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Contents

SECTION ONE	3
Introduction to Medical Sociology: Definition & Development of Medical Sociology	3
SECTION TWO	9
Theoretical Perspectives in Medical Sociology: Structural Functionalism, Conflict Theory, Symbolic Interactionist & Post- Modernist	9
2.2. Conflict theory (Marxist Perspective) view of health and health care: A General Overview	17
SECTION THREE	21
Prominent Figures and Medical Sociology: Max Weber, Talcott Parson, Erving Goffman and Michel Foucault	21
SECTION FOUR	25
Key Concepts in Medical Sociology: Health, Sickness, Disease and Illness, and Medicalization	25
SECTION FIVE	31
The Social Context/Determinants of Health: Age and Health, Health, Gender and Feminism and, Race, Ethnicity and Health.....	31
SECTION SIX.....	35
Health Behavior, Illness Behavior and Sick Role: Health Lifestyles, Preventive Care, Self- Care, Socio-Demographic Variables and Recognizing and Coping with Illness Symptoms.....	35
SECTION SEVEN.....	41
Urbanization and Health	41

SECTION ONE

Introduction to Medical Sociology: Definition & Development of Medical Sociology

1.1. Introduction

Many people (including students of sociology) often wonder (surprise) about the relevance of sociology to health issues. It is often a challenge to discuss the nexus between social science and health. Why medical sociology? What does sociology have to do with medicine or health? These are some of the pressing questions that require explanations. The fundamental problem starts with a lack of deeper knowledge of the meaning and focus of sociology. Therefore, it is necessary to proceed by defining sociology and briefly explaining some of its foundational focus. After this, its relevance to health will be explained. Sociology has been variously defined since Auguste Comte coined the term in 1838. Simply, sociology is the study of *human society and social problems*. Sociology is the scientific study of social *relations, institutions, and society* (Smelser 1994). In addition, sociology can be defined as the scientific study of the dynamics of society and their intricate connection to patterns of behavior. It focuses on social structure and how the structures interact to modify human behavior, actions, opportunities, and how the patterns of social existence engender (cause) social problems. Social institutions such as, kinship, economic, political, education, and religious institutions are like pillars that hold up society because they are the constituent parts of the social system (society). These parts are interdependent and interrelated with specialized functions towards the survival of the society. This is why the human society is often referred to as a social system. **Every institution** fulfils some functional imperatives. The family institution supports the procreation and socialization of new members of society while the economic institution deals with the production and exchange of goods. The economic institution employs people from the family institutions, and the family in turn needs the goods and services produced by the economic institution. The health institutions are organised to cater to the well-being and survival of human beings. Generally, sociology employs scientific approach to study and develops generalizations about human patterns, groupings, and behavior.

Social life is the most central part of the focus of sociology; it implies the connection which an individual holds with others in the society. To sociologists, social life or interaction is the essence of human existence. The process of social interaction itself may put individuals at risk of

some communicable disease such as tuberculosis (TB), severe acute respiratory syndrome (SARS), and measles. In terms of communicable diseases, mere contact with an infected person (in the process of social interaction) can normally put others at risk. The investigation of social “causes” and “consequences” is basic in sociological research. There is often a problem of biomedical reductionism, assuming “*only the germ causes the disease*” without an interrogation of the social conditions enabling vulnerability to diseases. For instance, commercial sex work puts an individual more at risk of human immunodeficiency virus (HIV) than many other occupation groups: that is a kind of *occupational condition*, which is a risk factor for HIV.

1.2. Definition of Medical Sociology

Medical sociology is simply the application of sociological perspectives and methods in the study of health issues in human societies with a skewed focus on the sociocultural milieu that accounts for human health and illness. These perspectives include sociological **theories and tools**, which can be applied in the analysis of human health. In this case, the individual is examined as a member of the society, who partakes in the day-to-day functioning of the social system. The pre-comprehension is that humans exist within a socio-spatial milieu, which often affects their health. Such social conditions and the nature of human interaction are instrumental to the well-being of every individual in society. It is also assumed that the nature of social interaction and networking is a part of the determinants of human health. Sociologists are interested in issues regarding human health and employ systematic procedures to examine social phenomena. In any case, medical sociology is the application of sociological theories, knowledge, and concepts to issues of health and illness (Hafferty and Castellani 2006).

Medical sociology can also be defined as the scientific *study of the social patterning of health*. In this case, it is a study of how social factors (e.g., class, race, gender, religion, ethnicity, kinship network, marriage, educational status, age, place, and cultural practices) influence human health. The idea of social patterning indicates that these social factors could be the determinants of human health status. It is in this sense that some diseases may be referred to as diseases of poverty (e.g., malaria and TB) because they are much more prevalent in poor regions or among the poor. For example, a person residing in a slum is at a higher risk of being exposed to certain diseases which a person in affluent area may have lower risk of being exposed to. Medical sociology is distinct in its approach because it considers the “import that social and structural

factors have on the disease and illness processes as well as on the organisation and delivery of health care” (Hafferty and Castellani 2006, p. 334). Hafferty and Castellani further observed that these factors also include culture (e.g., values, beliefs, normative expectations), organisational processes (e.g., hospital setting), politics (e.g., health care policy, health budget, political ideology), economic system (e.g., capitalism, the costs of health care), and micro level processes such as socialisation and identity formation.

1.3. Development of Medical Sociology- A Brief History of Medical Sociology

Medical sociology has become a substantive subfield of sociology. It can be argued that medical sociology began with the conception of sociology by August Comte (1896) through his concept of organismic analogy. This can be a **deductive argument** since Comte did not intend to establish medical sociology as a subfield and did not attach the importance of sociocultural issues in health. Comte, and later Herbert Spencer (1891, 1896), extensively compared human society to a biological being. Spencer observed that the universe consists of *organic (living), inorganic (non-living) and super-organic (society) entities*. The idea of organismic analogy is that the human society has similar characteristics as that of the *biological organism*. The similarities include *growth and development*, differentiation of parts, specialization of functions, interrelatedness, and interdependence of parts. The parts of the society include the social institutions, which work harmoniously for the survival of the society. The argument further relates that if one part is damaged, it will adversely affect other parts of the society. Health institution may be affected if the political institution is corrupt or not responsive to aspirations of the citizens. This is part of the reasons why strong political will is required in implementation of health programs.

The theory of Marx and Engels explains that **economic infrastructure** is the foundation on which other superstructures of the society rely. Inequalities in income translate to other forms of inequalities in human society, including health inequalities. This is why Marx’s proposition has been widely applied in all facets of life including health inequalities, accessibility to health care and allocation and distribution of health resources and infrastructures. Another major landmark is the work of Emile Durkheim (1897/1951) on suicide. This is directly related to medical sociology since it is about the issue of death. **Durkheimian perspective on suicide will be explained in detail later (Later see Sect. 2.1.2 for further elaboration)**. The perspective

examines the influence of **social factors in self-termination of life (suicide)**. Durkheim identifies two major factors, which fluctuate to increase or decrease propensity to suicide. These factors are **social regulation** and **integration**. This has been a major sociological perspective in the analysis of suicide because it was a theory derived from empirical investigations. The works of Max Weber on **bureaucratic rationality and social action** have also been substantially applied in medical sociology to explain organization of health care institutions and **why and how people care for others**.

At the time these classical sociological scholars (August Comte, Emile Durkheim, Max Weber, and Karl Marx) were writing, they did not have medical sociology in mind; however, *their works provided the land mark for the development of a subfield of sociology called medical sociology*. The works created the foundation for the emergence of sociological perspectives and methods that can be applied in the study of social patterning of health.

In 1848 Rudolf Virchow (a German physician) laid the foundation of social medicine (Holtz et al. 2006) by advocating for the relevance and consideration of social factors in human health and disease. While this set a new agenda for medicine, it opened a wide passage for the social sciences involvement in the understanding of human health. The early 1900s marked the beginning in the study of sociological dimension of medicine, especially with the works of Charles McIntire (“The Importance of the Study of Medical Sociology,” published in 1894), along with other scholarly works of that period including the book by Elizabeth Blackwell (1902) and another by James P. Warbasse (1909), both on medical sociology (Bloom 2002; Hafferty and Castellani 2006, p. 332).

In the 1950s, Talcott Parsons (1951) published a groundbreaking work with a section on the application of functionalism in medical sociology. He dedicated a substantial part of his work to the elaboration of the sick role, explaining the social trajectories of the sick within the social system and how the health institutions can support individuals to return to normal roles in the **society. Parsons recognised the relevance of medicine for the society** and drew attention to illness as a form of social deviance and the importance of sick role as a mechanism of social control (Freidson 1962; Stacey and Homans 1978). This is the first conscious application of sociological theory in the understanding of human illness. The sick role concept facilitated the expansion of other areas of research including the patient-physician relationship, illness

behavior, medicalisation of deviance, and medical professionalism (Hafferty and Castellani 2006). The works of Freidson (1961a/1962, 1961b) and Mechanic (1966, 1968) also promoted the relevance and understanding of medical sociology.

Conrad (2007) described Eliot Freidson's works as revolutionary in medical sociology. Freidson(1961,1970a,1975)devoted his time to the study of professionalism and professionalisation in medicine which presents a comprehensive view of the social and professional dynamics of medicine with a particular reference to how disease and illness are constructed, power relations between the physician and patients, division of labour, ethical conducts, increasing commercialism, and bureaucratic control in medical practice. Freidson's works were landmarks in the development of medical sociology. He practically demonstrated the relevance of sociology in medicine and health studies in general by situating his studies within applied domains.

During the same period, Glaser and Strauss (1965, 1968) also examined the social process of death and dying, and Erving Goffman (1961, 1963) released a master piece, Asylums, which introduced the concept of stigma and total institution. The Asylums focused mainly on the study of mental health patients and health care institutions. It was a remarkable breakthrough in the application of medical sociology to the study of health care institutions. The work of Goffman has been one of the most successful sociological pieces in the management of patients and health care institutions. The concern of this subsection is to trace the development of medical sociology.

The development of academic journals (e.g., Journal of Health and Social Behavior; Social Science and Medicine; Sociology of Health and Illness in 1979) in the discipline, especially in the 1960s, also aided the development of the discipline (Hafferty and Castellani 2006); and now there are many other dedicated and related journals including Health and Place, Health Affairs, Women and Health, Reproductive Health Matters, Social Theory and Health, Medical Anthropology, The Lancet, Social History of Medicine, and many others.

From the 1960s onwards, there has been increasing popularisation of medical sociology with many departments of sociology now having specialization in medical sociology as an option, especially for graduate programs. Cockerham has observed that medical sociology comprises one of the largest and most active sociological specialties in the developed world and the sub-

discipline is expanding in Asia, Africa, Latin America, and other regions. Specifically, Africa has not been left out in this development as medical sociology is now recognised as a subfield of sociology. Medical sociology is growing in strength and importance in South Africa (Gilbert 2012) like in other African countries. There is a growing realization that social issues are relevant and significant in explaining population health in Africa and elsewhere. The study of sexual behavior and other social aspects of HIV/AIDS seemingly demonstrate the sociological milieu in the understanding of health.

SECTION TWO

Theoretical Perspectives in Medical Sociology: Structural Functionalism, Conflict Theory, Symbolic Interactionist & Post-Modernist

The definition of medical sociology depicts the application of sociological theories in the understanding of human health and illness. Sociological theory is defined as a set of interrelated ideas that allow for the systemisation of knowledge of the social world (Ritzer 2010). Sociological perspectives or theories involve frameworks and insights derived from empirical observations and systematic reasoning about the social world. The theories focus on structural relationships and factors and consider individuals to be embodied (social) agents patterned to create and recreate the social world. Such perspectives are then used to understand, explain or interpret, control, and predict social phenomena and human society in general.

Apart from theoretical explanations, sociologists also rely on **observational explanations of events**. In sum, sociologists produce a body of knowledge based on theoretical and empirical facts. The multiple paradigms in sociology add great scientific value to the discipline. One perspective may demonstrate intellectual superiority on one issue more than the other. Continuous empirical findings provide opportunities for modification of existing paradigms. This means that the perspectives are not static.

In sociology, there are **three** major perspectives or paradigms, which include **functionalist, conflict, and interpretive perspectives**. Each of the perspectives includes a number of substantive or middle-range theories. These also represent categories of theories usually invoked in sociology to explain social issues. It is important to note that theory and research are very key in sociological imagination or enterprising. Theories are usually tested and validated or debunked as adequate coherent ideas to explain social phenomena. Theories often show patterns and motivations of behavior using various concepts. This helps sociologists in conceptual analysis and interpreting data based on the theoretical orientation. While there are a number of theories, there is no strict attachment to any particular theory or theoretical orientation. The selection of a perspective depends on the problem and the context from which the problem will be studied. In fact, the goal of research might be to test a particular theory—to know whether the theory is relevant in explaining a problem among certain groups.

While it has been argued that most sociological studies require a theory, it is important to note that a whole paradigm cannot form a theoretical framework of a particular research topic. A paradigm consists of a number of theories with each providing divergent explanations. Sociologists often apply middle-range theories or substantive theories in empirical investigations. These are particular models or explanations carved out of a broader perspective; some are specifically formulated to be applied in a sub discipline such as medical sociology. For instance, Parsonian sick role is a good example of a substantive model or theory in medical sociology. The theory is derived from the functionalist perspective and from the numerous works of the American sociologist, Talcott Parsons.

2.1. Structural Functionalist Theories in Medical Sociology

Functionalism (also known as the consensus paradigm) is a body of theories in social sciences in general. It is particularly the oldest theoretical tradition in sociology. It is dated to the works of August Comte (1798–1857), who coined sociology in 1838; *Positive Philosophy* (Comte 1896); *Rules of Sociological Methods* (Durkheim 1897); *Principles of Sociology* (Spencer 1896); and many other scholarly works. Functionalism is an approach that uses organismic analogy to explain human societies and social phenomena. The central concern of functionalism is how to maintain social order, equilibrium, or stability in human society. Social order means a state of normality in human society, especially when social institutions are functional and maintained for the continuous benefits and existence of the society (Amzat and Omololu 2012). It is important to understand the philosophical, epistemological, and intellectual foundations of functionalism. Functionalism grew with the rise of empiricism, rationalism, and, in general, the scientific revolution. First, functionalism is a realist tradition. The realists (also called essentialists or objectivists) believe in the reality of social existence and phenomena. To them, whatever exists is real and can be studied objectively and empirically. Health problems are a part of the realities of social existence.

Comte (1896), Spencer (1896), and Durkheim (1897) recommended that the application of scientific methodology should be the *modus operandi* of sociology. The discipline must be based on systematic empirical understanding of social events and to produce a body of knowledge based on precise and verifiable evidence. This is why the primary task of sociology is to produce universal laws to explain human action and behavior. Comte (1896) in *Positive Philosophy*

advocated that sociology should employ experimental, observational, and comparative methods in the understanding of its subject matter. This positivist agenda illustrates the reliance of sociology on coherent and structured theoretical and empirical stance. The structured procedural approach further promotes the close association between medical sociology and medicine. Having highlighted some basic foundations of functionalism, the next subsection will discuss some functionalist substantive theories in medical sociology.

- ❖ It is important to start with the first acknowledged explicit sociological work in medical sociology which is the “sick role” developed by Talcott Parsons in 1951.

2.1.1. Parsons’s Sick Role

Talcott Parsons (1902–1979) was an American sociologist and a structural functionalist. He analysed the works of Comte, Spencer, Durkheim, and Weber (among others), and he was particularly influenced by the ideas of these founding fathers of sociology. In his major work, *The Social System* published in 1951, Parsons introduced the concept of the sick role. The model of the sick role was the first theoretical concept that explicitly concerned medical sociology and enhanced the place of medical sociology in the mainstream of sociology. The model was primarily designed to explain illness behavior. Like other functionalists, Parsons was interested in **value consensus** and **social order**. His key focus is **how social interaction/action produce social order**. Parsons sought to analyse individual behavior in the context of large scale social systems (Bradby2012).The individuals are primary units that contribute to the society in terms of the roles performed. Unfortunately, a high prevalence of illness is dysfunctional for society (Parsons 1951), preventing people from fulfilling their social roles. This influences the wider functioning of the society

Bradby (2012) observed that the onset of illness was of interest to Parsons because it prevented the fulfilment of social roles, such as paid employment and parental duties. Illness is “*one of the most important withdrawal behaviors in our society*” (Parsons 1951, p. 31). Parsons argued that the ill take on a sick role, which (like all roles) provides them with a set of responsibilities and privileges (Emke 2002). Role constitutes socially recognised patterns of expectations of behavior on the part of persons in certain positions. Like there are a number of roles attached to the position of a father, the sick role depicts the social position of the sick in the society and the

expectations attached. There are expectations and obligations for them as well as for normal individuals in the society. This is why the concept is called the sick role or, put the other way around, the roles of the sick

2.1.2. Emile Durkheim: Understanding Mortality through Suicide

It is not common to read the elaboration of Emile Durkheim's theoretical dispositions on suicide in many texts in medical sociology. This is why Parsons' sick role is often the starting point and is commonly regarded as the first explicit contribution of one of the key sociological theorists in medical sociology. In fact, Durkheim did not actually aim to contribute to the field of medical sociology but to exercise the empirical relevance of sociology in studying various social phenomena—to develop a general theory of suicide and explicitly explain the “sociology” in suicidal currents. Other sub disciplines in sociology such as social deviance and criminology have extensively focused on the issue of suicide; perhaps suicide is a form of social deviance, and in many countries it is a crime. But more obviously, and as described by Durkheim, it is about morbidity and mortality—hence the significance of this contribution to the field of medical sociology. Durkheim presents a grand attempt to understand mortality through suicide. Like his other counterparts (Comte, Weber, Marx, and Spencer), he was interested in how to maintain social order in human society. An orderly society, at least to a large extent, is devoid of social and structural problems (including health problems) that can deny people access to good life. Emile Durkheim (1858–1917), a French sociologist, conceived sociology as the scientific study of social facts. In *The Rules of Sociological Method* (first published in 1895 and later in 1982), Durkheim argued that sociology should concentrate on understanding social facts. He viewed social facts as forces and structures that are external to, and coercive of, the individual. Social facts are determinants of human behavior and actions. As he noted, social facts exist *sui generis*— independent of human mind, as they are not abstractions but objective realities and, as he claimed, must be studied as things. Studying social facts is close to studying the social determinants of health, and such determinants are social facts that if understood could help in disease control and prevention. Ritzer (2011, p. 19) observed that Durkheim reasoned that if he could link an individual behavior such as suicide to social causes (social facts), he would be able to demonstrate the positivist stance in sociology. Ritzer further noted that Durkheim did not examine why individual A or B committed suicide; rather, he was interested in the causes of

differences in suicide rates among groups, regions, and countries. Suicide, first published in 1897 and later in 1951, presents an empirical application of sociological (scientific) methods in the study of a particular form of behavior called **suicide**.

Table 1.1. The four types of suicide

	Social Fact	Level	Kind of Suicide
1	Integration	Low	Egoistic suicide
		High	Altruistic suicide
2	Regulation	Low	Anomic suicide
		High	Fatalistic suicide

Suicide is the first major application of statistical methods in sociological investigation. It primarily involves an extensive explanation of social problems, focusing on social causes (independent and dependent variables). As noted in the editor’s preface, “Durkheim has treated or touched on normal and abnormal psychology, social psychology, anthropology (especially the concept of race), meteorological and other ‘cosmic’ factors, religion, marriage, the family, divorce, primitive rites and customs, social and economic crises, crime (especially homicide) and law and jurisprudence, history, education, and occupational groups” (Durkheim 1897, p. 13). These variables were correlated with suicide rate. This could be translated to studying the role of social factors in human morbidity and mortality, of course in this case, mortality through suicide. Without much argument, suicide is death, and death is a health phenomenon. Durkheim (1897, p. 44) defined suicide as “all cases of death resulting directly or indirectly from a positive or negative act of the victim himself [or herself], which he [or she] knows will produce this result [i.e., death].” Suicide exists when the victim, at the moment he/she commits the fatal act, is conscious of both the act and the outcome with certainty. After settling on a conceptual definition of suicide, Durkheim formulated a number of hypothetical ideas in order to establish the causes of suicide within the social system. He observed that the critical factors in differences in suicide rates were to be found in differences at the level of social facts (Ritzer2011). Various societies have different levels of social fusion, which affects an individual’s decision to commit suicide.

Durkheim (1897, p. 43) argued that “the causes of death are outside rather than within us, and are effective only if humans venture into their sphere of activity.” Durkheim then identified two major factors (social facts) which account for four different kinds of suicide (see Table 1.1 above). The factors include **integration** and **regulation**, and their fluctuations lead to the types of suicide that will be discussed.

1. Egoistic suicide: occurs when an individual has little or no connectedness (cohesion) with others in the social system—the social string is weak or nonexistent. Such individuals are detached from others, sometimes as a result of rejection, inability to fit into any functional role, or, more importantly, the inability to adapt with others and the environment. *Egoistic suicide is a manifestation of social alienation and a type of suicide springing from excessive individualism.* This is why Durkheim observed that individual (selfish) thought and fewer shared practices may predispose individuals to egoistic suicide (i.e., weakening of common faith positively affects suicide rate). Hence the conclusion is that suicide varies inversely with the degree of integration of the social groups of which the individual forms a part (Durkheim 1897/1951).

2. Altruistic suicide: on the other hand, **a high level of integration (too strong a social string)** will lead to altruistic suicide. Little wonder why this could also lead to suicide when it is previously argued that a low level of social integration leads to egoistic suicide. The response is simple: too little food is as dangerous as excessive food to human health. In life, no good is measureless: too little and too much are typical extremes that project negative effects. Hence Durkheim submitted that excessive individuation leads to suicide, and insufficient individuation has the same effects. Altruistic suicide could be optional or obligatory as a sign of group loyalty or when a social prestige is attached to suicide, a form of heroism or ultimate sacrifice in a struggle. This is done as a sign of a strong bond an individual has with a group. This form of suicide is mostly perpetuated by fanatics who seek to be martyrs (like terrorists), and among military with regimented life, mostly to save face from a failure or greater disgrace.

3. Anomic suicide: The pattern of **social regulation or control** also affects suicide rates. When the regulative role of the society is too feeble, a state of normlessness or anomy prevails. This accounts for anomic suicide. Weak regulations can reflect when the economic and political environment cannot ascertain the needs of the citizens or the traditional norms and values are dwindling.

4. Fatalistic suicide: this form of suicide results from excessive regulations. Those who encounter oppressive regulation or discipline, such as the slaves, are more prone to fatalistic suicide. While slavery should be over, unfortunately, there is increasing sex slavery, human trafficking, forced labour, and other forms of exercise of coercion on others which puts them in slavery conditions. Therefore “fatalistic suicide” is still a relevant concept.

The major inference is that there are **social determinants of mortality through suicide in human society**. This inference was derived through a large amount of data from various countries and groups. Durkheim incriminated a number of variables or factors, particularly *declining birth rates*, increasing *social discrimination*, and *exacerbated gender role tensions* (Kushner 2005), which he believed had negative consequences for population health (as evidenced through suicidal behavior). This is because, among groups, Durkheim found a number of what were often considered demographic variables affecting suicide rate. These variables include *marital status*, *socioeconomic status*, *occupation and occupational status*, and *religious affiliation*. Durkheim found that:

1. Suicide was higher among Protestants than Catholics and lowest among Jews.
2. Suicide was higher among single people (including widows and widowers) than married people and lowest among married people with children.
3. Childless widows are more prone to suicide than their counterparts with children.
4. Divorced men have a higher suicide rate than the un-divorced. Family life is inversely related to suicide.
5. Suicide is higher among whites than blacks, higher among men than among women, higher in urban areas than in rural areas, and suicide rate increases with age.
6. Suicide rates were relatively high among the highest income groups than lower income groups.
7. Suicide was higher among soldiers than civilians.
8. The suicide rate was higher in times of economic depression and economic booms than during more stable periods.

2.1.3. Social Capital Theory of Health

The idea of “social capital” is one of the major sociological contributions to health social sciences and health studies in general. Social capital is a major factor in social patterning of health. In sociology, the intellectual origin of the concept of social capital can be traced to the works of a number of classical scholars including Emile Durkheim, George Simmel, Karl Marx, Max Weber, and Talcott Parsons (Portes 1998; Song et al. 2010; Song 2013). The concern for social order and cohesion were predominant in the works of these early sociologists. Durkheim (1897/1951) discussed suicide in relation to social cohesion/integration noting that suicide rates vary according to the level of social bond in human society. **Simmel** is the proponent of **sociation**—by which he claimed that human society is an intricate web of multiple relations of individuals in constant interaction with one another (Coser2004).Simmel observed that the formation of groups: dyad, triad, small or large, is imperative in the society with resultant consequences. Karl Marx argued that men must enter in to social relationships in the social production of their existence—by implications, mutual dependence is a vital component of human existence. Parsons (1951) explained that the sick must seek assistance in order to get well. This creates a state of dependence on **social capital** or significant others and health care institutions.

2.1.3.1. Defining Social Capital and its Forms

The most fundamental stance about the concept of **social capital** is to view it as “**social resources**”—it *implies the links and support that individuals can access at a particular time*. The concept has generated multiple definitions, conceptualisations, and empirical measurements (Lin 2008). Where **capital** is *often defined in terms of property and cash in economic terms*, Hanifan(1916,p.130) explained that **social capital on the other hand**, refers to“... **good-will, fellowship, mutual sympathy and social intercourse among a group of individuals and families** who make up a social unit, the rural community, whose logical center is the school. Hanifan (1916) expatiated that social contacts beyond the family are essential ingredients in human wellbeing not just because people meet face-to-face, but a lot of sociological processes both tangible and intangible social exchanges take place. **Mutual socialsupport** is a reflection of accumulation of **social capital**, essential in community building and general living condition. Hanifan (1916, p. 130) further asserted that the individual is helpless socially, if left entirely to himself /herself. Even the association of the members of one’s own family fails to satisfy that

desire which every normal individual has of being with his/herfellows, of being a part of a larger group than the family. If he /she may come into contact with his/her neighbor, and they with other neighbors, there will be an accumulation of social capital, which may immediately satisfy his/her social needs and which may bear a social potentiality sufficient to the substantial improvement of living conditions in the whole community.

2.2. Conflict theory (Marxist Perspective) view of health and health care: A General

Overview

In sociology, Marxist theory (often called conflict theory) is a major perspective. It is traced back to the works of Karl Marx, Vilfredo Pareto, Georg Simmel, Lewis Coser, Randal Collins, C. Wright Mills, W.E.B.DuBois, and Immanuel Wallerstein, among others. In the field of medical sociology, this perspective is more prominent in the works of Vicente Navarro, Hans A.Baer, and Howard Waitzkin, among others. The perspective derived its other name, Marxism, from Karl Marx, who devoted most of his works to the elaboration of conflict and its implications for societal arrangements. In terms of features, *conflict perspective is a direct opposite of functionalism*. While functionalism recognizes the **existence of cooperation and consensus in human society**, Marxists argue that **conflict is inherent in social life**. Marx observed that the history of all hither to existing societies is the history of class struggle. This indicates that there are various groups in human society based on social inequality. There is also tension between these groups. Basically, there are bourgeoisie (those who occupy the upper class) and proletariat (consisting of those in the lower class of the society). A class refers to a group of people who share similar relations with the means of production. In other words, Gabe et al. (2004, p. 3) defined a social class as a segment of the population distinguished from others by similarities in labour market position and property relations. The **bourgeoisie** are the *owners, employers, or the rich*; and **proletariats** are the *non-owners, employees, and the poor*.

The proponents admit that production of material life is a basic historical and fundamental act of man. There are historical changes in human society with transformations from previous economic systems up to capitalism, which is now a dominant economic system. Capitalism allows for the private accumulation of wealth, which explains the differences in economic position of various individuals in the society. Economic status exerts great influence on an individual's behavior and general position in the society. Conflict paradigm, because of its

radical stance and strictures of capitalism, is widely influential (Amzat and Omololu2012). The perspective focuses more on the contradictions (e.g., exploitation, alienation, capital accumulation, and pauperisation) in capitalist societies. In all social considerations, the lower class is always at the receiving end, bearing the brunt of all social problems.

Furthermore, socioeconomic decisions, transformations, and reforms are exercised by the dominant class. Such reforms are mostly unfavourable to the lower class. The conflict perspective notes that the power of the dominant class holds the society together. Health politics and policies are enacted and implemented by the dominant class. There is continuous unequal access to and allocation of resources, which account for the poverty of the lower class. The lower class experiences social alienation and is often at the margin of the society.

Conflict theorists analyze how health and health care reflect inequality and competition among social groups. Conflict theory views society from the perspective of a competition for resources. Through this lens, sociologists see health care itself as a resource. There are only so many doctors, so many hospital beds, and so much medication. Conflict theorists ask how these things are distributed. The distribution of health care tends to follow the power differentials in a society. In the United States, people's wealth or employability is directly related to their access to health care and the quality of the health care they receive. However, even wealth may not ensure quality care, if other forms of discrimination are at play. Studies have demonstrated that doctors tend to give black women less pain medication than white women, believing them to be exaggerating their pain levels. Obese patients often report having difficulty convincing doctors that they have real medical conditions that need treatment. Transgender people are often refused medical services outright. Conflict theorists examine these discrepancies to better understand **how power affects health**.

2.3. Symbolic Interactionist & Post- Modernist

2.3.1. Symbolic Interactionist View of Health and Illness

Symbolic interactionism argues that the meaning of health and illness are dependent on historical, cultural, and situational contexts.

Symbolic interactionism emphasizes a subjective understanding of the individual and society. This approach seeks to analyze social phenomena and behavior by considering the ways that meaning is created through social interactions. Symbolic interactionists look at what health and

illness mean in a society and how this meaning is constructed. Members of society collectively define certain conditions as health or illness. One example is obesity. The tool typically used to diagnose obesity, the body mass index (BMI) uses a person's ratio of weight to height to calculate body mass. The BMI is widely used to determine whether an individual has a healthy weight, is overweight, or is obese. However, it does not always accurately predict health outcomes, to the extent that it classifies most professional athletes as obese. A symbolic interactionist analysis would point to how this tool reflects normative body standards. It would also point out how the BMI is given more medical authority than other tools, such as measurement of body fat in relation to muscle mass or evidence-based models that can be used to predict specific health conditions such as hypertension. The body mass index may be considered a reflection of the social construction of health and illness. A **social construct** is an idea that has been created and accepted by a society. Symbolic interactionism considers how a society comes to understand particular conditions as representing health or illness.

A focus of symbolic interactionism is interactions between individuals. Health care providers and patients interact in particular ways. These interactions are governed by social norms and expectations. Symbolic interactionists look at the language, symbols, and settings of these interactions. They might analyze how the uniforms worn by doctors and nurses impact the social exchanges they have with patients or at the ways that a doctor's office is set up and how that can impact patients' feelings about and understandings of their experience there. Symbolic interactionism also considers how people cope with or make sense of being ill and how attitudes toward an illness or condition shape people's experience of illness. For example, a 1998 study looked at how people suffering from ulcerative colitis, a bowel disease, reacted to their illness. Because the patients associated bowel disease with embarrassment, dirtiness, and loss of control, they developed strategies that helped them present themselves as "normal" and healthy to others. Symbolic interactionists look at this kind of interaction of individuals with illness, as well as the ways that people incorporate social constructions of health or illness into their sense of self.

2.3.2. Postmodernism in Medical Sociology

From the 1970s, postmodernism becomes an epistemological trend which has to be considered in most aspects of sociological investigation. Michel Foucault and Pierre Bourdieu are major postmodernist references in medical sociology. Bourdieu's work originated from post

structuralism. He is more interested in **social inequality in relation to power and agency in human society**. His assertion is that inequality still persists and accounts for various differences which are detrimental to living conditions. To Bourdieu, behavioral choices are typically a reflection of class position (Cockerham2007).Bourdieu (1984) questioned consumption patterns and submitted that class-oriented consumption habits account for health inequality. There are various disparities based on class division relation to smoking, drinking, and eating. The health deterioration observed with the increasing chronic illness and overall downturn in life expectancy support Bourdieu's assertion (Cockerham 2007). While the idea of lifestyle in relation to health is not new, it buttresses the postmodernist claim of the new trend of consumption.

SECTION THREE

Prominent Figures and Medical Sociology: Max Weber, Talcott Parson, Erving Goffman and Michel Foucault

3.1. Max Weber:

Weber was not particularly interested in medical sociology; he was one of those who laid the foundation for the conceptualization of sociology itself, methodology, and research directions in the field. Very often, Weber's social action theory has been adapted for the understanding of social capital in population health, and as the bureaucratic ideal type for the understanding of medical organisation.

Weber's Bureaucratic Rationality and Medical Institutions

Within the context of organisational studies or service delivery assessment, Weber's theory of bureaucracy is usually the starting point. Weber's ideal type, rationalisation, and bureaucracy have a wide range of applications including institutionalisation of medicine and health care, changing patterns in doctor-patient relationships, professional relationships (nurse-doctor, pharmacist-physician, etc.), organisational ethics/practices, power relations, professionalism, professionalisation and deprofessionalisation, organizational context of consumeristic attitude towards health, market relationships within health care, and global health phenomena. The genesis of Weber's discussion of bureaucracy started with his theoretical precept called the ideal type. Weber argued that one of the primary drives of sociology should be the construction of an ideal type, a kind of conceptual purity or perfection. This implies the provision of a utopian definition and attributes of sociological categories to serve as reference points in observational or explanatory analysis.

3.2. Talcott Parsons: Read about Talcot Parsons's contribution in Medical Sociology from previous section two above (i.e about the sick role)

3.3. Erving Goffman: Theory of Social Stigma

The theory of social stigma is a landmark contribution of medical sociology to the understanding of human health. It is one of the social reaction theories which has considerable practical applications in health, health care, and health policy. Erving Goffman(1922–1982)is the father of

stigma theory as a result of his 1963 publication, *Stigma: Notes on the Management of Spoiled Identity*. Since then, the theory of social stigma has been a major theoretical stance in medical sociology and health care in general. While Goffman's classical ideas will form the starting point and background of the discussion, ideas from some recent contributors (especially Falk 2001; Jones et al. 1984; Link and Phelan 2001) will provide an appropriate intellectual blend of the theory of social stigma. Stigma (plural: stigmata) is a Greek word which means a sign, mark, tattoo, or label placed on criminals and other morally degrading persons as a blemish in order to identify them (see Goffman 1963; Falk 2001; Jones et al. 1984; Link and Phelan 2001). The first account of stigma as a symbolic mark on humans is documented in the Bible (later in the Quran) as the mark of Cain; the mark has its origin in the criminal act (murder of his brother, Abel) committed by Cain. Since then, various degrading stigmata have been used in human history.

Social stigma is a mark or attribution of shame, disgrace, or social devaluation. Goffman (1963) defined social stigma as a gap between virtual social identity and actual social identity; the gap shows a discrediting effect. A virtual social identity is one created by people through subjective evaluation of other people; it acts as an interaction interface that has the tendency to predominate the actual social identity. Stigma exists when there is a negative gap between the virtual identity and actual identity. Impliedly, stigma emanates from social interaction; this is why Goffman called it a language of relationship and not an attribute. It is a socially discrediting status ascribed to an individual that is indicative of a social difference from others. Simply, according to Goffman, stigmatisation is a process by which the reaction of others spoils a normal identity.

Goffman (1963) argued that there are **three types of stigma**. First, there are **abominations of the body** (i.e., various physical deformities). Physical characteristics could form a source of social degradation. Campbell and Deacon (2006) referred to these bodily abominations as overt or external deformities that are often visible, such as scars or physical manifestations of some medical conditions such as leprosy, obesity, dystrophy, dwarfism, and autism. Blemishes of individual character or deviations in personal traits constitute the second type. These are traits which are unusual, unnatural, or asocial. These forms of deviation present a discrepancy from the normative and collective norms of the society. Examples include treacherous and rigid beliefs, dishonesty, mental disorders, imprisonment, addiction, alcoholism, unemployment, suicide attempts, and radical political and religious behaviors. Falk (2001) described this deviation of

personal traits as achieved stigma—where the role or behavior of an individual is the source of stigma. The last type is tribal stigma of race, nation, class, and religion. Goffman noted that these types of stigma can be transmitted through lineages and can equally contaminate all members of a family. Falk(2001)describedthisasexistential,akindofstigmathatisaresultofascription or natural attributes. The stigmatized have no control over the attributes. In this case, caste and class systems, especially where the social gap is wide, are accompanied with stigma. Atrocities committed by some members of a group may put others at the risk of stigma. For example, a long-bearded Muslim cleric may be branded as a fanatic and thus as a possible terrorist suspect, especially in the United States after the September 11th attack.

Goffman stopped at three types, but normative stigma should be the fourth category. Normative stigma is a discredited status based on the norms and values of society. The stigmatisation of women in a patriarchal society could fall into this category. Unmarried aged adults, infertile couples, widows, or a woman or family without a male child in most African and Asian communities can experience a form of normative stigma. It is neither existential nor achieved; it is generated based on the norms and values of the society.

Goffman (1963) included homosexuality as a personal trait that is stigmatised. During that time, homosexuality was not tolerated and was considered a medical abnormality and even a criminal act. While it has been normalised in many western nations, it is still a contested or stigmatised trait in many African societies. The implication is that stigma is a relative attribution. It varies by period, place, and person. There may be successions of alteration in attributes that are stigmatised over a period of time. Goffman (1963) observed that “an attribute that stigmatises one type of possessor can confirm the usualness of another, and therefore is neither creditable nor discreditable as a thing in itself.” This also signifies that stigma is a social creation, not the attribute of the “mark” itself. A dwarf who belongs to the upper class may enjoy adequate social tolerance unlike one in the lower class.

Goffman discussed three categories of individuals in relation to stigma. The first are the stigmatised, or those who bear the stigma or label that is discreditable or discredited. They live with the burden of the stigma in everyday life. For them, the experience of stigma is a reality that creates a “battle” between them and others in the society. Most times, it limits their social participation and forces them to explore life opportunities only at the margins of the society.

Stigma can be dehumanising and depersonalising. Second, the “normal” constitute the majority who do not bear any stigma. Most times they are those who place stigma on others by imposing discredited status on others. The last category is the wise, those who are tolerable of the stigmatised, those who hold unconditional love for the discredited persons. The wise are often empathetic and sympathetic; hence, they are highly tolerable of the stigmatised and do not allow the stigma to mediate social interaction.

3.4. Michel Foucault:

Michel Foucault is a French philosopher perhaps best known as **a theorist of power**. Foucault analysed several different types of power, including sovereign power, disciplinary power and the biopower.

Powers of life and death: from sovereign power to biopower

In *The History of Sexuality: An Introduction* (1990a) and in his 1975/6 Collège de France course, *Society Must Be Defended* (2003) Foucault describes biopower as a power which takes hold of human life. In both these works Foucault traces the shift from classical, juridico-legal or sovereign power to two typically modern forms of power, discipline and biopower, as a shift from a right of death to a power over life: "in the classical theory of sovereignty, the right of life and death was one of sovereignty's basic attributes ... The right of sovereignty was the right to take life or let live. And then this new right is established: the right to make live and to let die" (2003: 240-41). Sovereign power is a power which deduces. It is the right to take away not only life but wealth, services, labour and products. Its only power over life is to seize that life, to end, impoverish or enslave it; what it does not seize it leaves alone. Sovereign power's right over life is merely the right of subtraction, not of regulation or control.

SECTION FOUR

Key Concepts in Medical Sociology: Health, Sickness, Disease and Illness, and Medicalization

4.1. Introduction

There has not been an absolute consensus on the definitions of health, disease, and illness, even though these concepts are central not only in medicine but also in the health social sciences (e.g., medical sociology, health, psychology and medical demography). These are parts of the conceptual tools in various medical-related fields. A definition of each concept is imperative because they constitute parts of the analytical tools in medical sociology. The lack of consensus often prevents uniformity of interpretations and generates more polemics. One wonders why there has not been consensus, despite the long history of medicine. The concepts are multidimensional, complex, and often elusive. For instance, Larson (1999) observed that disagreements about the meaning of health are common because health is imbued with political, medical, social, economic, and spiritual components. It is subject to various conceptualization and interpretations. While all the concepts have their foundations in medicine, a biomedical perspective of health or disease may not be comprehensive enough. However, a fusion of the various perspectives often presents a complex definition like the WHO's definition of health. This is why the debate on the definition of health is still ongoing. That the debate continues is not a problem as refinement of definition could lead to a better conceptualization.

4.1.1. Definition of Health

The concept of health presents a form of ambiguity because it is multidimensional, complex, and sometimes elusive. Notwithstanding, various scholars, apart from the definition given by the WHO, have defined the concept. Although it is not the first definition of health, the WHO's definition will still be the starting point because it is relatively old and has been central to the debate on the meaning of health. WHO (1948) defined health as a state of complete physical, mental, and social well-being, not merely the absence of disease and infirmity. The definition is holistic, and it presents three major interrelated components of health.

❖ Components of health:

- i. **Physiological:** *the functionality of the body biological system*

- ii. **Social:***the ability to connect and function as a member of society*
 - iii. **Mental:** *the human psychological, emotional, and intellectual state*
- i. **The physical:** this is the physiological or biological component of the definition. It simply implies the maintenance of homeostasis. This is often used to infer a soundness of the body. Most often, disease represents a malfunction of a part of the body system or an intrusion of harmful organisms such as a virus or parasite. This may cause a breakdown of the individual affected.
 - ii. **The social:** this represents the behavioral aspect of human health. Being a member of society is being in the network of social interaction and being able to fulfil social roles and expectations. If an individual is not active in the social network, it represents a form of social pathology— an abnormality, which is an infraction on the norms and values of society.
 - iii. **The mental:** this indicates the psychological, emotional, and mental status of the individual. Emotional apathy, fixation, and maladjusted personality constitute a part of the manifestation of illness

Table 4.1- Models for defining health (Source: Larson 1999, p. 125)

1	Medical model	The absence of disease or disability
2	World health organization (WHO) model	State of complete physical, mental, and social well-being and not merely the absence of disease or infirmity
3	Wellness model	Health promotion and progress toward higher functioning, energy, comfort, and integration of mind, body, and spirit
4	Environmental model	Adaptation to physical and social surroundings—a balance free from undue pain, discomfort, or disability

4.1.3. Disease and Illness:

Health has been conceived in a biomedical model as the absence of disease while the holistic definition from the WHO signifies that health is not a mere absence of disease. Which ever form the definition takes, the question now is “what constitutes a disease?” One major issue is that disease is often conceived from a biomedical point of view. It can also have behavioral

manifestations, especially with regard to human functionality. The definition of health is complex, so also is the definition of a disease. If the lack of health can be defined as not a mere absence of a disease or infirmity, this signifies that there are a number of germ-and non-germ-related (medical) conditions that can signify the presence of a disease. This, however, also makes the definition of a disease complex because of variations in its conceptions. Mainly, Boorse (1975, 1977) was engrossed in a practical and philosophical discussion of what health and disease may entail. He defined disease as a type of internal state which impairs health (i.e., reduces one or more functional ability below typical efficiency)

Boorse's arguments have been a significant reference point in the discussion of health and diseases. Boorse discussed seven major themes that are prominent in the discussion of what health or a disease entails. It is important here to examine the seven themes in line with the notion of disease and see how important or otherwise those themes could be in identifying a disease.

1. **Pain, suffering and discomfort:** generally what is called disease accounts for human suffering by inflicting pain and discomfort, sometimes unbearable, thereby necessitating palliative care, like terminal sedation. Whitlow is a typical condition that could impose considerable pain on the sufferer, although it requires a simple medical procedure to resolve. A reason why the argument about pain may not be sufficient is because there are a number of normal procedures that require medical attention as a result of pain and discomfort, but are not diseases, such as teething, menstruation, childbirth, and abortion.
2. **Treatment by physicians:** normally diseases require the attention of medical doctors. A disease should be treatable. However, Boorse submitted that there are some conditions that cannot be treated, and doctors also attend to a number of conditions that are not diseases. With medicalisation of life, there are medical expansions beyond treatment of disease, such as certification of fitness for a study or travel. More so, circumcision, body modification or enhancement, and family planning procedures cannot be regarded as diseases but require attention of a physician.
3. **Statistical normality:** the species' average level of performance becomes a yardstick for determining normality and abnormality. There is also a measure of statistical normality

of clinical variables such as blood pressure, basal metabolism, weight, sugar level, height, pulse, and respiration. Any measure beyond the normal range is usually termed as an abnormality or a disease condition and signifies the need for medical attention. When normal blood pressure ends, there begins hypotension or hypertension. This average of normality is derived from the rate of mortality or functionality within normal and abnormal ranges. It is assumed that mortality or dysfunctionality is often higher when below or above normal ranges. This may not always be the case as clinical variables are measures of probability or propensity to a disease

4. **Disability:** disease could also lead to many forms of disability. Poliomyelitis is a typical example of a disease that can cause physical deformity. In another case, a disease may reduce active participation of an individual in the social network, such as the inability to walk or stand. Pregnancy, for instance, could not count as a disease even though it comes with some limitations. A number of skin diseases may not count as disease since they may not present with disabling effects.
5. **Adaptation:** the ability to adapt to the environment has also been categorised as a form of healthiness while those who are not fit are presumably diseased. Lack of adaptation prevents an individual from meeting the average level of a species' functionality. The presence of eumelanin pigmentation in the skins of black Africans helps in adapting to their environment, but it does not mean those with pheomelanin pigmentation cannot survive in Africa or that Africans cannot survive elsewhere. Environmental can even inflict suffering on humans in the process of adaptations.
6. **Homeostasis:** health is a state of bodily equilibrium while disease is a state of homeostatic failure. But the process of human growth as Boorse observed is itself leading to homeostatic disequilibrium.
7. **Value:** disease is undesirable while health is desirable. Health is thus a social value in human society. However, it is also impossible to exclusively delineate disease from the point of undesirability. Conditions such as shortness and ugliness cannot be counted as diseases even though they may not be desirable.

Q. How do you see obesity & homosexuality? (i.e are they disease or not?)

The Realities of Illness

Illness and disease have been major traditional concepts in sociology and medical sciences. The important role of these concepts for human-related medical endeavours was re-emphasised by Nordenfeldt (1993). These concepts are interwoven and often require some analytical clarifications. Most often, people use the words interchangeable. As conceptual and practical tools, they are not the same. The essence of this section is to make some conceptual clarifications of these concepts and not to join the body of unending debate evident in the works of various scholars (including Boorse 1975, 1977; Hesslow 1993; Nordenfeldt 1993; Stempsey 2000; Tengland 2007). More importantly, sociologists have laid more claims on the notion of illness because it is more of a behavioral concept than a medical one. Undoubtedly, illness has a number of undeniable social, moral, and legal contexts.

In a simple illustration, disease is a form of pathology or medical problem, defect, or impairment, while illness is a manifestation of such an impairment, defect/pathology, or disability. Illness is a presentation of a medical condition in a way that limits the functional capability of an individual in the society. This is why Nordenfeldt(1993) observed that to be ill is to be in pain, to be anxious, or to be disabled. The notion of illness fits appropriately into the concept of sick role described by Parsons (1951). It is a situation when an individual consciously feels that he/she is unhealthy, sometimes as a result of discomfort and pain. Therefore, illness is the live-experience of a diseased condition. While a diseased patient might not be real (i.e., without a self-awareness of the condition), an ill patient is real.

It can simply be observed that disease makes people ill. An individual is thus ill to some degree if there is some vital goal of his/her which cannot be completely realised (Nordenfeldt 1993). Illness is a progression from the mere presence of a medical problem or condition to the presentation of disabling symptoms and signs. The underlying meaning is that it is possible to have a disease without being ill and vice versa—invariably it is possible to have a disease without any awareness of it. Boorse (1975) advanced some clarifications on the character of illness.

1.1.4. Medicalization

The concept of medicalisation is another major contributions of medical sociology to medical practice and the understanding of human health. It depicts a cautionary note in the expansion of the medical domain. The notion of medicalization is closely linked with the social construction of realities. Participants in medical practice construct issues that are termed as medical in order to expand the scope of medicine. Medicalisation describes how ordinary issues (usually non-medical) are defined as medical problems, thus requiring medical attention in terms of diagnosis, prevention, and treatment. In other words, medicalisation involves defining a problem in medical terms, usually as an illness or disorder, or using a medical intervention to treat it (Conrad 2005, p.3, 2007, 2013). There is a growing tendency to define all social abnormalities or deviance as medical problems. The view stems from the notion that those who are healthy in a medical sense should not behave abnormally. In the same vein, Bell and Figert (2012, p. 776) observed that wider social processes such as rationalisation, systematisation of the medical domain, and rational application of science to everyday life foster the process of medicalisation. This implies that medicalising a situation gradually becomes a way to explain it, a form of medical explanatory model. Medicalisation also provides a way to eliminate mystical explanations of social events and gives room for the application of biomedical science to objectively explain such social events.

Medicalisation postulates that medicine has increased its relevance and domains in the management of human society. This reflects in all stages of human existence: pre-conception, conception, childhood, adulthood, old age, death, and posthumous condition. Invariably, medicalisation means increasing human dependence on medicine throughout the course of life, generated through professional expansions. At any point, anyone may be referred to the medical institution for certification. More importantly, the medical expansion of the domain of relevance involves the conversion of a social or moral problem to a disease (Filc 2004)

❖ Individual Reading Assignment----- Challenges of Health Care Delivery in Africa

Reference

✓ J. Amzat, O. Razum, *Medical Sociology in Africa*, DOI 10.1007/978-3-319-03986-2,

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SECTION FIVE

The Social Context/Determinants of Health: Age and Health, Health, Gender and Feminism and, Race, Ethnicity and Health

5.1. Introduction

This chapter provides an elaboration of the social determinants of health, dwelling more on how social factors interact to produce health or illness. The notion that health has a social context is traced to the father of western medicine, Hippocrates (460 BC–370 BC). Fathalla (2000) observed that Hippocrates suggested the consideration of social issues in human health. Such factors play significant roles in human health, and (preventive) medicine in particular should note such significant roles. The notion of social aetiology of health or illness is synonymous with the consideration of social factors in human health and illness. The social context accounts for exposure and vulnerability to diseases. The roles of the social determinants are considerably important in the understanding of human health. For instance, if the world is able to ensure gender justice and improve standards of living, the disease burden will be significantly reduced.

It is possible to reduce these social determinants of health (SDH) to social position in the society which affects human health. Simply, SDH refers to the full set of social conditions and characteristics within which living and working take place that invariably account for human health (Tarlov 1996; CSDH 2007). Social position determines social status and roles while social condition determines individual place in a social stratification system. The concepts mentioned in the preceding sentence have the prefix “social” because they are created or constructed by the society. This means that they are not static, natural, or biological. Social roles are created, allocated, and performed by individuals in various social positions in the society. Social roles are duties and obligations assigned to individuals in a specific social position within social organisations such as family (parents, children), occupation (lecturer, physician, nurse), or associations/clubs (president, secretary, or member). All of these positions are socially stratified based on power relations. Social stratification is the manner in which social condition and positions are ranked in terms of power, prestige, or status and wealth.

5.2. Age and health

Definition: In the context of health and medicine, age is a property of human individuals and groups that denotes the duration of the life span since birth and the membership of a specific cohort or generation

Age is correlated with both health and illness behavior. It is part of the determinants of exposure and preventive behavior. Most lifestyle-related medical conditions are relatively lower among children while some diseases are related to old age. The guardians take most decisions on health behavior on behalf of the school age children. The youth takes self-responsibility of health and often engage in risky behaviors like smoking and alcohol consumption. More so, health and illness behaviors have been observed to be socially and culturally acquired from childhood. Crane and Martins (2002) observed that patterns of illness behavior are learned during childhood and have a significant impact on both the way that individuals respond to symptoms and their beliefs about personal health in adulthood.

For many years, age has been a neglected variable in sociological analysis. Yet, arguably, age is just as important to the formation and maintenance of personal identity and social status as gender and ethnicity are. Age can act a positive source of self-esteem (not only for the young) but it can also act as a source of social division and discrimination. The relationship of age to health and medicine is, therefore, a complex one. While studying age is often treated as being synonymous with studying the elderly (as gender is often taken to mean the study of women), it should be remembered that age refers to many stages of the life course

Mortality rates vary considerably with age. In Western countries in the past (and in many poorer countries today) infant mortality has been dominant. High rates of mortality in infants and the young depress the average life expectancy of human groups.

Higher rates of self-reported poor health were also found among the older age group. Most surveys show that poor health and disability are found in older women (partly accounted for by the higher rates of conditions such as arthritis among older women) but this relationship is not always straightforward. Stroke, for example, is more common in older men. The relationship between disability and gender has been thoroughly explored by Arber and Ginn (1991), among others.

Apart from disability, another reason why old age is also emphasized in the context of health and illness is the costs of care, both to informal caregivers and to the health care system.

Age, then, like other features of social differentiation can lead to conflict and division as well as to feelings of solidarity and identification – as in the feelings associated with belonging to a specific generation. Medical sociology needs, therefore, to approach the concept of age and its relationship to health in both a realistic and critical spirit.

5.3. Health, Gender and Feminism

Definition: Gender relates to culturally appropriate behavior of men and women, whereas sex refers to biological differences.

A gender-informed analysis of the social patterning of health needs to consider the wider context of social and economic relations between women and men, and recognize the impact of gender inequalities of power and economic resources on the health of both women and men. It is also essential to take account of the importance of diversity (or inequality) among each gender.

Since the 1970s, it has become accepted wisdom that ‘women get sicker but men die quicker’. Women in most Western societies live longer than men, but have higher morbidity rates. This was discussed by Nathanson (1975) as a ‘contradiction’ which required explanation. Several of her explanations related to gender roles, for example, that women tend to over-report morbidity more often than men, and that women are more predisposed than men to rate their health as poor.

In most Western countries women outlive men on average by 5–7 years. This is largely the product of women’s biological advantage and men’s greater mortality from occupational hazards and risky behaviors, such as smoking, drinking, dangerous sports, fast driving, and violence. As women in Western countries have entered the workforce in greater numbers and there is no longer a male excess in smoking, there has been a reduction in the gender disparity of mortality. This trend is expected to continue, as lifestyles of women and men converge and women undertake more risky behaviors.

In some developing countries there is little gender difference in mortality or men outlive women, for example in Bangladesh, Pakistan and India. In these countries women’s social status is very low, and women are more likely to have poor nutrition, less access to health care, more frequent

births, and high maternal mortality (Doyal, 1995). In a few countries women outlive men by eight or more years, for example, in the former Soviet Union and among blacks in the USA. Here there has been deterioration in men's life expectancy since 1980, partly associated with threats to the economic and psychosocial well-being of men in these societies, many of whom have lost a secure 'breadwinning' role.

5.4. Race, Ethnicity and Health

Definition: Ethnicity refers to the identification with a social group – membership of a collectivity – on the basis of shared values, beliefs, customs, traditions, language and lifestyles.

Differences in health across ethnic groups, in terms of both morbidity and mortality, have been repeatedly documented in both the USA (Rogers, 1992) and the UK (Marmot et al., 1984; Nazroo, 2001). When looking at these data, the initial picture is one of uniform disadvantage for ethnic minority groups, with higher mortality (death) and morbidity (illness) rates. However, closer examination of the data suggests great diversity, with the extent of any health disadvantage varying across ethnic groups and by condition. For example, survey evidence from the UK suggests that within the ethnic minority group that is broadly described as South Asian, Pakistani and Bangladeshi people have very poor health, while Indian people have levels of health that are comparable to the general population (ibid.). And while Pakistani and Bangladeshi people have very poor health generally, their respiratory health is better than that of the general population (Nazroo, 2001). Mortality data also show the contrast by condition and ethnic group. For conditions affecting the cardiovascular system, for example, in the UK those who were born in South Asia have markedly higher death rates from ischaemic heart disease, while those born in the Caribbean have average or low death rates from ischaemic heart disease, but high death rates from strokes and other diseases related to hypertension (Marmot et al., 1984).

Overall, then, a more complex approach to the factors underlying ethnic differences in health is required than simply considering them to be socio-economic, or cultural, or genetic – such factors are unlikely to operate in isolation. Racism is of central importance here. First, ethnic identity and ethnic boundaries are assigned as well as adopted, and assigned on the basis of power relations. Second, the socio-economic differences between ethnic groups should not be considered as somehow autonomous. Rather, the socio-economic disadvantage of ethnic minority people is the outcome of a long history of institutional racism and discrimination that has produced the current levels of disadvantage

SECTION SIX

Health Behavior, Illness Behavior and Sick Role: Health Lifestyles, Preventive Care, Self- Care, Socio-Demographic Variables and Recognizing and Coping with Illness Symptoms

6.1. Introduction

Health and illness behaviors for various kinds of medical conditions have been widely researched in sociology. Sociologists continue to investigate how people respond to their health or illness condition. The basic concern includes the what, how, and why of health and illness behaviors. Generally, understanding human behavior has been the bed rock of sociological studies. Sociologists want to understand, explain, control, and predict human behaviors. Understanding human behavior involves the comprehension of the motivation behind behavior. Why do people behavior the way they do? What are the factors that trigger a particular behavior in any given situation? In health-seeking behavior, it is important to understand what people may or usually do in case of any concern about their health. For instance, what would people do to prevent cancer or any other illness conditions? Would people stop sun-bathing to prevent skin cancer or use a condom to prevent HIV? Understanding the use of appropriate preventive and treatment measures is a central focus in the study of health and illness behaviors.

6.2. Health Behavior

Health behavior (HB) is synonymous with preventive health behavior (PHB). It refers to a person's way of preventing a disease, defect, injury, and disability. In what has been cited as a classic definition, Kasl and Cobb (1966, p.246) posited that "health behavior refers to those activities undertaken by a person believing himself [or herself] to be healthy, for the purpose of preventing disease or detecting it in an asymptomatic stage." In other words, HB is an individually approved, socially appraised, and medically recommended action voluntarily undertaken by a person who believes himself or herself to be healthy that tends to prevent the occurrence of an undesirable health condition or detect it in an asymptomatic age (Alonzo1993).

The critical issue in the definition is that the individual perceives himself or herself to be healthy and carries out certain modalities to avert the occurrence of ill-health. This is why HB is the same as PHB.

Closely related to HB is protective health behavior, which is defined as “any behavior performed by a person, regardless of his or her perceived or actual health status, in order to protect, promote, or maintain his or her health, whether or not such behavior is objectively effective toward that end” (Harris and Guten 1979, p. 18). In this case, action is performed regardless of the health status of the individual. This implies that an individual may have perceived good health or not. Whether HB or protective health behavior, one common ground is that it is a form of behavior regarding personal health among individuals. Such behavior may be objectively effective or not. This mostly happens as a result of lack of knowledge about appropriate medically recommended preventive health practices. For instance, use of appropriate malaria preventive measures is still low in many malaria endemic countries (Karanja et al. 2002, Amzat 2011). Invariably, medical sociology is immersed in showing patterns of behavior whether effective or not in prevention and disease control. In either case, there could be intervention to intensify the effective behavior or change the ineffective behavior.

Furthermore, HB includes activities engaged in and modalities used by the individual voluntarily, and in specific instances under threat of sanction, and by society to(a) prevent and(b) detect disease, defect, injury and disability, (c) promote and enhance health, and (d) protect the individual and collectivity from risk of and actual disease, defect, injury and disability (Alonzo 1993, p. 1024).

6.3. Illness Behavior and Sick role: Health lifestyles, Preventive care, Self- care

Illness behavior is a concept that was introduced in the late 1950s by David Mechanic to depict the “variability in reactions to symptoms and illness, and to identify the various socio-cultural, environmental and psychological factors that affect such reactions” (Mechanic 1995, p. 1208). Illness behavior is further conceived as “the varying ways individuals respond to bodily indications, how they monitor internal states, define and interpret symptoms, make attributions, take remedial actions and utilize various sources of informal and formal care”(Mechanic1962,1995).In action is also a form of response to illness. One major difference between health and illness behavior is that in the former, the person defines himself or herself as healthy and tries to maintain his/her health status or detect if there could be anything wrong, while in the latter, the person defines himself/herself as ill and tries to find ways of recuperating.

In other words, illness behavior is the way an individual believing himself for herself to be ill interprets and responds to signs and symptoms in order to achieve wellness.

6. 3.1.Stages of Illness Behavior

There have been a number of suggestions on the trajectory of illness behavior. Illness behavior in this sense is synonymous with health-seeking behavior. An ill person follows a number of steps in the quest for wellness. Chrisman (1977) identified five major stages while Igun (1979) recognised 11 stages. That of Igun is an expansion of the basic major steps. This section will explain Chrisman's (1977) five stages because his model is more concise, but one stage will be added to make it six stages. In 1977 Chrisman introduced a concept that he referred to as the health-seeking process, a model to conceptualize behavior or the "steps taken by an individual who perceives a need for help as he/she attempts to solve a health problem" (Chrisman 1977, p. 353). He identifies five stages of health-seeking behavior, which includes symptom definition, shifts in role behavior, lay consultation and referral, treatment action, and adherence. Then, "recovery, reintegration, and retirement" is added as the last stage. Figure 3.1 presents the framework showing a downward movement from one stage to the next. Issues that may influence decisions are embedded.

This model shows the health-related actions that a sick person may exhibit, but they are not necessarily sequential as steps may be skipped (Chrisman 1977). It is also possible for some stages to occur simultaneously. As Chrisman (1977, p. 353) observed, "[I]f a sick person interacts with others at some point during the illness, he [or she] may be simultaneously receiving aid in categorising symptoms, bargaining for the legitimacy of avoiding role obligations, receiving support or information from peers, and obtaining treatment or practitioner suggestions." The stages or processes are from previous studies on illness behavior (see Fabrega 1973; Kasl and Cobb 1966; Mechanic 1962; Suchman 1965; Twaddle 1969, 1974) and the sick role (Parsons 1951; Segall 1976), which have provided significant advances in the understanding of health-related behaviors. The six stages are further explained in the next subsections.

6.3.1.1. Symptom Definition

The first step is to recognise and accept that something is wrong. This can be observed through bodily indications. This depends on perceived danger and disability. Chrisman noted that the

factors of danger and disability under lie this variable, which is significant in determining the likelihood of further health-related behaviors. In addition, factors such as symptom visibility or frequency of appearance are the perceptual data on which a person draws as the symptom experience is categorised, or defined, as illness. There have been several studies on illness perception in Africa. One of the major observations is that health-seeking behavior hinges on the ability of an individual to correctly recognize the illness in terms of perceived causes and symptoms. Beliefs about the aetiology of illnesses also invariably dictate the type of therapies and healers to be consulted. General research in the area of treatment seeking has documented that this is related to socio-cultural beliefs about the cause and cure of illness (Mwenesi et al. 1995).

6.3.1.2. Illness-Related Shift in Role Behavior

Chrisman observed that relaxation or cessation of a person's social obligations because of illness-based restrictions or inability to fulfill obligations are part of the indicative factors. A gradual shift in role behavior is more related to chronic diseases. Injuries or some acute diseases are often medically evaluated as emergent or urgent and have a high probability of producing death or disability if medical care is not expeditiously obtained (Alonzo 1980). In acute illness behavior, there may be a sudden cessation of obligation due to hospitalization or illness-imposed restrictions. On the other hand, chronic diseases often produce a gradual shift in role behavior.

6.3.1.3. Lay Consultation and Social Referral

A person may call upon other individuals for aid in identifying an illness, for suggestions about treatment, and for recommendations of competent help (Chrisman 1977). Lay consultation involves communication with significant others about the nature and course of illness. During lay consultation, an individual may take certain treatment measures prescribed by the significant others. For instance, in managing childhood malaria, Afolabi et al. (2004), in a study conducted in Nigeria, observed that a majority of caregivers had given one form of treatment or the other before visiting official health centres. In a Tanzanian study among 652 caregivers, Nsimba et al. (2002) found that a total of 54% of the mothers reported giving medication at home, 21% had taken the children to other health facilities, and 3% had visited traditional healers before referral to a modern health facility. More so, there may be re-definition of illness based on the

experience of the significant others. Generally, relatives and neighbours serve as the first contact and a source of social referrals. It has been reported that illness and pathology may not be reported if persons are able to contain its signs and symptoms of illness within socially defined situations and daily activities could not be interrupted (Alonzo 1979; Mechanic 1995). This signifies that illness will be reported if it is simply beyond containment, inflicts undesirable discomfort, or when the sufferer or significant others perceive dangers.

6.3.1.4. Treatment Actions/Initiation

For the purpose of assessing health care, treatment sources in Africa can be divided into three main categories: traditional, official, and self-treatment sources (McCombie 2002). The traditional treatment involves the use of traditional remedies or visits to traditional practitioners or faith-based healers. Use of official health facilities includes the use of hospitals, clinics, dispensaries, primary health care centers, and private care providers. Self-treatment, on the other hand, includes anything from home treatment with herbal remedies to the purchase and use of modern drugs. Home treatment or informal care refers to care, both affective and instrumental, provided in the domestic or private arena, mostly by women and often for family members, and mostly unpaid (Gabe et al. 2004). In an African setting, medical personnel can also provide informal care for relatives, friends and community members at a low cost. This has been part of the primary sources of treatment in Africa. The major issue is that treatment is initiated based on illness definition, availability of care providers, and other intervening variables. An individual, depending on the illness and available measures, may require one or more episode of treatment. If an illness has perceived mystical or supernatural causes, treatment would involve traditional methods of intervention (e.g., rituals, sacrifice, and other forms of spiritual interventions).

6.3.1.5. Adherence

Adherence or compliance encompasses the importance of continuing to follow the treatment plan as designed, including properly taking all medication(s) for the duration of the treatment, making and keeping follow-up appointments, and maintaining health behavior (Crespo-fierro 1997). Treatment adherence means not only taking the medications but also following the dosing, scheduling, storage, and administration requirements necessary to obtain and maintain the clinical benefits from the treatment. Non-adherence occurs when (1) the patient fails to obtain the

medication; (2) the patient fails to take the medication as prescribed; and (3) when the patient prematurely discontinues the medication (Lofholm and Katzung 2009). It is expected that the patient should comply with a therapeutic regimen as part of illness behavior in order to get better. Non-compliance or non-adherence is a negative illness behavior that has been implicated in the development, spread, and intensification of drug resistance, and, in particular, treatment failure (see Bloland et al. 2000).

6.3.1.6. Recovery, Re-integration, or Retirement

The last stage is recovery and reintegration or retirement (this is not in the original formulation by Chrisman). As Igun (1979, p. 450) opined, if treatment is having the desired effects, the stage of “recovery and re-integration” is next. An individual may require one or more episodes of treatment, especially if the initial treatment does not lead to a desired result. This may even lead to the re-definition of the symptoms/illness. It is not uncommon in Africa to start treatment at home, and then move to other care providers in case of treatment failure (Amzat 2009). Igun (1979) also noted that a lack of recovery may lead to re-labeling the illness. For example, a condition previously perceived as malaria could be re-labeled as another disease or a mysterious illness inflicted by supernatural agents.

After recovery, the individual is re-integrated into the society where he/she continues with previous role obligations and other daily activities. It is important for the person to be accepted and defined as a healthy member of the social system. This is very important, especially in the case of mental illness. It may be difficult to resume obligations if an individual is not defined as being healthy. This indicates that the process of recovery and reintegration might continue indefinitely (especially in a case of chronic illness) or cut short by permanent retirement (mortality) from social roles. This implies that not all patients get well and not all that get well fully resume normal social roles. Hence, adherence, recovery, reintegration, and retirement are affected by illness attributes and efficacy of regimen; illness attributes in particular because many diseases are not curable, but manageable for a long time, or might lead to a terminal end.

SECTION SEVEN

Urbanization and Health

7.1. Introduction

Urbanization is defined as the process of human movement and centralization towards and into cities and urban areas, with the associated industrialization, urban sprawl and lifestyle that brings. It is an inevitable phenomenon that accompanies the development of a country. Urbanization does not only involve the movement of people from rural to urban areas but also comes about as a result of natural increases in the urban areas. Nearly half the world's population now lives in urban settlements. The global proportion of urban population rose dramatically from 13% (220 million) in 1900, to 29% (732 million) in 1950, to 49% (3.2 billion) in 2005. It is projected that 62% of the population, 6.5 billion people will live in cities by 2025.

Cities offer the lure of better employment, education, health care, and culture; and they contribute disproportionately to national economies. However, rapid, and often unplanned urban growth is the source for many of the environmental hazards faced by cities within the developing world. Substandard housing on marginal land, crowding, increasing levels of air pollution, water pollution and over usage, inadequate sanitation services, inadequate solid waste collection, and motor vehicle traffic and traffic injuries are all associated with rapid growth of urban centers. Rapid construction of poor quality housing is a feature of many urban centers in the developing world. These poorly built tenements, shacks, and in some cases little more than tents area response other demands of ever increasing urban poor for some form of housing. These conditions place human health at risk.

7.2. The City as an Environment

A city creates an environment that is different from surrounding areas. City change local climate; they are commonly cloudier, warmer and rainier than surrounding areas. In a city, everything is concentrated, including pollutants. City dwellers are exposed to more kinds of toxic chemicals in higher concentrations and to more human produced noise, heat and particulates than are their rural neighbors. In general, life in a city is riskier because of higher concentrations of pollutants and pollutant-related diseases.

Urbanity and health involves the connection between urban life and the living conditions affecting human health. Urbanization affects human health in several ways, from dietary patterns to the physical environment. The concentration of people in urban areas, with a multitude of economic activity including industrial production and extensive transportation, contributes to air pollution, which is a major health hazard. Although urbanization allows more accessibility to health services, it also creates health hazards. In poor parts of the cities, health problems include inadequate water and sanitation, limited or no waste disposal and poor air quality, as well as crowded living conditions and general poverty. Urbanization affects human health in several ways, from dietary patterns to the physical environment. The concentration of people in urban areas, with a multitude of economic activity including industrial production and extensive transportation, contributes to air pollution, which is a major health hazard. In such urban areas the air, land and water are often contaminated, spreading disease. In cities in the more affluent parts of the world, health hazards resulting from urbanization are mainly connected to air pollution, as well as crime, traffic and lifestyle.