CHAPTER – 2

REVIEW OF LITERATURE

The previous chapter discussed the aim and scope of the present study from the wider perspectives of health status, health seeking and culture and health. Now an attempt is made to analyze the past trends in the area of research in health seeking behavior, health values and belief and health status both at the national level and at the international level. Many researchers have conducted studies on health seeking behavior, health beliefs and values and health care practices. Hence, there is a need to trace out the above areas of research.

Monasa Aslam and Geeta Kingdon (2010)\textsuperscript{55} examined the changes in the pattern of maternal health care practices and the extent to which inequities in access to those services have changed over the past two decades. The overall findings indicate that there is an improvement in inequity patterns of health care among married women beginning in the urban areas and more recently spreading to rural areas. Among the factors explaining the health care differentials, the effect of wealth and socio-economic status is significant, especially when examined for use of private and public health facilities. It is further noted that increased educational attainment level of women improves utilisation of maternal health care services.

Naydene de Lange and Claudia Mitchell (2012) used a digital archive containing HIV-stigma visual data - generated five years earlier by youth in the community - to engage the participants in the analysis. Drawing on such participatory work as Jenkins' participatory cultures framework, they focus on the idea of re-using, re-coding, and re-mixing visual data. A key concern in the work related to visual images particularly in projects such as theirs where a large amount of visual data is produced is to consider ways of extending its life through the use of community-based digital archives.

Anindita Chakrabarti (2012) estimated the role played by factors in determining the occurrence of diseases and utilization of formal health care for children under the age of three in India. The major findings are briefly enlisted as follows. First, a woman with greater educational qualification and autonomy in terms of her power to take decisions on her own, control over household resources and complete freedom to move beyond the confines of her household exerts a significant influence on the probability of seeking care. In addition to this, formal care is more likely to be sought for children whose mothers are more exposed to the media. Programmes devised to enhance utilization of formal health care for children should be targeted to catering to the needs of the vulnerable group i.e. female child, predominantly, residing in households belonging to Scheduled Tribe.


Angelika et al., (2012)\textsuperscript{58} investigated the adoption of an open health platform by patients, care givers, physicians, family members, and the interested public. Results suggest that open innovation practices in health care lead to interesting innovation outcomes and are well accepted by participants. During the first three months, 803 participants of the open health platform submitted challenges and solutions and intensively communicated by exchanging 1454 personal messages and 366 comments. Analysis of communication content shows that empathic support and exchange of information are important elements of communication on the platform. The study presents first evidence for the suitability of open innovation practices to integrate the general public in health care research in order to foster both innovation outcomes and empathic support.

Abass Kabila et al., (2012)\textsuperscript{59} examined the effects of socio-cultural practices on male involvement in reducing maternal mortality in rural Ghana. Both qualitative and quantitative data were collected for the study. The main methods used in data collection were structured interviews, focus group discussion and direct observation. The research revealed that male involvement in reducing maternal mortality was low. Polygamous marriages, the practice of “Dog kuli” and social stigma are among the key socio-cultural practices that inhibit male involvement in reducing maternal mortality.


mortality. The research notes that intensive public education, an increase in couple-friendly maternal health care services and increased engagement with traditional authorities on the need to modify some socio-cultural practices would help whip up male partners’ interest in promoting maternal health.

Shanmugam and Rangasamy (2011)\textsuperscript{60} contribute to the literature by estimating discount rate for environmental health benefits and value of statistical life of workers in India. The discount rate is imputed from wage-risk trade-offs in which workers decide whether to accept a risky job with higher wages. The estimated real discount rate ranges between 2.7 and 3 percent, which is closer to the financial market rate for the study period and consistent with earlier studies from developed nations.

Koonal \textit{et al.}, (2011)\textsuperscript{61} reported that social value judgments relating to equity in the distribution of health and health care have been less specific and systematic than those relating to cost-effectiveness in the pursuit of improved sum total population health. This paper aims to describe the social value judgments about equity in health and health care that NICE has hitherto guided its decision making. To do this, they reviewed both the general social value judgments reported in NICE guidance on methodology and the case-specific social value judgments reported in NICE guidance about particular health care technologies and public health interventions.


Vincent et al., (2011)\(^{62}\) explored current attitudes and referral behaviours of WMD towards use of TCM. They hypothesised that WMD would have positive attitude towards TCM, due to regulation and cultural affinity, but that few actual TCM referrals would be made given the lack of a formal collaboration policy between elements within the healthcare system. Their results support these hypotheses, and this pattern possibly is rooted in the structural inhibitions originating from the historical dominance of WM and failure of services to respond to espoused policy. These have shaped Hong Kong's TCAM policy process to be closer with situations in the West, and have clearly differentiated it from integration experiences in other East Asian health systems where recent colonial history is absent. In addition, their results revealed that self-use and formal education of TCM, rather than use of evidence in decision making, played a stronger role in determining referral. This implies that effective TCAM policies within WM dominated health systems like Hong Kong would require structural and educational solutions that foster both increased understanding and safe referrals.

Victor Igreja et al., (2010)\(^{63}\) assessed the prevalence rates of harmful spirit possession, different features of the spirits and of their hosts, the correlates of the spirit possession experience, health patterns and the sources of health care consulted by


possessed individuals in a population sample of 941 adults. A combined quantitative-qualitative research design was used for data collection. A major study outcome is that the prevalence rates vary according to the severity of the possession as measured by the number of harmful spirits involved in the affliction. The prevalence rate of participants suffering from at least one spirit was 18.6 percent; among those individuals, 5.6 percent were suffering from possession by two or more spirits. A comparison between possessed and non-possessed individuals shows that certain types of spirit possession are a major cause of health impairment.

Dongfu Qian et al., (2010)\textsuperscript{64} addressed the observed demand for both public and private providers and are believed to be the first to attempt this for urban China. The findings indicate that overall private clinics are important sources of medical care for low consumption households, that insured patients are less likely to use private clinics and more likely to use CHC and that children are more likely to see a high-level provider. A number of other factors, including city size and severity of illness were found to play a role in determining provider utilization.

Papreen Nahar, (2010)\textsuperscript{65} states that social class and the geographical location of the childless women determine their health seeking behaviour. Local healers in the informal sector were found to be the most popular health service option among the


\textsuperscript{65} Papreen Nahar (2010), “Health seeking behaviour of childless women in Bangladesh: An ethnographic exploration for the special issue on: Loss in child bearing” Social Science and Medicine, vol. 71(10), pp: 1780-1787
rural childless women. The factors for utilising them included low costs, the gender of the provider having a shared explanatory model with the healers, and easy availability. Unlike their rural counterparts, urban childless women predominantly seek expensive Assisted Reproductive Technologies (ART) treatment which is available only in the formal sector, in private services. However, despite their affiliation with modern treatment, urban childless women still believe, like their rural counterparts, that the remedy for childlessness ultimately depends on God. It was found in this study that in Bangladesh, where fertility control is the main focus of health policy, childless women are excluded from mainstream discussions on women's health.

Sadatoshi Matsuoka et al., (2010)\(^6\) identified the underlying causes of Cambodian women's non-use of maternal health services provided by skilled birth attendants. A qualitative study of 66 reproductive-age women was conducted in Kampong Cham Province, Cambodia. Data were collected through 30 semi-structured interviews and 6 focus groups. The authors identified 5 barriers to the utilization of maternal health services: (i) financial barriers; (ii) physical barriers; (iii) cognitive barriers; (iv) organizational barriers; (v) psychological and socio-cultural barriers. The Cambodian Ministry of Health and its development partners should take these barriers into account when promoting the use of maternal health services. These barriers should be addressed proactively. A successful approach to increasing use of maternal health services should involve changes in both service programs and public education.

Peter la Cour and Niels (2010)\textsuperscript{67} proposed a framework of concepts for the field of existential meaning-making in secular cultures such as those of Northern Europe. Seeking an operational approach, they narrowed the field's components down to a number of basic domains and dimensions that provide a more authentic cultural basis for research in secular society. Reviewing the literature, three main domains of existential meaning-making emerge: Secular, spiritual, and religious. In reconfirming these three domains, they propose to couple them with the three dimensions of cognition practice resulting in a conceptual framework that can serve as a fundamental heuristic and methodological research tool for mapping the field of existential meaning-making and health. The proposed grid might contribute to clearer understanding of the multidimensional nature of existential meaning-making and as a guide for posing adequate research and clinical questions in the field.

Monasa Aslam and Geeta Kingdon (2010)\textsuperscript{68} investigated the relationship between parental schooling on the one hand, and child health outcomes and parental health-seeking behaviour on the other. It they examined educated parents' greater household income, exposure to media, literacy, labour market participation, health knowledge and the extent of maternal empowerment within the home. It is found that father's education is positively associated with the 'one-off' immunisation decision and


mother's education is more critically associated with longer term health outcomes in OLS equations.

Bobbie Person et al., (2009)\(^69\) collected qualitative data from 56 Dominican women and 48 Ghanaian women with lymphedema. A lymphedema-related stigma framework was developed from constructs derived from the literature and emergent themes from the data. Women described a spectrum of enacted, perceived, and internalized stigma experiences, such as being criticized and isolated by the community, health providers, and even by friends and relatives; they were often denied access to education and meaningful work roles. Some antecedents, consequences, coping strategies, and outcomes of these experiences varied across cultures, with Dominican women faring somewhat better than Ghanaians. Poverty, poor access to health care resources, limited education, and diminished social support challenged the coping strategies of many women and exacerbated negative consequences of lymphedema-related stigma.

Aki Tsuchiya et al., (2009)\(^70\) consider two societal concerns in addition to health maximisation: first, concerns for the societal value of lifetime health for an individual; and second, concern for the value of lifetime health across individuals. Health-related social welfare functions (HRSWFs) have addressed only the second concern. The authors propose a model that expresses the former in a metric – the adult


healthy-year equivalent (AHYE) – that can be incorporated into standard HRSWFs. An empirical study based on this formulation shows that both factors matter: health losses in childhood are weighted more heavily than losses in adulthood and respondents wish to reduce inequalities in AHYEs.

Judy and Yang (2009)\textsuperscript{71} examined the role and value of traditional Chinese medicine (TCM) in the current health care system in China. Methods were based on literature review and publicly available data in China. The study shows that TCM is well integrated in the Chinese health care system as one of the two mainstream medical practices.

Lucia and Pranitha (2009)\textsuperscript{72} reported that the majority of respondents consulted public health services. Despite this, it was possible to determine that income-based poverty and access to medical aid were the most significant predictors of healthcare choice. Poverty was related to other predicting factors such as employment, level of education and household size. Surprisingly, a sizable proportion of the poor without access to health insurance were using private health services. Although the reasons for this could not be determined, this presents opportunities for further research.


Aurelien Franckel et al., (2008) show significant variations in therapeutic practices, disease management and health care planning strategies from one village to the next. At different levels, individual health-seeking behaviours appear to be conditioned by a set of collective norms developed by the village community. The spatial analysis shows that these variations in behaviour describe two distinct geographic sets, distinguished by different levels of access to health facilities and different historical, social and cultural characteristics. These results challenge the validity of a unified approach to the African rural environment and call for further research to analyze the impact of numerous contextual, quantitative and qualitative factors on health-seeking behaviour.

Helen B. Miltiades and Bei Wu (2008) examined predictors of western physician utilization using the Andersen's Behavioral Model of Health Services Use for Chinese elders who reside in Shanghai and immigrant Chinese elders who reside in the US. Chinese elders are under-studied relative to their population size and in the US are known to underutilize the healthcare system. Multiple regression analyses were conducted separately for each sample. Predictors of physician visits for the Boston sample are insurance status, health, and social network, and for the Shanghai sample, use of Chinese medicine, health, and marital status predicted physician visits. The author found that access to care variables significantly affect physician utilization for immigrant elders, and that Chinese elders in Shanghai utilize a bicultural system of

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care. The results indicate that in order to create effective healthcare practices for elder Chinese, alternative healthcare beliefs should be understood by western physicians.

Srinivasan Kannan (2008)\textsuperscript{75} studied the health seeking behaviour on the above framework. This is a cross sectional study which examines the impact of the three major subsystems of health among the rural population of two villages of Tamil Nadu. Kerri Cavanaugh et al. (2007)\textsuperscript{76} explored the components, impact, benefits, and barriers of current diabetes disease management models, and also present a novel hybrid model incorporating elements of both on-site and off-site programs. On-site disease management programs include strategies characterized by unique patient identification and evaluation, implementation of intervention methods, on-site health provider team members, and specific environmental resources. Advantages of this model include the face-to-face encounter between patients and providers, the proximity of the healthcare team members to facilitate ease of communication and build independence and trust between patients and providers, and technology resources.

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Mohabbat Mohseni and Martin Lindstrom (2007) \(^{77}\) investigated the relationship between institutional trust in the health-care system, i.e. an institutional aspect of social capital, and self-rated health, and whether the strength of this association is affected by access to health-care services. In conclusion, low trust in the health-care system is associated with poor self-rated health. This association may be partly mediated by "not seeking health care when needed". However, this is a cross-sectional exploratory study and the causality may go in both directions.

Meghan and Rebecca (2006)\(^{78}\) reported that increasing providers' knowledge about culturally specific beliefs and behaviors will both assist providers in caring for particular, traditionally underserved groups and enhance the quality of health care delivery for all patients. Meanwhile, a number of critics have challenged the presuppositions of the "culture" concept underlying cultural competency, arguing that such well-intended efforts may merely exacerbate received stereotypes. Despite such criticism, the influence of cultural competency, along with the related categories of cultural sensitivity, cultural humility, cultural proficiency, and cultural awareness continues to grow in medical schools, governmental agencies, and health care organizations, particularly in the United States.


Jay Bhattacharya and Darius Noshir Lakdawalla (2006)\textsuperscript{79} found that survival gains and reductions in the number of work-days missed due to poor health have added about 8 percent to the remaining labor force value of black males, and about the same to the value of 60 year-old white males. This is almost as large an effect as a full year of schooling. Gains for younger white males appear to be approximately 5\%, and gains for women are around 2\%. Overall, health improvements have added $1.5 trillion to the value of labor market human capital over this period.

Sirpa Wrede \textit{et al.}, (2006)\textsuperscript{80} made the case for a context-sensitive and reflexive analysis of health care that allows researchers to understand the important ways that health care systems and practices are situated in time and place. The approach-decentred comparative research-addresses the often unacknowledged ethnocentrism of traditional comparative research. Decentred cross-national research is a method that draws on the socially situated and distributed expertise of an international research team to develop key concepts and research questions.

Simon Carmel (2006)\textsuperscript{81} argued that theoretical emphases on nursing's unique perspective and on differences between medicine and nursing are exaggerated in clinical practice. For example, there are many similarities between what nurses and


doctors actually do. Reasons for the persistence of these claims in academic nursing discourse are put forward—nursing seems to be quite unusual in needing an explicit theory of practice, and the paper speculates on why this is the case. The general lesson of the paper is that analytical evidence about the context and content of practice needs to be afforded a more fundamental role in the development of theories about practice-based disciplines.

Nicola et al., (2005) explored United Kingdom (UK) and United States (US) adolescents' perceptions and experiences of using the internet to find information about health and medicines, in the context of the other health information sources that are available to them. The study involved a series of 26 single-gender focus groups with 157 English-speaking students aged 11-19 years from the UK and the US. Many students reported that the internet was their primary general information source. Information sources were defined during analysis in terms of previous experience of the source, saliency of the available information, and credibility of the source. Most focus group participants had extensive personal experience with the internet and some information providers therein.

Durre Nayab (2005) found that less than half the women reporting any symptom related to reproductive tract infections seek help, while for some symptoms

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the proportion seeking help goes down to a mere one-fifth. The decision to seek help depends on a woman’s educational and economic status, the extent to which she is worried about the symptom, duration of experiencing the symptom, and inter-spousal communication about the symptom. Lack of finances to access any health service and considering the symptom as something common not needing attention are the two main reasons for not seeking help. The choice of the health provider consulted for a symptom is linked to the perceived cause of the symptom, but allopathic doctors are preferred by the majority of women seeking health care.

Stewart et al., (2005) examined the views of key stakeholders of the project in the context of broader cultural and social issues faced by exiled Tibetans. Twenty individual interviews were conducted with 'officials' (members of the Tibetan government-in-exile, religious leaders, and the clients themselves. The interviews were taped, transcribed, and analysed using a grounded theory approach. All interviewees considered that mental health was an important issue and that awareness of psychological health in the community improved since the initiation of the project.

Werner B.F. Brouwer and Job van Exel (2005) presented evidence on own expectations regarding length and quality of life, using data obtained from a Dutch convenience sample (n=600). Data were obtained through a written questionnaire and

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a web-based survey. Own expectations regarding future quality of life were obtained by using the EQ-5D descriptive system on which respondents could indicate expected health profiles for the ages 60-90. We find that respondents significantly overestimate life expectancy (by 4.1 years, males 7.0 years and females 1.7 years), but appear to underestimate future quality of life from the age 70 onward. Regression analysis is used to explain individual expectations. Age, current health status and the perception of current lifestyle are especially important explanatory variables of people's own expectations regarding length and quality of life.

Anne Case et al., (2005)\textsuperscript{86} examined choices made concerning public and private medicine, western and traditional medicine, and non-prescribed self-medication. It is found that virtually all adults who were ill prior to death sought treatment from a western medical provider, visiting either a public clinic or a private doctor. In this district, which is predominantly poor, ninety percent of adults who sought treatment from a public clinic also visited a private doctor. Fifty percent also sought treatment from a traditional healer, suggesting that traditional medicine is seen as a complement to, rather than a substitute, for western care. Better educated people who were ill for less than a month before dying were significantly more likely to visit a private doctor, while those least well educated were more likely to visit a traditional healer.

Fariyal F. Fikree *et al.*, (2004) explored traditional beliefs and practices, to assess puerperal morbidity, and to understand care-seeking behaviors, a qualitative and quantitative study was conducted in low socio-economic settlements of Karachi, Pakistan. Five focus group discussions and 15 in-depth interviews were conducted in July and August 2000. 525 Muslim women, who were 6-8 weeks post-partum, were then interviewed at home. Maternal care was relatively good--more than three-quarters of recent mothers sought antenatal care and more than half delivered in a hospital or maternity home. Counseling to attend post-partum clinics among facility deliveries was of which only attended. Practices during the delivery and puerperium, such as massaging the vaginal walls with mustard oil during labor to facilitate delivery and inserting vaginal or rectal herbal pessaries to facilitate 'shrinkage of the uterus' 'strengthening of the backbone', were pervasive. The high prevalence of perceived post-partum morbidity illustrates the demand for post-partum community-based health care programs. The authors suggest promoting maternal health education that encourages women to seek appropriate and timely care by accessing public or private health services.

Matthew Jowett (2004) observed the development of risk-sharing systems for health, in low- and middle-income countries. It questions whether insurance theory

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developed in wealthier economies, in particular the central ideas of adverse selection and moral hazard, has relevance in the context of poorer countries with high levels of unmet health needs, and low utilisation of health services. Empirical evidence on these two issues is reviewed, as is the debate around social capital and collective action, and its relevance to extending risk sharing in poorer countries. Drawing on thinking and evidence from development economics, it is argued that informal risk sharing may crowd-out formal risk-sharing schemes, the reverse of arguments found in much of the literature. Rooted in a holistic framework of household risk-reducing strategies, the paper considers the dynamic of demand for insurance in poorer countries, influenced by factors such as social cohesion, perceived corruption, and duty to the state.

Ina Vandebroek et al. (2004) believed that indigenous people have an impressive knowledge of useful plant species and that this knowledge reflects the plant wealth of their living environment. However, the present study shows that healers' knowledge of collected medicinal plants is higher in the Andean area characterised by a long history of anthropogenic activity than in the biodiversity-rich rainforest. Therefore, medicinal plant knowledge does not seem to depend on the level of plant diversity, degree of modernization or absence of western health care infrastructure.

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David Lawson (2004)\textsuperscript{90} found differences in health seeking behavior to be related to age and gender, and that increased levels of education are consistently associated with a transfer away from government provided health care, possibly indicating that people regard its quality as inferior.

Robin Thompson \textit{et al.} (2003)\textsuperscript{91} analyzed the findings of an extensive household survey; uncovering interesting evidence of variation in health-seeking behaviour across rural and urban areas due, it is suggested, to differences in real costs, quality of care, and perceptions of the value of health and health care. It is shown that, ceteris paribus, urban households in Kazakhstan are more likely to consult, to be admitted to hospital, to report illness, and will spend relatively more on health care.

Renee Gravois Lee and Theresa Garvin (2003)\textsuperscript{92} examined and challenged commonly accepted practices of information transmission in health settings, demonstrating how such practices are insufficient because they are rooted in a one-way model of information transfer. Three case studies show how this model is pervasive in different health and health care milieus: patient/provider encounters, health promotion programs, and national health policymaking. Drawing on critical theoretical perspectives, the work shows the limits of current information transfer

\textsuperscript{90} David Lawson. (2004). \textit{“Determinants of Health Seeking Behaviour in Uganda - Is It Just Income and User Fees That Are Important?”} No 30553, Development Economics and Public Policy Working Papers from University of Manchester, Institute for Development Policy and Management (IDPM)


approaches by critiquing the dominant assumptions that underpin current practice. At the same time, it provides empirical examples of the usefulness of critical approaches to identify relations of power in health communication. The paper concludes by suggesting that researchers and practitioners move beyond traditional practices of information transfer and toward a more useful and appropriate notion of information exchange.

Nyamongo (2002)\textsuperscript{93} states that patients ordinarily use multiple sources of health care. This study reveals the transitions patients in a rural region of Gusii, Kenya, are likely to make beyond the homestead in their search for alternatives to combat malaria. Malaria is a very common health problem in the region resulting in enormous human and economic losses. Results show that patients are more likely to start with self-treatment at home as they wait for a time during which they observe their progress. This allows them to minimise expenditure incurred as a result of the sickness. They are more likely to choose treatments available outside the home during subsequent decisions. The decisions include visiting a private health care practitioner, a government health centre or going to a hospital when the situation gets desperate.

Andrea S. Wiley (2002)\textsuperscript{94} reported widespread and increasing usage of biomedical services for prenatal care and birth among women in Ladakh, India, over the course of the past 20 years. This trend is at odds with that typical of other parts of South Asia, and can be attributed to the unique ecological, cultural, and historical


characteristics of this region. These include the hypoxia of this high-altitude region, which poses substantial problems for successful birth outcome, along with the socio-ecology of maternal diet and work patterns that further compromise birth outcome. These risk factors exist in the context of the absence of involvement of traditional institutions such as Tibetan medicine or traditional birth attendants in pregnancy and birth, and government-sponsored efforts to establish institutions of modernity in Ladakh such as biomedical facilities. Hence, the penetration of biomedical services into the domain of reproductive health has been facilitated. Idiosyncratic aspects of the obstetrics practice itself, particularly the social position and personality of the obstetrician, have also played an important role in recruiting women to make use of hospital-based prenatal care and birth.

Carol Vlassoff and Claudia Garcia Moreno (2002) argued that a gender analysis is fundamental to health and health planning. They begin with a definition of gender and related concepts including equity and equality. The authors discussed why gender is key to understanding all dimensions of health including health care, health seeking behaviour and health status, and how a gender analysis can contribute to improved health policies and programming. Despite the many reasons for incorporating gender issues in health policies and programmes, many obstacles remain, including the lack of attention to gender in the training of health professionals and the lack of awareness and sensitivity to gender concerns and disparities in the biomedical community. The authors argue that the key to placing gender values firmly

in place in Health for All renewal is a change in philosophy at all levels of the health sector and suggest ways in which such a change can be implemented in the areas of policy, research, training and practical programmes and interventions.

Dinah McLeod and Maurizia Tovo (2001)\textsuperscript{96} identified 99 projects that finance at least $1.6 billion in social services. While most of the projects surveyed deliver "traditional" services such as nutrition, maternal and child care, and literacy, the scope of many projects has expanded to include newer services such as counseling, home-based care for the elderly and disabled, and early childhood development.

Pierre-André Michaud, Robert W. Blum and Gail B. Slap (2001)\textsuperscript{97} deal with adolescent health surveys administered in different countries or regions often described as cross-cultural. Although most include youth of different ethnic and cultural groups, a few attempt to define these constructs or to collect data that allow their characterization. This paper explores four challenges shared by large-scale surveys of adolescent health-related behaviors and beliefs. First, adolescent health investigators have used the terms culture and ethnicity loosely. The growing interest in contextual analysis demands standardization of the definitions as they apply to adolescents, followed by correct usage of the terms. Hypotheses regarding the associations between race, ethnicity, culture, health-related behaviors, and health outcomes should be clearly stated and incorporated into conceptual models. Second,


cross-cultural analyses are interpretable only when the study designs and sampling methods provide adequate representation of cultural and ethnic minorities and when the survey items allow differentiation of factors related to race, ethnicity, culture, and socioeconomic factors. Third, cross-cultural research may expose traditions, beliefs, and behaviors that are supported by one population yet criticized by another. Investigators must recognize their own personal biases and must work collaboratively to analyze and interpret their data correctly. Fourth, generalizations about cultural/ethnic comparisons can evoke powerful emotional reactions. Interpretation and dissemination of research findings should be done sensitively and with the help of experts from the cultural/ethnic groups that have been studied.

Syed Masud Ahmed et al. (2000) reported that socioeconomic development assumed importance in rectifying gender and socioeconomic inequities in health care access, and service use. Differences in health care seeking are explored by comparing a sample of households who are BRAC members with a sample of BRAC-eligible non-members.

Laura Anne Schmidt (2000) reported that medicine's traditional ethos of community service and fiduciary ethic seems to have given way to the unbridled spirit

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of corporate capitalism. And the organizations that now populate the landscape of the health care system seem radically unfamiliar. Gone are the autonomous community hospitals and solo medical practices that most Americans grew up with. Entrepreneurs and venture capitalists have replaced them with a whole menagerie of integrated delivery systems, managed care plans, provider networks and national health care chains. Perhaps the most striking changes are in the medical profession. For much of the 20th century, medicine was a heroic exception to the otherwise waning tradition of independent professionalism in America. But in recent decades, much of the profession has succumbed to the iron rule of the large corporation and bureaucracy.

Geissler et al., (2000) investigated, in a rural area of western Kenya, primary schoolchildren's health seeking behaviour in response to common illnesses. Each child experienced on average 25 illness episodes during this period. Most episodes could be categorised into 4 groups: 'cold', 'headache', 'abdominal complaints' and 'injuries'. Of the episodes without adult involvement, 81% remained untreated, while 19% were treated by the children themselves with either herbal or western medicines. Of all the medicines taken by the children, two thirds were provided or facilitated by adults. The proportion of western pharmaceuticals used for self-treatment increased with age from 44% in the youngest age group to 63% in the oldest. Again, there were differences between boys and girls: among the youngest age group, boys were twice as likely to use pharmaceuticals as girls and in the oldest age group they were nearly three times

more likely. These differences in self-treatment practices and choice of medicines between girls and boys may reflect the higher income potential of boys, who can earn money by fishing.

Reuben Granich et al. (1999)\textsuperscript{101} reported that in Chiapas, Mexico, diarrheal disease causes the majority of all deaths in children under the age of five. Treatment of childhood diarrhea may be influenced by local beliefs and cultural practices. The rapid ethnographic survey approach allows for assessment of changes in the approach to health care option utilization in cultures incorporating new health care paradigms. Public health interventions targeting local stores may lead to increased use of ORT, thereby potentially reducing early morbidity and mortality due to childhood diarrhea.

Kilonzo and Simmons (1998)\textsuperscript{102} traced the historical development of mental health services in Tanzania from traditional practices through custodial institutions during the colonial period, efforts towards decentralization, including the development of innovative agricultural rehabilitation villages during the 60s and the introduction of primary mental health care during the 80s right up to the present. Available resources in Tanzania, including the traditional healing system, the family and ample arable land were examined as to how these might be used in the care of mental patients and the promotion of mental health in general. The article points to real opportunities and a possible course of action for the future.


Nicolaas and Anne Rogers (1998) addressed the combined use of quantitative and qualitative methodology to understand the relationship between need, demand and use of primary care services. The study conducted in three different areas in the North West of England was designed to link health status to subsequent use of health care in a way which might be used for service planning and the allocation of resources, and to provide data to inform a long term programme examining the relationship between need and demand for primary care. The study was in two stages, a survey and diary study designed to ascertain frequency of health care utilisation and health status of households, followed by a linked qualitative study consisting of in-depth interviews on a subset of people experiencing a range of common complaints seen in primary care. The mixture of methodologies gave a broader understanding of the dynamics of health utilisation in the localities studied.

Shubh et al. (1997) identified characteristics of the existing child and the maternal care environment that could be used as a basis for designing policies and programs to improve the nutritional status of children. For the present study, all children between 6-18 months of age were selected from a nutrition survey of a cross section of 741 households conducted by the IFPRI Bangladesh Food Policy Project in February-March 1992. Information was obtained on feeding practices of infants and mothers, indicators of psychosocial care, and health and hygiene practices. In this


study, information on child care practices obtained together with information from the original nutrition survey on maternal and child nutrition, individual food consumption, and household demographic and socioeconomic status was used. A selection of caring practices and indicators were identified for infant feeding, complementary feeding, maternal diet and health, psychosocial care, and health and hygiene practices.

Kwadwo Asenso-okyere and Janet A. Dzator (1997) used data collected from 1289 households in two districts in Ghana to estimate the direct and indirect costs of malaria treatment. Malaria was ascertained not by parasitological tests but through symptoms described by the respondents using a recall period of one month. It was found that substantial amount of time was spent in seeking malaria care and taking care of the sick, which makes the indirect cost per case of fever represent 79% of the total cost of seeking treatment in the survey area. The results provide ample economic justification for malaria control. The average cost of treating an episode of the disease including direct costs and the opportunity costs of travel and waiting time amounted to $8.67 or 3.7 days of male output or 4.7 days of female output. When compared with the average five days loss of output for the patient due to malaria morbidity and caretaking, it can be concluded that the cost of controlling malaria is lower than lost earnings or the value of output.

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Komla Tsey (1997) highlighted some of the key issues which policy-makers may wish to explore with regard to the future of traditional medicine in Ghana and other African countries. These include: the role of "spiritually based" traditional practitioners in the provision of care, especially for people with mental health and other psychosocial problems; professional relationships between the biomedically trained and the traditional practitioner, particularly with regard to policies aimed at integrating traditional medicine into the formal health sector; equity of access, given that efforts to "control" the quality of herbal preparations through biomedical research can dramatically alter costs, thereby undermining ease of access normally associated with traditional medicine; a need to re-examine underlining reasons for the current popularity of traditional medicine in Ghana and other African countries, given the fact that the introduction of user pay services may be forcing the poor to sometimes turn to obsolete therapeutic practices in the name of "traditional medicine"; and potential public health benefits accruing from better understanding of traditional African notions of illness causation and preventative health.

Christopher et al., (1996) states that many Vietnamese possess traditional health beliefs and practices which differ from those of the general U.S. population. Yet, the data do not support the hypothesis that these traditional beliefs and practices act as barriers to access western medical care or utilization of preventive services.

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Being married and poverty status were the most consistent predictors of health care access. Furthermore, the components of access to health care were the strongest predictors of preventive health care services utilization. Importantly, the cultural attributes of individuals did not explain either lack of health care access or underutilization of preventive health care services.

Hazel Barrett and Angela Browne (1996)\textsuperscript{108} explored the ways in which women's education influences domestic hygiene practices and use of health care services in a traditional agricultural village in The Gambia. The "environment of health" is one of poverty, high morbidity and low levels of female literacy. A detailed household survey was undertaken in the rainy season when agricultural work is demanding of people's time and energy and morbidity rates are high. Mothers with and without formal education and with at least one child under 5 were included in the study. Small differences were found between the educated and uneducated group in the knowledge and practice of household hygiene. The healthcare services in the village were utilised by all women regardless of whether or not they had been to school, but educated mothers appeared to have a better understanding of health education messages. The case study illustrates the synergy between health, hygiene and maternal education and discusses the implications of the findings.

Ghulam Mustafa Zahid (1996)\textsuperscript{109} examined the Mother’s Health-seeking Behaviour and Childhood Mortality in Pakistan. Infant and Child mortality rate is

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likewise higher among first and higher order births than among births of second or third order. It has further found that mortality declines as the length of the birth interval increases. The results reveal that the education of mother has significant effect on the neonatal, infant and child survival, as mother’s education increases the chances of survival of neonatal, infant and child. Health care factors such as antenatal care, place of delivery, assistance at delivery and immunisation also influenced neonatal, infant and child mortality. The paper suggests that for the improvement of the health conditions of children in Pakistan, first, it is necessary that the educational status of the population in general, and of mothers in particular, should be improved, and second, the health services should be accessible and available for the promotion of health care practices.

Xochitl Castaneda Camey et al. (1996) analyzed the concepts, resources and process of care during birth in rural areas of the state of Morelos. Results show that the socio-economic characteristics of the TBAs are similar to those of the patients, that they share the same precarious living conditions, and the resources to which they have access for providing care during births. When choosing a TBA as a health care provider, both the economic aspect and the importance of a shared symbolism come into play. The authors observed advantages in some of the traditional practices which should be incorporated into the medical system, for example protection through the massage of the perineum at the moment of expulsion.

Eva Lindbladh et al. (1996)\textsuperscript{111} argue that the group-centred analyses of social epidemiology should follow from theoretical considerations that take the situation of the individual as their natural starting point. The authors developed a framework for the analysis of health-related behaviour. Such behaviour is modelled as a process of decision-making at the individual level. Within economics, we draw specifically on the demand-for-health literature and the new institutional economics. Within sociology, Bourdieu's habitus theory is presented in combination with a macro-structural approach where the focus is on the process of individualization. The relationship between these different approaches to health-related behaviour and their implications is discussed.

Bruce Barrett (1995)\textsuperscript{112} described contemporary and historical interactions of medical belief and practice among the six ethnic groups of Nicaragua's Atlantic Coast-Mestizo, Creole, Miskitu, Sumu, Garifuna and Rama.

The expansion of preventive medicine and primary care under the Sandanista-led government during the 1980s is presented, along with brief descriptions of counter-revolutionary attacks on the health care system. Traditional uses of medicinal plants and various forms of spiritual healing are then juxtaposed with the sporadic introduction of European and North American biomedicine throughout history.


the results of a health care survey carried out in 1990 are used to: (1) demonstrate the widespread use of the official health care system; and (2) show that traditional practices--use of herbal medicine, visits to spiritual healers, and home birth--are more prevalent among specific ethnic and socioeconomic strata of Nicaraguan Atlantic Coast society.

Christiana E. and Okojie E (1994) examined gender inequalities of health in Third World Countries. Gender inequalities in health are manifested in traditional medical practices which attribute women's illnesses to behavioral lapses by women; differential access to and utilization of modern healthcare services by women and girls, including maternal care, general healthcare, family planning and safe abortion services. Reasons for gender inequalities in health include--emphasis on women's childbearing roles resulting in early and excessive childbearing; sex preference manifested in discrimination against female children in health and general care.

Yannick Jaffre and Alain Prual (1994) conducted focus group discussions in Niamey with women users of maternal health services, with student midwives and experienced midwives. Sources of complaints between providers and patients appeared to be numerous. However, they are centered on two themes, delivery techniques and cultural requirements, which correspond to two types of constraints: technical constraints and social representations and practices of the population. A description of traditional practices and beliefs related to delivery were obtained.


through discussion groups with old women and traditional birth attendants (TBAs). Both women and midwives are tied up by the same social rules such as linguistic taboos, respect and shame but technical constraints force midwives to violate those rules, making the application of their technical skills very difficult. Thus, the mutual relationship between users and providers is source of dissatisfaction, which often degenerates into an open confrontation. Midwives must learn how to implement obstetrical techniques within specific cultural environments.

Rousham (1994)\textsuperscript{115} conducted a survey on 131 mothers in rural Bangladesh to examine knowledge and perceptions of helminth infection in relation to use of health facilities and treatment-seeking behaviour. Almost all respondents considered worms to be a cause of bad health and a high percentage of mothers had obtained deworming treatment for their children. However, marked differences were found in mothers' descriptions of the causes and prevention of helminth infection in two adjacent areas; the study highlights the influences of social and cultural factors on treatment-seeking behaviour, which in turn affect women's exposure to health education and biomedical knowledge of helminths. Further questions are raised, however, on the ability of women to implement preventive measures and the impact of health education on rates of parasitic infection.

Raija-Leena Punamaki and Hanna Aschan (1994) reported that Health maintenance, self-care practices, coping resources and feelings of helplessness, as indicators of daily mastery, were studied among a group of 142 Finnish primary care patients using a two-week diary method. The main themes related to health maintenance, self-care, and coping resources were found to be: meaningfulness of life, social relations and togetherness, activities, recreation and enjoyment, discipline and good health, and treatment of symptoms and diseases. The most frequent causes of feelings of helplessness were: diseases and symptoms, discrepancies between demands and capabilities, and negative psychological and emotional states.

Karl Atkin and Michael Hirst (1994) reported that general medical practice has changed significantly in the past ten years, reflecting a range of innovations giving greater priority to health prevention and promotion and to primary health care generally. This paper provides unit cost estimates of practice nurses and discusses the implications for their future role and deployment. As well as direct costs, it considers the wider opportunity cost associated with the growth in practice nurse numbers.

Judith McLaughlin and Ib Zeeberg (1993) compared and contrasted self-initiated self-care practices of 51 Danish and 35 American persons with multiple sclerosis at various levels of disability. Respondents were asked about ways they


managed their symptoms and problems during periods of non-medical contact-including methods of following the medical regimen; alternative treatments; use of lay-referral systems; and sources of information regarding physical, psychological, social, and environmental dimensions of coping with the illness. The two groups of respondents varied regarding adaptation strategies and primary sources of information used. The ultimate aim, however, of using these strategies was similar; to gain control over uncertainty, dependency, and physical and emotional decline. This study suggests that the empowering role of self-initiated self-care strategies in chronic illness may transcend differences in health care systems.

Linda Stone (1992)\textsuperscript{119} traced the changes in the way that the role of culture in relation to community health issues and in particular with respect to 'community participation'. A look at recent perspectives shows that the fate of community health programs has come to be seen as relying more on structural factors in health care systems than on cultural factors within local communities. There has also been an increasing emphasis on political factors or power relationships within and between health agencies, governments, and various levels of national health care systems. These perspectives raise new questions for community health programs and the strategy of community participation.

Pisani and Keita (1992)\textsuperscript{120} show that the frequency of morbidity episodes is inversely proportionate to the household's level of hygiene. It also appears that factors such as the household's hygienic, socio-economic and educational levels along with the type of illness and its duration are more decisive when resorting to treatment than is the proximity factor. This seems particularly true in the case of traditional medicine, chosen even where cosmopolitan resources are available and by people with a relatively high socioeconomic, hygienic and educational level. In the specific situation under study, this paper indicates those areas for further study with a view to improving public health education.

Janice M. Morse, David E. Young and Lise Swartz (1991)\textsuperscript{121} compared Cree Indian methods of treating disease are compared with the treatment process and procedures used in the western health care system. Ethnographic data permitted the identification of the five components of Cree healing: the ritual, contract, treatment, didactic, and closure components. These components are compared with equivalent phases in the physician-patient and nurse-patient relationship. In particular, the process of comparison permits the identification of incongruities that the Cree may encounter when using the western system. These include the inability to identify one's own state of health and abnormalities; a passive, rather than a participatory role in healing; the incomprehensible notion of "silent" diseases and preventative treatment;

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the specialization of the caring, curing, and counseling roles of practitioners and the limited perspective of "holism" in health care.

Perminder S. Sachdev (1990)\(^{122}\) estimated that a significant proportion of this excess morbidity and mortality can be attributed to at least four behavioural factors: smoking, obesity, alcohol use and accidents. This paper examines the inter-cultural differences in these factors, both from a contemporary and a historical perspective. Some of the reasons for the continuation of these adverse patterns of behaviour are explored, in particular the role of psycho-cultural stress. Some possible mechanisms of effecting behavioural change in modern Maori society are discussed.

Duncan Pedersen and Veronica Baruffati (1989)\(^{123}\) reported that the emergent 'popular' medical system draws from both the professional and folk models, and in its actual practice, integrates both popular beliefs and materia medica with elements drawn from popular religions and pre-Hispanic deities. The degree of competitiveness, co-operation or 'integration' among medical systems depends mainly on the asymmetrical distribution of power and resources, and is conditioned by the population's behaviour in the management of disease.


Jean Brainard and Amy Zaharlick (1989)\(^{124}\) described traditional and changing health-related beliefs and behaviors of ethnic Lao refugees now resettled in the United States and how these compare with those of other ethnic group of resettled refugees from Southeast Asia. New data are presented for Southeast Asian refugees resettled in Franklin County, Ohio, including resettlement agency utilization statistics for refugees of each local ethnic group, which reveals that Laotian refugees have the most persistent use of resettlement agency services. The results of in-depth, open ended interview with members of the Franklin County Lao community are also presented. These data are compared with the results of the limited relevant health-related research on other ethnic groups of Southeast Asian refugees, revealing that Laotian refugees rely to a relatively great extent on the Western biomedical system.

Mark Nichter (1987)\(^{125}\) states that a wide range of behavior from folk dietetics to bathing and from water boiling to the taking of birth control pills is influenced by hot/cold reasoning. It is emphasized that the hot/cold conceptual framework serves an integrative function in the traditional health care arena and provides a rationale for participatory action in a health culture undergoing rapid medicalization.

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Linda Stone (1986)\textsuperscript{126} finds that in the enthusiasm for the PHC concept in Nepal, important socio-cultural processes have been overlooked. This paper describes the relationship between certain socio-cultural factors and PHC activities in rural Central Nepal. It reveals a contradiction between the stated PHC intentions to address local interests and promote community participation on the one hand, and the actual approach taken on the other hand. Specifically it argues that PHC is encountering problems in Nepal for three reasons: (1) PHC fails to appreciate villagers' values and their own perceived needs. In particular, PHC is organized primarily to provide health education, whereas villagers value modern curative services and feel little need for new health knowledge. (2) PHC views rural Nepali culture only pejoratively as a barrier to health education. Alternatively, local cultural beliefs and practices should be viewed as resources to facilitate dissemination and acceptance of modern health knowledge. (3) In attempting to incorporate Nepal's traditional medical practitioners into the program, PHC has mistakenly assumed that rural clients passively believe in and obey traditional practitioners.

Heggenhougen and Shore (1986)\textsuperscript{127} discussed the association of culturally linked behaviour and epidemiology: that pattern of disease is significantly related to cultural sets of normative beliefs and behaviour. The article is divided into four sub-sections which give an indication of our focus: (1) culture, disease and illness

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causation; (2) utilization and provision of health resources; (3) health, illness and normative socio-political and economic behaviour and (4) primary health care, community participation and culture-implications for the future.

Duncan Pedersen and Veronica Baruffati (1985)\textsuperscript{128} reported the origins and development of traditional medicine cultures in the Latin American and Caribbean regions, beginning with an overview of terminology and definitions related to 'medicine' and 'medical systems'. A short look is taken at original medicine cultures and at how they syncretised with colonial European medicine to give birth to a mosaic of lay and traditional medicine practices still in evidence in the New World today. The authors conclude by stressing the need for closing the gap between the social and medical sciences in order to reach a better understanding of the health needs of the population. Biology and culture are at the centre of the discussion between medicine and anthropology where two trends dominate, viz. the socio-cultural and the biomedical models. The main task for ethno-medical researchers in the Latin American region is to work towards the creation of a bio-socio-cultural model in an attempt to enrich systems qualitatively in the development of more humane and efficient interventions, both in the clinical field as in the field of health policies and strategies. Rance and Lee (1983)\textsuperscript{129} focused on three major aspects of the PHC development in Hong Kong: (1) public health and preventive care; (2) food supply and

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\item Duncan Pedersen and Veronica Baruffati. (1985). “Health and traditional medicine cultures in Latin America and the Caribbean” Social Science and Medicine, vol: 21(1), pp; 5-12.
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nutrition; and (3) first-contact medical care and referral network. It is argued that in a newly developed society, the emphasis on developing both the quality and the quantity of PHC in the scientific biomedical stream is justifiable. However, at least two kinds of problems need to be taken into consideration, i.e. the prevalence of traditional beliefs and practices and the ever-rising demands of the public for health services.

Allan Young (1983)\textsuperscript{130} assessed the relevance, for advancing primary health care goals, of particular classes of traditional healers--e.g. herbalists, midwives, and bonesetters--and technologies within different types of medical systems. Four possibilities are described; integration, complementarity, rivalry and intercalation.

The review of above studies highlight how people’s health choices are influenced by various factors like culture, occupation, income, religion, etc, The studies on attitudes, health practices and health seeking behavior highlight how geographical location, religion, income status and social environment influence people to make choice of their health related behavior. The studies on different health models and health behaviors highlight the various socio -economic and cultural factors in influencing the health behavior of the people. In order to understand how for tradition and culture influence the health choices of the rural people the presents study has been taken up in Kancheepuram District.