**SOC. 314: SOCIOLOGY OF HEALTH AND HUMAN BEHAVIOUR**

This is an introduction to concepts and social aspects of

COURSE CONTENT

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**DISEASES, ILLNESS AND HEALTH**

**Introduction**

Disease is a universal phenomenon and therefore affects all people everywhere, but not always to the same degree or in the same way. The study of how diseases affect human groups and the ways in which groups react to them provides an important substantive area for the application of sociological knowledge and research techniques in certain ways (Coe, 1970):

* Diseases are neither uniform nor random in their occurrence; rather they are usually observed to more or less common among various social groupings. The study of these differential distributions of illness in terms of our knowledge of the social structure and the differing life-styles it imposes on people frequently provides clues about the nature and cause of disease.
* People tend to view the event of disease from the perspectives of their particular culture, and, based in part on these perspectives, they tend to respond to the disease in predictable ways.
* People developed an array of institutions to treat systematically the diseases, which appear in their group.
* The treatment of disease involves more than the mere application of medical knowledge through medical institutions.

Because of these reasons, the study of the distribution of diseases in the society, responses of the society to illness and health, and the institutional arrangements put in place in the treatment of diseases are important and of interest to individual, the community and the society.

**Definition of Disease**

Diseases are specific kinds of biological reactions to some kind of injury or change affecting the internal environment of the body. When a person is sick, he feels that something is wrong with him or her as an individual, and his or her sickness affects everything that he or she does and the ways he or she thinks about himself or herself. Quite often, people around the sick person may not be aware of the sickness because of the nature of certain diseases and the way the individual reacts to them. Disease alters the normal functioning of the body, and creates a lot of anxieties for the sick person. Diagnosis of a disease is often made by correcting the observable signs or symptoms of disease with knowledge about the functioning of the human organism. Diseases constitute a threat to group unity and survival and disrupt the social and economic life of the people, and reduce the ability of group members to carry out their social roles and tasks. Diseases can also alter the ways in which group members perceive and respond to one another, whether as a family or a larger group.

**Definition of Illness**

Illness is a phenomenon in which individuals perceive themselves as not feeling well and therefore may tend to modify their normal behaviour by not attending to their day to day duties or act in ways which are different from those which might normally be expected of them. When a person is ill, his or her primary concern is to get well quickly. Therefore, he or she tries to seek help from someone who can understand and deal with whatever disease is making him or her to feel ill. The basic difference between disease and illness is that while disease is an objective phenomenon characterized by altered functioning of the body as a biological organism, illness is a subjective phenomenon in which individuals perceive themselves as not feeling well. Diseases may be objectively observed or measured with some degree of certainty. Knowledge of illness tells very little about the type of disease that causes illness or about the state of the illness.

**Definition of Health**

According to the World Health Organization (WHO), health is a state of complete physical, mental, social and spiritual well being not merely absence of disease or infirmity.Two concepts are important in the understanding of health. They are individual or family health and public health or community health. An individual is a member of a community. His or her needs including health needs are part and parcel of the needs of the larger community, which he or she belongs. A community is a group of people with a common identity and who are living together within a define territory. Quite often, they share the same goals and aspirations. Such goals most often include good health for all members of the community and the society in general. The community has a direct responsibility for the health of the individual in the community. A sick person is a community’s liability, and it is the responsibility of the community to provide certain minimum of both preventive and curative health services to all members of the community at an affordable price, and to assist members in the Processes of treatment, recovery and rehabilitation.

**SOCIAL EPIDEMIOLOGY AND HEALTH: Determinants of disease, illness and health**

**Introduction**

This chapter discusses the determinants of disease, illness and health in human populations. It focuses on age, sex, the environment and social class as major determinants of disease, illness and health. At the end of the chapter, readers should be able to explain the major determinants of disease, illness and health; discuss the variations from one society to another and apply the knowledge to their immediate environment.

**Age and Sex**

It is a common knowledge that patterns of disease; illness and health vary with age and sex of the population. However, it is absolutely clear how the pattern varies or the extent to which it varies.

Data on disease, illness and health by the characteristics of the population are, very difficult to come by in Nigeria. In developed societies with long history of data collection and utilization, there have been consistent patterns, which can be applied to our situation in Africa, and in indeed Nigeria. The general pattern all over the world is that infants and old people are known to have the highest incidence of illness and hospitalization than the adult population. Therefore, they constitute a very significant proportion of the total health service needs. For example, young people are more prone to infections, parasitic diseases and respiratory conditions than adult members of the society. On the contrary, the rates of chronic conditions, such as heart disease, cancer, diabetes and arthritis, increase with age.

Although, there has been a higher rate of illness from chronic diseases among older persons because chronic diseases are primarily due to the degeneration of body tissue and the inability of organs to function normally, older persons may be more immune to communicable diseases because they have had greater exposure. Among infants whose systems have not built up strong defense mechanisms, a higher rate of diseases and acute illnesses is often experienced. Socio-cultural factors also often have implication for disease and rate of differences in illness and recourse to hospitalization. There are differences in the attitude of family and the public toward the general wellbeing and care of children that toward care of the aged. In certain parts of Africa, mostly now rural areas, children are still subjected to all kinds of discrimination in terms of feeding and nutrition. This has implications for the building of strong defenses to ward off the attack of communicable and parasitic diseases that are prevalent among this group. It has been generally observed that males experienced higher morbidity and of strong defenses to ward off the attack of communicable and parasitic diseases that are prevalent among this group.

It has been generally observed that males experienced higher morbidity and mortality rates, and lower life expectancy at birth than females. The explanation of the sex differential in rate of illnesses and deaths between male and female is partly biological and socio-cultural. In a given year, among any human population, more males than females are born. At any given stage of the life cycle, children, adult and old age, there are always more females than males. There are several explanations for this phenomenon. Females are believed to be physiologically stronger than males. In African culture, females are assumed to be the weaker sex, hence, the culture prescribed certain roles and activities for males which expose them to hazards than the females. For example, in our society, men mortality rates, and lowers life expectancy at birth than females. The explanation of the sex differential in rate of illnesses and deaths between male and female is partly biological and socio-cultural. In a given year, among any human population, more males than females are born. At any given stage of the life cycle, children, adult and old age, there are always more females than males.

There are several explanations for this phenomenon. Females are believed to be physiologically stronger than males. In African culture, females are assumed to be the weaker sex, hence, the culture prescribed certain roles and activities for males which expose them to hazards than the females. For example, in our society, men climb palm trees but women are prevented from doing so not because they are physiologically incapable of doing so but because the society ascribed that role to males. Females by their nature take more precautionary measures to protect their health, while males often take their health for granted. However, women in their reproductive years, 15-49 years old, tend to have a high rate of illness and hospitalization than men of the same age group. Most of the illnesses and hospitalization are as a result of the problems arising from complications of pregnancies and childbirth. In communities where there are civil strives and wars certain age groups may experience some depletion in their numbers. The groups that are mostly affected are males between 15-35 years of age. This age range is likely to take part in physical combat, which may result into loss of lives. In an event of war, they protect other groups against the enemy. Children and women are likely to suffer some kind of deprivation, which may increase the potential to acquire diseases that may increase their level morbidity.

**Environment**

The importance of environmental factors on disease has been a major focus in the study of diseases in human groups. Climate, location, soil, water and other natural features are closely linked to disease and illness causation. Certain environmental conditions enable some disease-causing agent to flourish and others to die. The natural habitats of the anopheles mosquito that causes malaria are the tropical regions of the world. This species of mosquito survive better because of the wet and humid conditions. The type of water people drink, the food they eat and the living conditions tend to influence the type of diseases and illnesses that affect them.

The advent of advanced technology has enabled man to change his environment and protect himself from certain diseases and illnesses. Technological advancement has created a scenario whereby the level of health is related to the stage of technological and economic development of the country. The countries that have progressed technologically and economically tend to have the lowest level of morbidity, while those that are technologically and economically disadvantaged tend to have highest level of morbidity and illnesses.

Rural population suffers more from illnesses and experience higher rate of hospitalization than their counterparts who live in urban areas. Rural populations are often deprived of social amenities that could improve their health status compared to those who live in the urban area. Rural populations are less educated, have low incomes and limited access to health services. Hence, they are more vulnerable to attach of diseases and illnesses.

**Social Class**

Diseases are usually observed to be more or less common among various social groups. Differential social groups in the society do not often suffer from the same kind of disease or illness and recourse to health care services. Studies have shown that the rate of diseases and illnesses varies from the highest to the lowest social class. Communicable, infectious and parasitic diseases associated with poverty are major phenomena among the lower class. On the other hand, degenerative diseases such as cancer and heart diseases are known to be more common among the wealthy and high class. Explanations have been provided for the differences between the low and high class. The differences in the patters of diseases and illnesses can be ascribed to the relatively healthy and extremely poor environment in the wealthy and the poor live respectively. The lower social class lives under conditions of poverty, filth, overcrowding, and poor health conditions. The high social class on the other hand lives in a healthier environment and has access to better health facilities and is willing and able to take the advantage of modern technology to combat diseases and the occurrence of illnesses among their family members.

In populations where there is a major divide by race, differential incidence of diseases and illness tend to occur along racial groups. Blacks and coloured people in the United States of America and South Africa are known to experience lower life expectancy at birth than the white populations. The black and coloured populations suffer more deprivations in terms of access to education, employment and health facilities than the white population. The apparent deprivation of certain groups tends to widen the gap between the races and thus creating the class of the poor and the rich.

**Summary**

The study of the determinants of diseases, illnesses and health are important for the understanding of the pattern and distribution of disease in the society. It is also important for the how diseases can be managed between the various age groups, male and female, and between social groups and within the different environment which they live.

**The Social Construction of Health**

If sociology is the systematic study of human behaviour in society, **medical sociology** is the systematic study of how humans manage issues of health and illness, disease and disorders, and health care for both the sick and the healthy. Medical sociologists study the physical, mental, and social components of health and illness. Major topics for medical sociologists include the doctor-patient relationship, the structure and socioeconomics of health care, and how culture impacts attitudes toward disease and wellness.

The social construction of health is a major research topic within medical sociology. The idea of the social construction of health emphasizes the socio-cultural aspects of the discipline’s approach to physical, objectively definable phenomena. Many medical sociologists contend that illnesses have both a biological and an experiential component, and that these components exist independently of each other. Our culture, not our biology, dictates which illnesses are stigmatized and which are not, which are considered disabilities and which are not.

For instance, social stigmas hinder individuals from fully integrating into society. The **stigmatization of illness** often has the greatest effect on the patient and the kind of care he or she receives. Many contend that our society and even our health care institutions discriminate against certain diseases—like mental disorders, AIDS, venereal diseases, and skin disorders. Facilities for these diseases may be segregated from other health care areas or relegated to a poorer environment. The stigma may keep people from seeking help for their illness, making it worse than it needs to be.

The social construction of the illness experience deals with such issues as the way some patients control the manner in which they reveal their disease and the lifestyle adaptations patients develop to cope with their illnesses. Today, many institutions of wellness acknowledge the degree to which individual perceptions shape the nature of health and illness.

**Theoretical Perspectives on Health and Medicine**

**Functionalism**

According to the functionalist perspective, health is vital to the stability of the society, and therefore sickness is a sanctioned form of deviance. Talcott Parsons (1951) was the first to discuss this in terms of the **sick role**: patterns of expectations that define appropriate behaviour for the sick and for those who take care of them. According to Parsons, the sick person has a specific role with both rights and responsibilities. To start with, in the context of modern norms of individualism and individual responsibility, a person has not chosen to be sick and should not be treated as responsible for his or her condition. The sick person also has the right of being exempted from normal social roles; the person is not required to fulfill the obligation of a well person and can avoid normal responsibilities without disapproval. However, this exemption is temporary and relative to the severity of the illness. The exemption also requires **legitimation** by a physician; that is, a physician must certify that the illness is genuine.

The responsibility of the sick person is twofold: to try to get well and to seek technically competent help from a physician. If the sick person stays ill longer than is appropriate, he or she may be stigmatized. Parsons argues that since the sick are unable to fulfill their normal societal roles, their sickness weakens the society. Therefore, it is sometimes necessary for various forms of social control to bring the behaviour of a sick person back in line with normal expectations. In this model of health, doctors serve as gatekeepers, deciding who is healthy and who is sick.

**Critical Sociology**

Theorists using the critical perspective suggest that many issues with the health care system, as with most other social problems, are rooted in capitalist society. According to critical sociology, capitalism and the pursuit of profit lead to the **commodification** of health: the changing of something not generally thought of as a commodity into something that can be bought and sold in a marketplace. In this view, corporations, private insurance companies, pharmaceutical companies and investors have a disproportionate influence over how the health care system is run and funded, which type of diseases are researched, whether cheaper generic versions of patented drugs can be sold, the nature of the health care delivered, and even how the physiology of the human body is understood. When health is a commodity, the poor are more likely to experience illness caused by poor diet, to live and work in unhealthy environments, and are less likely to challenge the system.

**Symbolic Interactionism**

According to theorists working in this perspective, health and illness are both socially constructed. Interactionists focus on the specific meanings and causes people attribute to illness. The term **medicalization of deviance** refers to the process that changes “bad” behaviour into “sick” behaviour. A related process is **demedicalization**, in which “sick” behaviour is normalized again. Medicalization and demedicalization affect who responds to the patient, how people respond to the patient, and how people view the personal responsibility of the patient.

**CULTURE AND HEALTH**

Culture consists of shared beliefs, ideas, and symbols among a group of people. Culture guides our placement of meaning in the world; it channels our behavior. All realms of human endeavor hang on kin webs of cultural norms and expectations—including medicine.

Consider the following questions: What is the relationship between health beliefs and accepted treatments? How are biological processes influenced by culture? What happens when Western medicine is introduced into a foreign culture? And, how are people chosen and trained in a curing system?

**PATIENT AND HEALTH CARE GIVER RELATIONSHIP**

**Introduction**

This chapter discusses the main features of the patient-health care giver relationship and how it affects the recovery and rehabilitation processes. Emphasis is on the under- standing of the relationship of that of a layman and an expert, where although there is no equal chance of participation but there is room for mutual cooperation. The chapter also discusses the issue of privilege of access and recognized uncertainty; assess the impact on health-seeking behaviour, recovery and rehabilitation.

**Relationship of the Expert and the Layman**

The relationship between the sick person often referred to as the patient and the health care giver known as the doctor or the physician can only be understood in the context within the relationship is set. The patient and the doctor occupy certain social positions and there are roles and responsibilities attached to the positions, which they occupy, and the society has expectations about the positions. Patients and doctors may and often hold different conceptions of illness. One of the fundamental roles of the patient is to get well, as soon possible, while the primary responsibility of the doctor to his patient is to facilitate the recovery and rehabilitation of the patient to the best of his ability. In meeting this obligation, the doctor assumes the role of an expert. This is so because of the specialized training acquired to deal with the morbid condition of the sick. The sick therefore assume the social position of the layman in the relationship. By implication, the layman is dependent upon the expert’s specialized knowledge acquired during training in dealing with his illness.

In the course of treatment, the patient (the layman) is wholly submissive to the activity of the doctor (the expert). This social position is more apparent in the case of complicated treatment that requires surgery; during the process the patient is immobilized and passive in the relationship. Certain forms of restraint are employed to enforce total submission of the layman to the wills of the expert. The patient has his own feelings and aspirations but because of his illness, the need for help and desire to get well, sometimes at all costs, he is ready and willing to cooperate with the expert, who is in advantage position of power. The interaction between the layman and the expert is expected to follow what has been described a model guidance cooperation. Most of the time the doctor initiates more of the interaction than the patient, and the latter is mandated to do what he is instructed to do by the expert.

**Mutual participation**

The second feature of patient-health caregiver relationship is that of mutual participation. By mutual participation, the patient is able or required to take care of himself. This type of relationship is more appropriate in the case of chronic illness or during the process of recovery and rehabilitation. This type of interaction is also manifest when the doctor does not know exactly what is wrong with his patients. In certain cases of chronic illness such as diabetics and HIV/AIDS, the period of treatment is often long and painful; patients are required to do more of the care than the health care-giver. Treatments and care for diabetics and AIDS patients are mostly done outside the hospital environment and the family and the individual assumes greater responsibility of care than the doctor. Chronic illness demands that medicines have to be taken at specific periods of times, which can better be managed by the patient or his family members. Hence, the concept of home-based care has been widely accepted in HIV/AIDS management and care.

**Privileged access**

The third feature of patient-health caregiver relationship is that of privileged access. Because of the desire of the health care-giver to assist his patients for quick recovery, he or she has unlimited access to the patient. The patient’s body is exposed, touched, sometimes mutilated and its biochemical functioning altered. It is not a usual occurrence to see a person naked or to touch and manipulate the body. This is a privilege, which the health care-giver must justify. In health care practice, the health care-giver is granted this privilege because of the roles and responsibility bestowed on him by virtue of his training and occupation. The health care-giver has access to the body of his patient in order to perform his function as someone doing everything possible for the well-being of the patient, whether in terms of prevention, diagnosis or treatment. Outside the patient-health caregiver relationship, most of the health care-givers actions may be regarded as criminal, immoral and scandalous, and may be subject of litigation. It may involve the professional body regulating the medical practice.

The privilege of access may cause conflict, tension and even upset the patient because of his preconception of the body as a sacred entity that must not be touched anyhow by anybody. Quite often patients adjust to the inevitable circumstance because the need for help and the desire to get well quickly. The privilege of access may go beyond touching, manipulation and mutilation to obtaining vital information about the life of the patient, if such information will aid the process of healing. For example, a health care-giver may want to know the family history or a diabetic patient or asthmatic patient to determine whether the diseases are hereditary or as a result or the way of life of the patients. This information is vital for dealing with them. There are examples of health care-givers who have abused the privilege access of their patients. Where this happened and the cases reported to the appropriate authority, they have dealt with within the context of rules and regulation of the medical profession or within the confine of the law. People are conscious of the conflict, tension and upset that the privilege of access may pose to the patients to an extend which certain defensive mechanisms are put in place to minimize abuse. In some societies, male doctors are not allowed to treat female patients at all. In orders, a male doctor can only treat a female patient only in the presence of another female person.

**Handling of recognized uncertainty**

It is not always that a health care-giver will be able to prevent, diagnose and treat all diseases. When a health care-giver investigates an illness to find out the cause but has positive findings the onus is on him to choose between further assessment and evaluation or call off the diagnostic process or seek a second opinion from colleagues. This may be a very difficult choice to make, but it is one of the ethics of the medical profession. The risks associated with further assessment and evaluation may be too high in terms of time and resources. The social, emotional and economic risks to the patient’s health by continuing the diagnostic procedures may be enormous and economically undesirable for the society. On the part of the health care-giver, failure to continue may result in a failure to detect a potentially serious condition, which requires early evaluation, prevention or treatment. It may pose a serious danger to the society, if the illness is contagious or can lead to serious epidemic.

**Summary**The person who is sick and care-giver, whether in traditional and orthodox health care delivery system, perceive illness differently, and the perception has serious implications for their relationships. The patient sees the health-caregiver as a person he or she can entrust himself or herself for his or her care, undergo the procedures the health care-giver felt were necessary for treatment, recovery and rehabilitation. In attempt to achieve the desired goals the patient therefore surrenders himself totally to the orders of the health care-giver. He or she makes himself available for all kinds of experiment, takes the medication that has been prescribed for him or her and follow the health care-givers’ orders and takes the role of a passive observer in the relationship.

**RESPONSE TO DISEASES AND ILLNESSES**

**Perceptions of Disease and Illness**

The definition of concepts of disease and illness has been done in the earlier part of this book. This chapter discusses perception of disease and illness, the sick role, variations in response to disease and illnesses and stages of illness behaviour. When an individual is afflicted with a disease and eventually becomes ill, he or she feels that something is wrong with him or her. His or her condition tends to affect everything he or she does and the way he or she perceive himself or herself. The illness also affects members of the family, the community and the society when they are aware of this condition. In much of Africa, when a person has a disease and becomes ill, there are several options open to him or her to seek medical help. The options depend on the nature, severity and the perception of the illness by the affected individual, the family, the community and the society in general. Several of the options are often adopted either concurrently or sequentially in the course of illness episode. A wide range of social, cultural, economic and behavioural factors also influences the choice of a particular treatment system.

In traditional societies, response to care is usually twofold. When a member of the household is ill, health care is usually first sought within the household from older members of the family who are perceived to have through experience the knowledge of the correct treatment for such illness. At this stage, treatment is usually herbal therapies. If this fails, help is then sought from traditional specialists whose diagnosis is by divination and treatment offered on the basis of the diviner’s perception of the illness. In modern times, and with advent of modern scientific medicine, when a person is sick he or she is far more likely to consult a western trained health care provider. In the process of consultation, diagnosis of a disease is made by correlating the observable signs or symptoms of a disease with knowledge about the functioning of the human organs.

There are differences between the person who is ill and seeking care and the person offering care in the perception of disease and illness and their approaches to health care. The person, who is ill, often referred to as the layman and the person giving care, the specialist, have widely divergent understandings about the events of illness. The layman may assume certain level of scientific knowledge of the nature of the disease causing his or her illness, that knowledge may be scientifically inadequate from the point of management and cure of the disease. The person who has a disease and who is ill understands his or her situation differently the person who has a disease and who is ill understands his or her situation differently from the perspective of the specialist. He or she is emotionally involved in a way other people around him or her can never be. While the specialist exercises objectivity in his assessment of the condition of the patient, the latter is subjective. This is understandable because he or she is the one who feels the pain and whose life is being threatened by disease and illness. The specialist perceives a case of disease in terms of knowledge he already acquired to deal with it. Quite often, the specialists may learn from their patients and further broadened their knowledge of a particular disease. The specialist’s basis for deciding what action to take in respect of a disease is often different from that of the patient. The specialist is more knowledgeable about the disease progression and the conditions of the patients than the patient. He has professional standards against which to evaluate his ability and effectiveness in diagnosis and treatment

**The Sick-Role**

When a person ill, there are certain roles or obligations which the social system which he or she belongs imposed on him or her. These roles and obligations are discussed in this section.

According to Talcott Parsons, there are four main aspects of the sick role.

* The sick person is exempted from certain normal social responsibilities.
* He or she cannot be expected to take care of himself or herself or get rid of his or her illness by willpower.
* A sick person should want to get well.
* A sick person should seek medical advice and co-operate with medical experts.

**Exemption from normal social responsibilities:** It is generally assumed that the sick person is not at fault for his or her condition, therefore one of the rights accorded him or her is to be excused from normal duties. The patient is not expected to carry on as normal but to adapt his usual way of life by shedding some or all his normal duties. Such duties may be occupational, domestic or recreational. Alternative arrangements are made for carrying out necessary tasks in the event of an illness of a group member. This new role arrangement is important for continuity. For example, if the person who carries out the household chores is ill somebody must be around to perform that function during the period. Similarly, if the doctor who looks after some patients or the driver of the school bus took ill, someone must be available to carry out such duties for the continuity of the system. However, exemption from normal duties is not solely a right to be had on demand, especially in occupational duties. A bus driver who is not able to perform his normal duties on account of illness may be required to produce a sick note from a doctor to legitimize the right to stay away from duty.

**Getting rid of illness by willpower:** A patient cannot be blamed for his or her condition or get rid of the illness by willpower. He or she must be taken care of, and the condition must be changed. One of the ways to change the condition is to provide the opportunity to receive medical care from the specialist. This is a social responsibility of the group to the sick.

**The desire to get well:** Being well means, illness is undesirable, and, therefore, a sick person would want go get well as quickly as possible. It is the social responsibility of the sick person to seek help from expert and cooperate in the process of getting well.

Although it is always the desire of the sick person to get well as quickly as possible, and to resume normal responsibility, certain types of disease are not amenable to this condition. In the case of long-term, chronic or permanent illness conditions, the desire of the people in such conditions to get well as quickly as possible are often far-fetched.

**Seeking help:** It is a social responsibility on the part of the sick person and the group he or she belongs to seek help from the expert. It is also obligatory for the sick person and the group to cooperate with the expert as far as possible to facilitate the consultation, treatment, recovery and recuperation processes.

**Variations in Response to Disease and Illness**

Illness behaviour is the way an illness is perceived, evaluated and acted upon by those who have the feelings of pain and discomfort. By implication there are variations in the way individuals and groups respond to disease and illness.

People are more likely to take action to control and prevent illness or seek help if they are ill under the following conditions:

* If they believe it to have potentially serious consequences.
* If the course of action available to them would be beneficial in reducing either their susceptibility to or the severity of the condition.
* If the anticipated barriers to (or costs of) taking action outweigh its benefits (Glanz, 1997 and Van Landringham et. al., 1995).

According to Mechanic and Volkart (1961), two persons having much the same symptoms, clinically considered, may behave quite differently; one may become concerned and immediately seek medical aid while the other may ignore the symptoms and not consider seeking treatment at all. Factors that may influence illness behaviour include effects of group structure, general cultural prescriptions, the concern for financial cost of care and fear of the possible outcome of the disease.

A sick person’s peers, family, community and associates may exert pressure on him or her to seek immediate treatment. Quite often, these groups may individually or collectively arrange and even meet part or whole cost of treatment for the sick person.

Cultural beliefs about causes of diseases and illness may motivate the sick person to seek treatment or not. In Nigeria, studies of illness and health seeking behaviour have clearly indicated that health attitudes, treatment systems, the degree of access to health facilities and the cultural, social and cultural factors are the determinants of individual and community response to illness and treatment behaviour (Orubuloye, 1999).

The degree of fear or anxiety of the possible outcome of an illness may determine treatment behaviour. If a sick person perceived the outcome of a disease may lead to a major disability or prolonged suffering he or she may seek immediate treatment. On the contrary, he or she may do nothing if the perception is that the illness will eventually lead to death. The latter attitude is often manifest in respect of chronic diseases and may well be extended to HIV/AIDS because of the general lack of known cure.

**Stages of Illness Behaviour**

Each episode of illness involves a series of stages or phases. Such man identified five stages of illness behaviour. They are symptom experience stage, assumption or the sick role stage, medical care contact stage, dependent-patient role stage and recovery and rehabilitation stage. The various stages are discussed below in details.

**Symptom experience stage:** This stage begins when an individual feels that something is wrong with him or her. This perception may include awareness of physical and emotional change, such as pain and restlessness. At this stage, the affected person may decide to keep the problem to himself or herself. During this stage, the person may attempt self-treatment by a variety of means to achieve relief from the symptoms. The person then awaits further development of the symptoms before taking the next step. If the symptoms persist, he or she then assumes the sick role.

Assumption of the sick role: At this stage, the affected person may have the courage to discuss his or her symptoms with people regarded as trustworthy such as friends, spouse and family members. Help from experts may be sought at this stage or self-medication may continue. Such self-medication may include use herbal preparations, purchase of drugs from hawkers of medicine and patient medicine stores. Studies have shown that a large number of people, particularly in rural areas of Africa rely heavily on these sources of health care. A period of self-medication often leads to a significant delay in seeking expert advice. During this stage, the illness may deteriorate and may result to death. However, those who survive this stage proceed to the third stage of medical contact stage.

**Medical contact stage:**

At this stage, the sick person makes his or her first contact with someone who has professional training in medicine. The sick person may decide to seek help from a low order medical person such as the chemists or the pharmacists or a nurse in the neighborhood. At this stage, prescriptions are made based on symptoms given by the sick person without diagnosis or laboratory tests. Quite often, the sick person may have temporary relief from the symptoms. If the symptoms persist, he or she moves to a higher order of health care where the experts would make a scientific assessment of the case. The sick person hereby assumes the sick role and move to the next stage of dependent-patient role.

**Dependent-patient role:** At this stage, the person becomes a patient. The patient then assumes the role of a sick person and people around him recognize his or her social role as a patient. The patient is expected to subject himself or herself to the doctor and obey all the instructions to facilitate the road to recovery and rehabilitation.

**Recovery and rehabilitation**: This is the final stage of illness experience. In certain cases, recovery process may be rapid or prolonged depending on the severity of the illness, the competence and cooperation of the sick person. Nevertheless, the process of recovery and rehabilitation is without problems. The patient might be denied certain rights and privileges, which the expert considers to be vital for the recovery process. For example, a diabetic patient may have to forgo his or her traditional pattern of eating for a completely new eating regime, which the experts consider necessary for the recovery process. In addition, medication has to be undertaken at times not convenient for the patient. Once the recovery and rehabilitation process is completed successfully, the patient joints the ranks of the well and can now assume his or roles and responsibilities in the family, the community and the larger society. In certain cases of chronic illness, recovery may not take place, and death may become the ultimate. The family, the community and the society share the grief of their loved ones, and a new process of group adjustment begins. Differences in illness behaviour are important for the understanding of how the individual, the community and the society respond to disease and illness. The part play by the sick person in the various stages of illness experience is important for the recovery and rehabilitation process and the assumption of his or roles in the family, the community and the larger society.