) demonstrates that a woman’s decision to attend a particular health care facility is the composite result of personal need, social forces, the actions of health care providers, the location of services, the unofficial practices of doctors, and in some contexts has very little to do with physical facilities at a particular service point. The complexity of such findings is rarely traced in detail, and is usually disaggregated, losing all sense of the actual reality. Thus what seems to be missing in much of the literature around health seeking behaviour is a sense of how that process of ‘seeking’ extends over time, space *and* the health system in complex ways, and cannot be picked out as something intrinsic to the individual and their social, economic or cultural circumstances alone. Williamson (2000) suggests that

while health promotion places emphasis on individual behaviour, the lens needs to be broadened to other determinants of health, including policy directives to enhance population health, reduce inequality and improve social justice. To a large extent such spheres fall outside the traditional mandate of health seeking behaviour models and this is where the relevance of a wider framework, such as the one offered here, becomes strikingly clear.

So without wanting to dismiss the work which has been conducted to date on health seeking behaviour, we need to build on this and move the research agenda into a new and more holistic dimension. One thing clear from the literature is that although there are many overlaps and similarities across countries and populations, there are also marked differences between individual countries, places, localities and systems. The exciting dynamic of this area is getting health systems to use and work with the information and build it effectively into their management structures. This clearly isn't easy. Many countries are now setting up communication channels with local people acting as lay representatives on health councils or forums. However, these structures do not reach everyone. There continue to be groups who are traditionally excluded, and the new structures have the potential to reinforce pre-existing patterns of exclusion. This programme is specifically concerned with the health of the poor; health seeking behaviour of the poor is a neglected theme in the literature. If we take the health seeking behaviour strand anywhere, it must be focused on this, exploring how those experiencing extreme poverty might be included in a more participatory framework for a health system they need to be a part of if that system is to have a real role in protecting their health.

In this paper I have suggested using the lens of social capital to view health seeking behaviour and its relationship with health systems development. Social capital may have effects at two levels on the health of populations. Firstly, it has been shown to have a direct effect on the health of communities. Secondly, the act of participation in networks or community centred projects has been demonstrated to have an indirect effect on the health seeking behaviour of participants. For our purposes, it has also been shown to be of relevance in looking at organisational and system development, and the mechanics of participation. Thus it would seem logical, if we wish to move this debate into new and more fruitful arenas, that we develop an interest around *social capital* as a tool for understanding *how populations engage with health systems*, rather than *health seeking behaviour* as a tool for *describing how individuals engage with services*. Some of the most innovative and exciting work carried out to date around such ideas is in the field of HIV and sexual behaviour, particularly in the context of South Africa (Campbell and Mzaidume, 2001; MacPhail and Campbell, 2001), and there is also some interesting material available on maternal health (Alam, 2000; Bedri, 2001). Therefore to build on this it may be interesting to develop a comparative study across the four partner countries exploring the intersection of social capital, health seeking behaviour, community participation and sexual health.

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