Introduction

Harriss (2002) recently called for a more interdisciplinary approach in studies of international development, referring to both the methods we use and the theories we develop. One field of study where such cross-fertilization is particularly pertinent is that of health-seeking behaviour (HSB). Although the methods used to study HSB are multi-disciplinary, drawing on a mix of health psychology and both qualitative and quantitative methods from social science, there has, on the whole, been a less rigorous exploration of what theoretical frameworks we can bring to bear on our studies of HSB. Studying these theoretical frameworks could help us move beyond the traditional health promotion focus of trying to alter individual behaviour, a method which has met with limited success. Often, studies conclude that HSB is a complex and messy thing, which leads us some way down an interesting, informative pathway, but leaves us hanging on a precipice; tantalizing as the evidence may be, we do not know where to turn next. If there is no wider theoretical framework to ground the findings in, there seems nowhere to go other than to feed the findings back at the local level and reiterate the complex, situated and problematic nature of HSB.

This paper reviews the development of HSB as a tool for investigating the individual’s or a population’s interaction with the health system. It suggests what may be learnt from studies to date, and begins to explore how we might make studies of HSB more useful from a health policy and planning perspective. We suggest there have been some theoretical developments in social science, which might be extremely helpful in moving the tool of HSB in a more fruitful direction.

In particular, we begin to explore how HSB studies could be complimented by an appreciation of the growing bodies of literature around two key concepts: reflexivity and social capital.

Key words: health seeking behaviour, health systems, reflexive communities, social capital

Health-seeking behaviours: the journey so far

Researchers and practitioners have long been interested in what facilitates the use of health services, and what influences people to behave differently in relation to their health. Thus there is a large literature on HSB and utilization of health services in both developed and developing countries. There are two dominant approaches: the development of ‘pathways models’ of HSB, which tend to describe a series of steps an individual takes; and studies of ‘determinants’ of behaviour, highlighting the factors influencing that journey (Bedri 2001).

Pathways models

Suchman (1965) was the first to describe HSB in a logical sequence of steps beginning with perception and evaluation of symptoms and ending with the use of different care types. Fabrega (1974) developed a theoretical model of illness behaviour, which concentrates on the information an individual might be expected to process during an illness episode. However, the approach is based on economics and elementary decision theory, and so assumes people use the principle of cost-benefit in evaluating best courses of action. This leaves out other possible influencing factors that could play a part. Dingwall’s model of illness action focuses mostly on...
lay responses to disturbances in body functioning (Dingwall 1976). The model, however, is based on individual choice, which assumes that individuals are autonomous in making decisions and hence may underplay the social context in which they act. Ignor (1979) developed a model of 11 stages of HSB, from the point of recognizing symptoms until care is sought. The model details the process of HSB, moving from one stage to another, but does not describe the factors that influence this movement. Young’s decision-making tree describes the pathways individuals undertake during the process of decision-making around seeking help and the factors that may change or hinder initial choice of care (Young 1981).

Since HSB is a social process and involves the individual’s interaction with the social network, it is important to examine the decision-making processes from this perspective. Previous studies of these decision-making processes have employed either individual models or social process models separately and rarely in an integrated form (Young 1981). Hence, Rogers and Elliot (1997) suggest the adoption of the Network-Episode Model that promises to bridge the gap between the two forms. This model focuses on how and when care is accessed and received, and on how the choices and strategies of health-seeking are socially organized. The model, however, does not consider the alternative choices of self-treatment or the decision not to use care during the health-seeking process.

**Determinants models**

Examples of models investigating the different determinants of HSB include Andersen’s grouping of factors influencing utilization into three main categories: population characteristics, health care systems and the external environment (Andersen 1995). The model is comprehensive in its organization of possible factors and is widely used by health services research. Kasl et al. (1966) focus on the individual’s health behaviour and adoption of the sick role. However, since their model focuses on individual health behaviour, it ignores the impact of the social network on the decision-making process. Zola (1973) investigated the ‘triggers’ that induce an individual’s decision to consult care. The model does not concentrate on how a decision to utilize care is made, but on why such a decision is made.

These models of determinants and factors influencing HSB are important in understanding how individuals seek care and why some people seek care earlier than others. Accordingly, for illnesses that require swift care, such models are informative and can contribute to interventions for the reduction of transmission and complications arising from ignoring or not seeking care.

In these studies, which categorize the types of barriers or determinants which lie between patients and services, there are as many categorizations and variations in terminology as there are studies. Even so, they tend to fall under the divisions of geographical, social, economic, cultural and organizational factors. These categorizations can be further broken down to illustrate the types of empirical measures frequently used. Figure 1 illustrates how these can be conceptualized as falling into three spheres of influence: informal, infrastructure and formal.

As mentioned above, there is another clear distinction in the literature – those studies that emphasize the ‘end point’ (utilization of the formal system, or health care-seeking behaviour), and those which emphasize the wider ‘process’ (health-seeking behaviour).

**Seeking health care: utilization of a complex system**

There is a tendency in the literature for studies to focus specifically on the act of seeking ‘health care’ as defined officially in a particular context. Although data are also gathered on self care, visits to more traditional healers and unofficial medical channels, these are often seen largely as something which should be prevented, with the emphasis on encouraging people to opt first for the official channels (Ahmed et al. 2001). Yet a consistent finding in many studies is that for some illnesses, people will choose traditional healers, village homeopaths or untrained allopathic doctors above formally trained practitioners or government health facilities (Rahman 2000; Ahmed et al. 2001; Yamasaki-Nakagawa et al. 2001); or as Ward et al. (1997: 21) suggest, health-seeking behaviour does not always take ‘the form that scientific medicine thinks is most appropriate’.

Despite the ongoing evidence that people do choose traditional and folk medicine or providers in a variety of contexts which have potentially profound impacts on health, few studies recommend ways to enable individual preferences to be incorporated into a more responsive health care system. Nonetheless, there is now growing recognition of the need to be more sensitive to the realities of health care-seeking behaviour, and increasingly, researchers are coming to the conclusion that, in relation to some health problems in developing countries, traditional and unqualified practitioners should be recognized as an important resource (Ingstad 1990), and perhaps even as ‘the main providers of care’ (Rahman 2000).

Paying closer attention to the range of providers that may make up a local health system reveals that some groups appear to ‘wander’ between practitioners rather than seek care through one avenue or provider (Moses et al. 1994; Rahman 2000). With this broader appreciation of behaviour, some have suggested the need to improve integration of private sector providers with public care (Needham et al. 2001). Calls have been made for explicit recognition of the potential to combine the two worlds by involving unofficial providers in official training and service provision (Green 1994; Outwater et al. 2001). However, Ahmed et al. (2000) concede that whilst extending training to such providers may enhance their services, training in itself will not change practice. For this, managerial and regulatory intervention is needed. Thus, the provision of medical services alone in efforts to reduce health inequalities is inadequate. Clearly, any research interest in health care-seeking behaviour, focusing on end-point utilization, needs to address the complex nature of the process involved, cognizant of the fact...
that the particular ‘end point’ uncovered may be multi-
faceted and may not correspond to the preferred end points
of service providers.

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

A number of genres of such model exist, and variations have
been developed around them. One of the most widely
applied is the ‘health belief model’ (for examples, see
Hochbaum 1958; Becker et al. 1977; Sheeran and Abraham
1996). However, health belief models have been criticized for
portraying individuals as asocial economic decision-makers,
and applications to major contemporary health issues, such
as sexual behaviour, have failed to offer any real insights
(Sheeran and Abraham 1996).

A second genre of model is linked to the general assumption
that those who believe they have control over their health are
more likely to engage in health-promoting behaviours
(Norman and Bennett 1996). The ‘health locus of control’
construct is therefore utilized to assess the relationship
between an individual’s actions and experience from
previous outcomes. The most popular of these is the ‘multi-
dimensional health locus of control measure’ (Wallston
1992). However, this approach to social cognition models has
been criticized for taking too narrow an approach to health
and insufficiently explaining the amount of variance
(Norman and Bennett 1996). Others, including ‘protection
motivation theory’ and ‘theory of planned behaviour’, have
equally met with mixed reception (Boer and Seydel 1996;
Conner and Sparks 1996). Figure 2 represents a visual
summary of the approach of social cognition models.

Where to next?
The models presented so far are, on the whole, predicated on
two assumptions central to classic health promotion: health
is influenced by behaviour, and behaviour is modifiable
(Conner and Norman 1996b). The downfall of these models
is that most view the individual as a rational decision maker,
systematically reviewing available information and forming
behaviour intentions from this: ‘I know, therefore I act’. This
loses the sense that we are all rooted in social contexts that
affect, in a far more complex manner, the way we process and
act on information.

So how might we move the debate forward? MacPhail and
MacPhail and Campbell (2001) begin to explore the neglected societal, normative and cultural contexts in which individual-level phenomena such as knowledge, attitudes and behaviour are negotiated or constructed. In their work on risk-taking behaviour and sexuality amongst young South Africans, they criticize much previous work which focuses on the individual-level KABP approach (knowledge-attitude-belief-practice), as this assumes individual behaviour is built upon rational decision-making based on knowledge. MacPhail and Campbell believe developed country research has a better track record of exploring the broader contextual picture, whilst work in developing countries tends not to acknowledge the poor relationship between knowledge and HSB. This suggests we need to develop a more critical approach to our conceptualization of HSB in developing countries. It is our belief that recent theoretical developments within social science may aid this process.

Resituating health-seeking behaviour: from the knowledge-processing individual to the reflexive collective

There has so far been little synthesis of knowledge and understanding around structural influences on HSB, conceptualizing it as a socio-structural phenomenon rather than one that resides in the individual. Here, we suggest that locating our understanding of HSB within a framework informed by the concepts of reflexivity and social capital will remove the overriding emphasis on the individual and will open up the possibility for a more situated understanding. Despite the fact that repeated studies of HSB throw up the centrality of social factors, these problems are recast, and solutions to address them are focused on the individual. The way in which the research is actually conducted is also predominantly rooted in the individual in their immediate home environment (Tipping and Segall 1995). It would be more rewarding to explore the inter-relationships of individuals within containing social systems, cultural norms and system constraints, and understand resulting behaviour as a product of these inter-relations rather than something intrinsic to the individual. This removes HSB from the locus of control of the individual and places it within the enabling and constraining framework of the social system and health care structures.

MacPhail and Campbell (2001) begin to do just this. They used focus groups to tap into the socially negotiated nature of sexuality for young people in South Africa, playing down the role of individual decision-making. MacPhail and Campbell’s work begins to explore the complexity of the worlds these young people inhabit and the influence of this on decisions, or forced choices, made around sexual behaviour. They demonstrate that far more insight can be gained by exploring social issues related to health behaviours within a social context than by talking to individuals in their homes and asking them to talk about specific acts of illness response. This shifts the emphasis and recognizes that the force for control – the potential driving force behind change – often lies not in the individual, but within surrounding structures and relations. As Singer et al. stress, “while “symptoms are grounded in the social and cultural realities of individual patients” (Good and Good 1981: 166), social and cultural realities are grounded in particular political-economic and historical contexts” (Singer et al. 1988: 374).
Risk and reflexive communities

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

Whilst ‘information’ is a central part of the process of reflexivity, the notion of ‘information’ is ‘too one-sidedly cognitive’ (Lash and Urry 1994). Lash and Urry (1994: 222) suggest an individual’s relationship with information must be seen also as possessing ‘moral, affective, aesthetic, narrative and meaning dimensions’. Hence the availability of ‘information’ (from a variety of sources, including health promotion, knowledge about facilities or experiences of family members) for individuals to make HSB choices around is only a small part of the equation. There is a wider ‘aesthetic reflexivity’ which means ‘making choices about and/or innovating background assumptions and shared practices upon whose bases cognitive and normative reflection is founded’ (Lash and Urry 1994: 316).

In order to understand how people reach the decisions they do around their HSB, we need to understand not only the wide range of ‘information’ sources and how they are interpreted, but also the underlying, unspoken and unconscious feelings and assumptions which support that cognitive process and the journey taken during it. We have to ‘comprehend meaning as it emerges in practice’ (Hastrup 1995: 82). This reflects findings of previous studies on HSB that confirm this and further suggest we need to focus on populations and health systems, thus encompassing something far broader than the majority of HSB studies – broader both in terms of the channels which the individual may engage with (i.e. not purely official medical ones) and in terms of how we look at the influences on people’s behaviour in particular places. In order to do this we need to address the hitherto neglected collective, social element of HSB, and the relations between this and health systems. We suggest one way of doing this is to borrow from the literature around social capital.

Social capital and health

In order to develop new insights into HSB it is necessary to locate it within a broader understanding of the social and organizational terrain the individual inhabits. The difficulty in moving the debate from the individual to the social embeddedness of that individual’s behaviour is that social phenomena are so all-pervasive, yet often only vaguely defined (Narayan 1999). One way in which authors have attempted to untangle and analyze the way in which social forces interact in the development process is through the lens of social capital (Woolcock 1998). This paper suggests social capital is a framework that allows us to locate issues of collectivity and health systems dynamics theoretically.

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

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

There have been numerous interpretations of, and attempts to operationalize, the concept of social capital across a range of fields. The health and health care literature tends to focus on the role of social capital in sustaining or generating healthy lay communities (Narayan and Pritchett 1997; Morrow 1999). In this context, social capital is seen as a framework for thinking about the broader determinants of health and how to influence them through community-based approaches (Gillies 1998).

Another literature, rooted in sociological and organizational theory, explores the role of social capital in supporting institutional success at local, national or international levels (MacKian 2002). The structures of co-operation which are witnessed in association with successful corporate enterprise are explored within a social capital framework (see for example Romo and Schwartz 1995; Gabbay and Zuckerman 1998; Honig 1998). Here, social capital is utilized to explore the nature of those interactions which appear to sustain and accelerate system development. As the HSB literature suggests, it is often the health system itself which serves to limit an individual's capacity to engage with it, and Morris (1998) highlights a growing recognition that far more people rely on informal social capital than formal institutions. Thus, HSB studies which are either facility- or household-based miss the opportunity of capturing the wider community picture, which could be all important in understanding why, when and how people use health system facilities. To return to the framework outlined in Figure 1, understanding the interaction of formal and informal systems with local health care infrastructure, through the lens of social capital, may seem particularly apposite in relation to HSB.

Social capital serves an extremely useful purpose in the area of HSB, as it provides a means of shifting the focus from individuals to social groups, and the social embeddedness of the actions of individuals. In relation to the health of individuals, there is growing evidence that a high level of social capital in itself may have positive effects on health and HSB (Brown and Ashman 1996). The point to stress is that this sort of benefit is an attribute of social structures, and therefore cannot be observed by interviewing the individual as an isolated agent, as most health-seeking behaviour studies attempt to do.

It is our belief that, although there has been much description of the contextual nature of an individual's HSB, the importance of social context has been overshadowed. The dynamic nature of this context is also often overlooked. For example, Singer et al.'s research on Haitian women's HSB around reproductive health highlights the dynamic and responsive nature of indigenous health beliefs (Singer et al. 1988). This dynamism is not readily acknowledged by medical professionals who feel their patients' beliefs are irrational, backward and stagnant.

Furthermore, whilst much emphasis is placed on cultural norms, social conventions and expectations, little has been done to translate this into a contextual picture of how the structural preconditions of the health care system reinforce or contribute to the related set of problems. Social capital offers us a lens through which to do this. By shifting the focus we will begin to see the value of understanding HSB not as something that resides in the individual, but as a reflection of wider social processes. Rather than concentrating on the individual as the potential source of solutions, this shifts the gaze onto the wider contextual setting. In the view of social capital theorists, it is this wider setting, not the individual, that is the source of an individual's advantage or disadvantage (Portes 1998), and it is therefore this that is of greatest interest.

Policy lessons

We can begin to map the understanding provided by social capital onto the ideas of Lash and Urry around reflexive communities (Figure 3). The framework could be used to explore the relative positions of the 'reflexive communities' that particular groups or individuals inhabit, how they may benefit from or miss out on locally constituted social capital, and help us begin to understand how guided improvements could be brought about. Here the emphasis would not be on the knowledge of an individual, but their engagement with wider structures around them. This sort of understanding makes it increasingly clear that to alter HSB, we need to address the social capital of communities and the various reflexive communities within this.

Box 1 gives an example of an on-going piece of research utilizing such a framework of understanding, and Box 2 draws on a similarly embedded approach to illustrate what insights might be gained.

It may not be as easy for policy developers to grasp or plan from research which produces such a complex picture. However, there are a number of ways in which careful collaboration with research efforts could enable better policy planning and service delivery:

Targeted education campaigns to influence HSB – Governments are often uncertain where to target health promotion messages (Parkhurst et al. 2003). Studies that explore HSB as an embedded process, rather than something which rests ultimately with the individual, will help to develop understanding around appropriate measures in specific contexts.

Targeting investments – Many low-income country
Figure 3. A framework allowing us to understand the formal health care system as being embedded within an informal system, surrounded by a wider background of social capital (particular reflexive communities will occupy unique positions across this terrain; policy developments can cut across this terrain to reflect the circumstances of particular reflexive communities)

Box 1. Access, health-seeking and utilization of maternal health services in Bangladesh and Uganda*

A number of studies have identified a variety of potential barriers to women’s use of professional delivery services in developing countries. What is lacking in the literature, however, are investigations into how some women are able to overcome these barriers, and what social networks and support structures exist or are tapped by those women who are able to do so. Policymakers need to know which barriers to address first, and where interventions will be best targeted. For example, governments are often uncertain about where to target health education messages – at individual women, at families or in larger communities. In order to move understanding of barriers to service utilization to a higher level, this project’s research methodology taps into the enabling and supporting factors within communities that provide the context in which individuals must face and deal with access issues, and ultimately act out their health-seeking behaviour. Thus moving from an individual view of health seeking, to an understanding of how communities deal with health systems, and how individuals draw on their communities to address health problems.

*Adapted from Parkhurst et al. (2003).

Box 2. Condom use among young people in South Africa*

A MacPhail and Campbell’s work with adolescents and young people in a Southern African township uses focus groups to highlight the social and cultural processes behind the negotiation and construction of sexuality and resultant behaviour. This was based on a dissatisfaction with the preponderance of survey approaches based on the KAPB model, which do not enable policy developers to consider the contexts in which knowledge is gained and incorporated into sexuality. MacPhail and Campbell’s open-ended focus groups were frequently characterized by fierce arguments and debate, indicative of the complexity of young people’s sexuality. Thus such an approach highlights the fact that young people’s sexuality is a contested and complex process, and by uncovering some of the areas for debate and difference, the research highlighted where there may be space for appropriate interventions that lead to actual behaviour change. In particular they suggest a fertile starting point would be to focus on those young people who actively challenge stereotypical norms and beliefs, in order to facilitate the negotiation of new norms and values through peer group education.

*From MacPhail and Campbell (2001).
governments are looking to improve health-seeking behaviour of their population through a variety of interventions (such as service quality improvements, transportation infrastructure development, behaviour change campaigns or community development programmes). However, budgets are limited and resources must be allocated strategically (Parkhurst et al. 2003). A more detailed understanding of the ways in which social networks and community factors influence HSB can guide interventions at the appropriate level.

Community development and health improvement – Global calls for community participation in catering for health needs are premised on the notion that participation has the potential both to improve health care systems from a management perspective and empower local people, thus serving a wider social development function. Participation is now institutionalized into mainstream development discourse (Morgan 2001), nonetheless there remain stark differences in definitions and practice. Providing information on the importance of community and social network influences on behaviour will support such policies aimed at improving health situations generally.

Conclusion
It seems therefore that the HSB literature does not adequately address either the nature of how people reach the decisions they do in the context of their daily, socially and culturally embedded lives, or the complexity of health care systems. This review suggests it is high time we take a few more steps down the garden path, drawing together and theorizing the existing scattered, and rather descriptive, knowledge around HSB; and begin to integrate it with theoretical developments that help us grasp the wider picture.

The fact that HSB is 'not even mentioned' in widely used medical textbooks (Steen and Mazonde 1999) perhaps reflects that many HSB studies are presented in a manner that delivers no effective route forward. We know how people behave, but are no closer to understanding how to work with or influence this. Thus HSB as a tool is made redundant for health professionals. This results in an unfortunate loss for medical practice and health systems development programmes, as proper understanding of HSB has the potential to reduce delay to diagnosis, improve treatment compliance and improve health promotion strategies in a variety of contexts (Rahman 2000).

This review has explored how HSB has been addressed to date. It has then suggested that we need to move the debate forwards. HSB is not just a one-off, isolated event. It is part and parcel of a person's, a family's or a community's identity, which is the result of an evolving mix of social, personal, cultural and experiential factors. What seems to be missing in much of the literature is a sense of how the process of 'seeking' extends over physical and social space, time and the health system in complex ways, and cannot be picked out as something intrinsic to the individual. Williamson (2000) suggests that while health promotion aimed at altering HSB places emphasis on individual behaviour, the lens needs to be broadened to other determinants of health, including policy directives to enhance population health, reduce inequality and improve social justice. To a large extent, such spheres fall outside the traditional mandate of HSB models and this is where the relevance of a wider conceptual framework, such as the one offered here, becomes strikingly clear.

A framework of social capital places the emphasis on social structures, interactions and systems, and the theoretical tool of reflexivity helps us to uncover how this is played out for particular people. Understanding HSB in this way would enable us to visualize where formal institutions may need to nurture informal networks, or highlight those individuals and groups who lack the benefit of being embedded in supportive networks, and thus make HSB a more useful concept for health policy and planning.

So without wanting to dismiss the work that has been conducted to date on HSB, this review suggests we need to build on it and move the agenda into a new and more holistic dimension. In brief, we must develop our understanding of how populations engage with health systems, rather than using health seeking behaviour as a tool for describing how individuals engage with particular services.

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