



Understanding Health-Seeking Behaviour in Africa Local Communities using U. A. Igun's Descriptive Model (1979)



*¹Zakariyya, Muhammad, ¹Hamisu, Aminu and ²Ibrahim, Mashkur U.

¹Sociology Department, Faculty of Social Sciences, Federal University Dutsin-Ma, PMB 5001, along Kankara-Katsina Road, Katsina State, Nigeria,

²Rabi'u Musa Kwankwaso College of Advanced and Remedial Studies, Tudun Wada Dan Kadai, Jos-Kano Road, Kano State, Nigeria.

*Corresponding Author's email: mzakariyya@fudutsinma.edu.ng Phone: +2348060889819

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ABSTRACT

Health-Seeking Behaviour (HSB) remains a central concern in Sociological and Anthropological studies of health, illness, and care utilization. Understanding how individuals recognize, interpret, and respond to symptoms is vital for improving access to appropriate healthcare. This paper explores U. A. Igun's (1979) descriptive model of HSB, situating it within broader theoretical and empirical frameworks of health behaviour research. The study synthesizes the contributions of various descriptive and explanatory models, including Suchman's stages, Andersen's behavioural model, and Young's decision-tree model, to identify their major assumptions and limitations. Through a sociological lens, the paper digests Igun's eleven-stage model and examines its relevance for understanding pluralistic healthcare contexts in traditional African societies. Methods include a qualitative synthesis of literature, conceptual analysis, and interpretive comparison of descriptive frameworks. Findings highlight Igun's contribution to processual understanding of HSB and underscore the importance of integrating socio-cultural, structural, and behavioural determinants in health research. The paper concludes with recommendations for applying Igun's model in contemporary research and policy planning.

CITATION

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INTRODUCTION

Health-seeking behaviour (HSB) refers to the sequence of actions individuals undertake when they perceive themselves to be ill, ranging from symptom recognition to recovery (Oberoi & Kaushal, 2016). The sociology of health and illness provides key insights into how cultural beliefs, social networks, economic conditions, and structural barriers shape these behavioural trajectories (Poortaghi et al., 2015). Within the field, several models have been proposed to describe or explain the dynamics of health-seeking behaviour. Early frameworks such as Suchman's (1965) stages of illness and Andersen's (1968) behavioural model sought to capture, respectively, the sequential and determinant-based logic underlying individuals' use of health services.

Among these contributions, U. A. Igun's (1979) descriptive model stands out for its contextual sensitivity to African societies, particularly those characterized by plural medical systems where traditional, spiritual, and biomedical care coexist. Igun conceptualized health-seeking as a multi-stage process involving repeated assessments, choices, and shifts between care sources. His work remains relevant today as many low- and middle-income countries, including Nigeria, continue to experience complex patterns of medical pluralism and health service underutilization.

This paper aims to provide a comprehensive analysis of Igun's (1979) descriptive stages model of health-seeking behaviour, situating it within broader sociological theories of illness behaviour. It begins with a review of existing

descriptive and explanatory models, detailing their assumptions and contributions. It then introduces a methodological approach based on conceptual synthesis of existing literature. Subsequent sections examine Igun's stages model in detail and assess its application in traditional and pluralistic healthcare settings. The paper concludes by discussing implications for health policy, research, and sociological theory development.

LITERATURE REVIEW

Understanding of Health-Seeking Behaviour in Traditional Settings

Health-seeking behaviour (HSB) refers to the action's individuals take in response to perceived illness or health needs. It includes pathways, choices, decisions, and behavioural patterns that determine where, how, and when people seek healthcare (MacKian, 2003 in Zakariyya, 2024). In social science and medical sociology, HSB is understood not as a random activity but as behaviour influenced by cultural norms, social structures, belief systems, economic conditions, and individual perceptions of illness. Scholars define HSB as the sequence of remedial actions individuals undertake to rectify perceived ill-health (Shaikh & Hatcher, 2005; Zakariyya, 2024). The concept covers: recognition of illnesses, interpretation of symptoms, decision-making regarding care options, use of formal or informal health services and witching between providers of these healthcare services.

Human beings rarely make health decisions irrationally. Rather, choices reflect commonsense reasoning, influenced by experience, accessible resources, and cultural interpretations of disease causation. In traditional African societies, HSB is shaped by worldview systems that integrate physical, social, spiritual, and supernatural interpretations of illness (Amoah, 2018). These culturally embedded interpretations significantly influence care-seeking patterns and align with the logic expressed in Igun's seminal model of medical pluralism and treatment pathways.

Health-Seeking Behaviour in the African Traditional Setting

In African societies, health and illness are traditionally viewed holistically: the body, spirit, ancestors, social harmony, and environmental forces are interconnected (Gyekye, 1995 in Amoah, 2018). Consequently, Zakariyya (2024) affirmed that illness may be attributed to four (4) major causes peculiar to traditional communities in Nigeria such as: natural causes (germs, accidents, aging), spiritual causes (witchcraft, ancestral displeasure, curses), social causes (broken taboos, strained relationships) and human causes (accident, lifestyle and illiteracy).

Thus, HSB in African contexts can be said to be pluralistic, involving a combination of: self-medication and home

remedies, traditional healers (herbalists, diviners, spiritualists), faith-based or religious healing and modern biomedical health facilities. This creates what sociologists call a therapeutic continuum, where individuals move back and forth between different healing options. If an illness is believed to be spiritual, visiting a hospital is "commonsensically" seen as inappropriate, because hospitals treat physical, not supernatural problems. When herbal remedies have historically worked for certain ailments, people logically choose them as first aid. Cost, distance, and trust in providers are also commonsense considerations influencing choices.

Literature Review on Descriptive Models and Their Major Assumptions

Health-seeking behaviour has been examined through a wide range of conceptual models that fall broadly into two categories: descriptive (process-oriented) and explanatory (determinant-based) frameworks (MacKian, 2004). Descriptive models focus on how individuals navigate illness trajectories, while explanatory models address why individuals behave as they do. For this paper, the scope is centred on both descriptive (process-oriented) and explanatory (determinant-based) models in the understanding of health-seeking behaviour in African local communities. Some of the most prominent process-oriented and determinant-based models as reviewed for the purpose of this work were Suchman's stages of illness model, Andersen's behavioural model and Young's decision-tree model.

Suchman's Stages of Illness Model

Suchman (1965) proposed one of the earliest process-oriented frameworks for understanding illness behaviour. He identified five sequential stages: First is the symptom experience stage. Here, the perceived sick person starts to develop symptoms that were socio-culturally presumed ton that of the sick. In this stage, the person can perform social functions. Second, the assumption of the sick role. The perceived sick has been overwhelmed with the symptoms and it has started affecting effective social functions of such individual in the society. Third, the medical care contact stage. In this stage, the individual is now conceived as been sick with a state of social role malfunctioning where the perceived sick person needs to evaluate the state of his/her health to ascertain the body condition. This will be led to contracting medical examinations. Fourth, the dependent-patient role stage. After the perceived sick has been medically certified to be sick, steps into the sick role proper which demands his/her cooperation with medical regimen in regaining health again and rehabilitated into the society for effective role functions. Fifth, the recovery or rehabilitation stage. After a successful medical diagnoses and medication, the sick regains health and is gradually incorporated back into

proper normal role function. This model assumes that health-seeking unfolds linearly and that each stage is influenced by both subjective symptom interpretation and social validation. Its simplicity made it widely applicable but also limited, as it did not fully capture cultural or systemic variations in healthcare behaviour (Young, 1981) most especially in local communities in Africa.

Andersen’s Behavioural Model of Health Services Use

In contrast, Andersen (1968) developed a behavioural model emphasizing the determinants of health service utilization rather than the stages of the process. He proposed that healthcare use is influenced by predisposing, enabling, and need factors. Predisposing factors include demographics and social structure that opens an individual to healthcare utilization. Enabling factors refer to resources and access. These enabling factors include income and other capabilities that facilitate the access of healthcare and need factors involve perceived or evaluated illness severity (Babitsch, Gohl, &

von Lengerke, 2012). The model has been widely used to explain variations in healthcare utilization but is more explanatory than descriptive.

Young’s Decision-Tree Model

Young (1981) advanced the decision-tree model, highlighting the branching nature of healthcare-seeking decisions. Unlike linear models, this approach acknowledges that individuals often face multiple options simultaneously such as traditional healers, pharmacies, or hospitals and must navigate constraints of cost, access, and belief to make decisions for healthcare in the advent of any illness episode. Decision-tree models assume rational evaluation within socio-cultural limits and align closely with real-world pluralistic systems.

Tabular Comparative Summary of Descriptive Models as Revised

Table 1 below summarizes key descriptive models, their central assumptions, and major limitations.

Table 1: Comparative Overview of Major of Health-Seeking Behaviour Model as Revised

Descriptive Models	Central Assumptions	Major Limitations
Suchman (1965)	Involves (5) chronological stages: symptom experience, assumption of the sick role, medical care contact, dependent-patient role and recovery or rehabilitation stages to HSB.	Presents Linear process which is not always true in chronic illness, euro-culturally generalizable, oversimplification of non-linear behaviour and recognizes Uni-pathway (orthodox system) to HSB.
Andersen (1968)	Proposed (3) major factors: Predisposing, enabling, need factors to HSB.	Utilization depends on individual and structural determinants which is not always tenable, focuses on determinants and neglects processes which makes the theory Unifocal.
Young (1981)	Decision-tree of multiple choices	Individuals rationally select care paths which is not obtainable in all individuals for all illness episodes, Underplays the influence of emotion and uncertainty in HSB.

Source: Authors’ Presentation, 2025

MATERIALS AND METHODS

This study employed a conceptual-analytic systematic and literature-based methodology appropriate for theoretical research in sociology. Rather than collecting primary empirical data, the approach focuses on synthesizing and critically analyzing existing scholarly literature related to health-seeking behaviour models.

Data Sources

Relevant literature was gathered from peer-reviewed journals, books, and institutional repositories using academic databases such as PubMed, JSTOR, Scopus, and Google Scholar. Key search terms included: health-seeking behaviour, Igun 1979 model, descriptive models of health, traditional medicine, and sociology of health. Foundational works by Suchman (1965), Andersen (1968),

Young (1981), MacKian (2004), and Poortaghi et al. (2015) were prioritized alongside African and Nigerian studies on traditional healthcare.

Studies and theoretical papers were included if they: (a) addressed conceptual models of HSB; (b) examined health-seeking in pluralistic or traditional contexts; and (c) were published in English between 1960 and 2024. Also, articles focusing solely on clinical or epidemiological outcomes without behavioural analysis were excluded. More so, articles published before 1960 and after 2024 were intentionally ignored. This was so, as it delineates the scope of this paper.

The analysis employed descriptive synthesis and thematic comparison to identify patterns, assumptions, and implications across models. Key themes such as linearity versus iteration, individual agency versus social

embeddedness, and explanatory versus descriptive orientation were identified and used to contextualize Igun's contribution. Comparative matrices and conceptual diagrams were created to visualize relationships between models.

Ethical Considerations

Since the study relied entirely on secondary literature, ethical approval was not required. However, due academic integrity was ensured through proper citation and adherence to APA 7th edition referencing standards.

RESULTS AND DISCUSSION

Digesting U. A. Igun's Descriptive Model in the Understanding of Health-Seeking Behaviour in African Traditional Settings

Igun's (1979) descriptive model of health-seeking behaviour emerged as a groundbreaking framework that reflected the realities of plural medical systems prevalent in African societies (Zakariyya, 2024). The model under discussion is profoundly adept at elucidating the dynamics of interpersonal relationships, social structures, cultural paradigms, and the implications of lay referrals on health-seeking behaviours. A significant advantage of this model lies in its capacity to evaluate the effectiveness of various treatment interventions. This characteristic renders it not only a pertinent instrument for clarifying the complexities associated with acute medical conditions but also a valuable resource for comprehending chronic illnesses. By examining the range of remedies available, the behaviours exhibited throughout the illness process, and the strategies adopted by individuals seeking to restore their health, this model contributes substantially to the understanding of HSB as a multifaceted phenomenon in traditional African societies.

Furthermore, it is noteworthy that this model was conceptualized and developed within the African context and Nigeria to be specific, thereby addressing both the epidemiological and ecological dimensions pertinent to the study's geographical focus. This contextual alignment is crucial, as it allows for an authentic representation of the local health-seeking practices without necessitating extensive modifications that could compromise its validity and foundational integrity.

In addition, the model sheds light on the factors contributing to medical pluralism, which is particularly relevant to individuals' pursuits of health restoration. It delves into the intricate interplay of cultural beliefs, cognitive frameworks, and socio-political power dynamics, elements that serve as the central thesis of this research. By exploring how these factors influence the decisions individuals make about when, where, and how they seek healthcare, the model captures the complexities inherent in navigating the healthcare landscape. This nuanced exploration not only enriches our understanding

of health-seeking behaviour but also highlights the critical intersection of sociocultural determinants and health outcomes in diverse populations. The theoretical framework underpinning this model is constructed upon six fundamental assumptions, each of which highlights a critical aspect of the relationship between illness, culture, and healthcare.

Firstly, illness is perceived as an unwanted or undesirable phenomenon within African communities. This prevailing notion carries profound implications, as the societal stigma associated with illness often leads to marginalization of affected individuals. The prevailing societal values and beliefs dictate that health is synonymous with normative functioning, and deviations from this norm are frequently viewed with apprehension or disdain.

Secondly, the understanding of illnesses is mediated through a specialized language, often referred to as taxonomy, which is intricately tied to lay African culture. This language varies significantly across different social ecologies, reflecting the diverse cultural contexts that shape individuals' perceptions of health and illness in Africa. As such, the manner in which diseases are conceptualized and communicated is not static but rather fluid, evolving alongside shifts in societal values, knowledge, and practices aligned with the customs of the people. This highlights the complex interplay between culture and healthcare, as the discourse surrounding illness is rooted in the prevailing African cultural narratives of the time.

The third assumption posits that illnesses possess both micro (personal) and macro (social) functions, as well as dysfunctions. On the micro level, illnesses can serve as a catalyst for personal transformation, prompting individuals to reevaluate their priorities and relationships. Conversely, from a macro perspective, illness can have significant social implications, potentially influencing healthcare policy, economic stability, and community cohesion. Thus, the multifaceted nature of illness invites an exploration of its implications at both individual and societal levels, revealing the intricate connections that bind personal experience to broader social dynamics.

Moving to the fourth assumption, the conception of healthcare is inherently subjective, as it is influenced by personal beliefs, experiences, and cultural narratives. This subjectivity stands in contrast to the objective, scientific understanding of health that is often championed by medical professionals. It underscores the importance of recognizing that patients approach healthcare not merely as passive recipients of medical expertise but as active participants who bring their own perspectives, concerns, and preferences into the healthcare encounter.

Furthermore, the fifth assumption acknowledges that individuals suffering from illness possess cultural knowledge and insights regarding the etiology of their

Stage 1: Symptoms Experience

An examination of the initial phase in HSB. The phenomenon of health-seeking behaviour encompasses a series of steps individuals undertake in response to their health status, particularly when they face a decline from a previously healthy state to one marked by illness. The inception of this process is characterized by the "Symptoms Experience," which represents the initial stage in an individual's journey toward regaining health. During this phase, the person begins to notice atypical manifestations or signs indicative of bodily dysfunction. Notably, this stage serves as a crucial precursor to the subsequent decisions and actions an individual may take in pursuit of medical assistance or self-care interventions. The Symptoms Experience is underpinned by four essential analytical phases, each contributing uniquely to the individual's understanding of their health condition. The first of these phases is the "Physical Experience Phase." In this phase, the individual begins to recognize a degree of physical weakness that disrupts their ability to execute daily social roles effectively. These roles encompass a range of responsibilities and activities that are typically performed with relative ease and confidence. However, the emergence of a new and unfamiliar sense of physical inadequacy may impede their capacity to fulfill these obligations.

It is imperative to underscore that this physical weakness does not merely manifest as transient fatigue or tiredness; rather, it represents a more profound and atypical condition that signals a departure from the individual's normative state of health. During this period, the individual may not immediately associate their experiences with the presence of a medical ailment, as the signs observed at this stage are often subtle and may not overtly present as recognizable symptoms have associated with illness.

Moreover, an individual's perceptions of physical weakness are significantly influenced by their subjective cultural knowledge and the sociocultural framework within which they reside. This cultural context plays a vital role in shaping how symptoms are interpreted and classified. For example, what might be universally acknowledged as signs of illness in one culture could be viewed differently in another, depending on regional beliefs, practices, and understandings of health. Therefore, individuals draw upon their culturally defined conceptions of health and illness to navigate their experiences, which in turn informs their recognition of what constitutes a health problem.

Thirdly, we arrive at what can be identified as the cognitive phase of symptom experience. This phase is fundamentally concerned with the cultural significations attributed to the individual's emotional responses associated with certain categories of symptoms. In this context, it is essential to recognize that these culturally informed meanings must be internalized by the individual,

who begins to perceive specific physical sensations as indicative of a health issue. The cognitive processing of these symptoms transforms them into a subjective problem, one that the individual must contend with in their understanding of personal health. In this stage, an individual's capacity to recognize and conceptualize bodily dysfunction as a legitimate concern plays a pivotal role in eliciting emotional responses such as anxiety. This anxiety arises from a natural human inclination to avoid discomfort and to pursue experiences that are pleasurable. The recognition of symptoms as problematic ultimately compels individuals to seek solutions or interventions, thus marking a critical transition into the subsequent phase of the symptom experience.

The final phase is characterized by what can be termed the emotional response phase. Within this stage, the interplay between anxiety and fear becomes particularly pronounced, as individuals grapple with their health concerns. This heightened emotional state drives them to seek resolution, often leading to the exploration of various potential responses or interventions. The choices they make regarding the management of their symptoms are heavily influenced by their personal interpretations of cultural definitions, beliefs, and prevailing knowledge concerning the symptoms they are experiencing. Understanding this phase not only highlights the intricate nature of personal health experiences but also emphasizes the importance of cultural factors in the assessment and acknowledgment of symptoms that signal a departure from health which will lead to the next stage.

Stage 2: Self-Medication and Treatment

In this second stage of the health-seeking process, the individual embarks on a journey of self-medication and self-treatment. This phase is activated immediately upon the individual's successful identification and labeling of a symptom as a minor health issue that can be managed without the immediate intervention of a healthcare professional. The ability to appropriately label these symptoms is significantly influenced by the individual's cultural knowledge and beliefs, which are derived from a combination of personal experiences, societal narratives, and culturally defined understandings of health and illness. Such frameworks guide individuals in categorizing their experiences of symptoms and deciding upon appropriate responses.

At this juncture, the individual has not yet reached a definitive conclusion that they are unwell in a significant or alarming manner; instead, they acknowledge the presence of a minor health concern that warrants attention. Their actions are indicative of a thoughtful approach to health management, highlighting their inclination toward autonomy and self-efficacy in addressing perceived health challenges. The engagement in self-medication typically

involves familiar remedies, over-the-counter medications, or alternative treatments that are easily accessible and culturally endorsed.

It is important to note that during this stage, the experience of symptoms is predominantly internalized by the individual. The associated dysfunctions in their social roles or everyday activities may remain largely unnoticed by others, as these issues may not be openly communicated. Consequently, individuals may navigate their discomforts and health challenges in solitude, opting not to inform family members, friends, or colleagues about their condition. This self-reliance reflects a common tendency to manage minor health problems privately, reinforcing the notion that such problems are manageable without recourse to professional medical assistance.

This self-treatment phase persists until the individual reaches a critical awareness, prompting a reevaluation of their initial strategy. This turning point occurs when the individual begins to perceive that the self-medication efforts do not yield the desired relief or improvement in symptoms. Alternatively, if the symptoms intensify or manifest in unexpected ways, this realization often catalyzes the transition to the next stage in the health-seeking process. At this point, the individual may find it imperative to seek advice or intervention from close associates in addressing their health concerns which lead to the next stage.

Stage 3: Communication to Significant Others

In the third stage of this process, a pivotal development occurs: the communication of the individual's struggles to significant others, encompassing both verbal and non-verbal exchanges. This communication may manifest in various forms, some of which could be voluntary, while others may occur involuntarily, driven by the observable changes in behaviour or psychological state. Close relatives and friends, often attuned to the nuances of the individual's social role, begin to sense that something may be amiss. These significant others may not only notice changes in the individual's demeanor, but they may also perceive a broader dysfunction in the way the individual engages with their environment, ultimately prompting deeper conversations concerning the individual's well-being.

At this juncture, the situation expands from a singular experience to a communal one, as the family and friends engage in discussions aimed at understanding the individual's condition. The individual experiencing the symptoms often seeks clarity regarding their illness; they may express a desire to comprehend the nature of their situation better and actively listen to a variety of interpretations and explanations provided by their close contacts. This interaction can be crucial, as the significant others, armed with their unique perspectives and insights,

may offer the individual a sense of validation and support during a confusing time.

Additionally, various lay referral options and self-medication strategies may come into play, especially if the individual has yet to explore these avenues. This could involve suggestions for alternative therapies, lifestyle adjustments, or even informal remedies that family members believe could alleviate some of the individual's symptoms. As these conversations unfold, it is common for the family to deliberate on the effectiveness of any home treatments that have been instituted previously, thereby facilitating a collaborative approach to understanding the challenges faced by the individual. These ongoing discussions not only serve to solidify familial bonds but also lay the groundwork for the crucial next stage.

Stage 4: Assessment of Symptoms

Transitioning to the fourth stage, the assessment of symptoms becomes a collaborative effort, primarily involving the individual's significant others, such as family members and close friends. During this critical phase, they engage in a comprehensive evaluation of the symptoms that have been manifesting in the individual. This assessment process is not merely observational; it involves a systematic gathering of information regarding the individual's behaviour, emotional responses, and overall functionality within their daily life.

Through this evaluative dialogue, two major conclusions typically emerge. The first conclusion often pertains to the recognition of the severity and impact of the symptoms on the individual's daily functioning and social interactions. This provides the family with essential insights regarding the necessity for further intervention or professional assistance. The second conclusion frequently centers around the effectiveness of current home remedies and self-management strategies that have been attempted thus far. This dual-pronged assessment process is pivotal, as it not only aids in clarifying the individual's needs but also fosters a sense of collective responsibility among family members, driving them toward potential solutions or the exploration of professional medical guidance if warranted that leads to the next stage.

Stage 5: Assumption of the Sick Role

Once an individual receives a tentative diagnosis that is subsequently confirmed, they enter a pivotal stage characterized by the assumption of the sick role. In this context, the individual gains access to a set of rights, privileges, and responsibilities that are socially prescribed for those identified as ill within their particular community. These rights often include exemptions from certain social roles and responsibilities that the individual is traditionally expected to fulfill. For instance, they may be relieved from work obligations, communication duties, or familial

responsibilities, depending on the gravity and nature of their illness.

The extent of these social role exemptions is frequently proportional to the severity of the individual's health condition; that is, the graver the diagnosis, the broader the range of social exemptions afforded to the affected individual. In this sense, the sick role is not solely dependent on the clinical evaluation of the illness but is also significantly influenced by cultural beliefs, societal norms, and the prevailing interpretations associated with the symptoms presented. This indicates that the perception of illness within specific cultural contexts can profoundly shape the experiences and expectations of both the sick individual and their social circle.

However, the enactment of the sick role often precipitates a disruption within the social fabric of the individual's surrounding. Specifically, as the affected individual temporarily withdraws from their conventional responsibilities, other family members, friends, colleagues, and the broader community are often tasked with the burden of compensating for the roles that the sick individual can no longer fulfill. This redistribution of duties can lead to feelings of tension and imbalance, as those who take on additional responsibilities may experience stress or resentment, particularly if they perceive their efforts as unacknowledged or undervalued.

Moreover, the implications of assuming the sick role are multifaceted and can lead to strained relationships and altered dynamics within various social units. The community's response to the sick individual may also vary, influenced by prevailing cultural attitudes toward illness and health, which could either foster a supportive environment or compound the feelings of isolation and stigma. As the individual navigates this phase, interactions with healthcare providers also become critical, as their cooperation with health personnel can affect not only treatment efficacy but also the perceived legitimacy of the sick role.

This complex interplay of social dynamics and individual experience culminates in what can be viewed as a transitional phase, setting the stage for the next developmental step in the process of coping with illness. The next stage will delve into the intricate examination of how individuals negotiate their identities and roles in light of their health challenges.

Stage 6: Expression of Concern by Kin, Friends, and Close Neighbours

The sixth stage in the illness episode reflects a significant turning point that marks the formal commencement of the individual's health crisis. During this critical period, the sick individual becomes the focal point of attention and concern from a network of close relatives, friends, and Neighbours. This manifestation of care is vital, as it fosters an environment of support that is essential for

psychological and emotional well-being. In many cultures, including among the Gbagyis, community involvement is particularly pronounced. Relatives and friends engage actively in providing food, necessary supplies, and emotional support that the ailing person is unable to procure due to their illness and the consequent incapacitation from fulfilling their usual social roles.

For instance, it is customary within the Gbagyi culture for kin and friends to ensure that the sick individual has access to nourishing meals and other essential items that facilitate recovery, as these responsibilities typically fall upon the patient in times of good health. The implications of such expressions of concern extend beyond mere physical assistance; they are laden with cultural significance, serving as a demonstration of solidarity, empathy, and moral encouragement. The visitation rituals encompass not only the provision of material goods but also emotional support, creating a sense of unity and shared concern among the community members.

The duration of this expression of care is contingent upon the health status of the individual, persisting until they achieve full recovery and are successfully reintegrated into the social fabric of their community. It is important to note that the awareness of the individual's illness often transcends the immediate family circle, reaching a wider audience among friends, Neighbours, and other acquaintances. This broader recognition of the individual's health challenges lays the groundwork for collective support and advocacy. During these visits, discussions frequently include suggestions for alternative or traditional treatment options, which can serve as informal referrals to other community sources of care. Such interactions not only provide practical advice but also facilitate a deeper exchange of knowledge about the illness and its potential remedies.

As the community rallies around the sick individual, the importance of emotional support cannot be overstated. These gatherings reinforce the bonds between the sick person and their immediate social circle, helping to mitigate feelings of isolation, anxiety, and fear often associated with illness. The intermingling of emotional support and practical assistance during this stage is instrumental in promoting recovery and nurturing resilience. Ultimately, this stage serves as a precursor to the subsequent phase of the illness episode, where a thorough assessment of potential treatment options will take place, signaling a critical transition in the trajectory of the individual's health journey.

Stage 7: Assessment of Probable Efficacy of or Appropriateness of Sources of Treatment

Every culture possesses its own unique framework for evaluating the efficacy and suitability of various treatment modalities. This assessment process, crucially informed by both traditional beliefs and contemporary medical

practices, reflects the cultural underpinnings that guide health-seeking behaviour within a community. When a member of the community falls ill, the subsequent discussions that arise during the expression of concern phase often lead to collective deliberations about the most appropriate and effective sources of treatment available. Such deliberations are heavily influenced by cultural beliefs, individual experiences, and the availability of resources, which shape the decision-making process regarding health interventions.

In this stage, individuals and families navigate a complex landscape of treatment options, weighing the merits of conventional medicine against traditional healing practices. The degree to which these treatment modalities are considered appropriate can vary significantly across different sociocultural contexts, as they are often rooted in historical narratives and local understandings of health and wellness. The communal aspect of this evaluation process serves to validate the concerns of the sick individual while also promoting engagement with various forms of care, thereby enhancing the likelihood of adherence to the chosen treatment path that leads to the next stage.

Stage 8: Selection of Treatment Plan

In the eighth stage of the healthcare process, a critical decision is made regarding the selection of a treatment plan from the diverse array of options that are available. This selection process is undertaken with careful consideration of various factors, which encompass both the costs and benefits associated with each potential treatment modality, while also taking into account the resources that are accessible within the community. Within the context of the Gbiri-Naa ethnic group, the treatment selection phase involves evaluating several key considerations, including the availability and expertise of traditional healers, the accessibility of orthodontists, and their respective proximity to the patient's location.

Moreover, the nature of the ailment is paramount in guiding the choice of treatment, as it may be classified either as a spiritual affliction or through a more conventional medical lens that aligns with widely accepted definitions of physical illnesses. This distinction can significantly influence the treatment approach, as certain practitioners may be preferred based on the perceived spiritual implications of the condition. Additionally, the urgency of the medical situation, marked by the severity of the disease, plays an indispensable role in the decision-making process. A more critical or rapidly deteriorating health condition may necessitate a swift response, thereby prioritizing immediate intervention. Ultimately, the culmination of these considerations leads to the identification of the most suitable treatment plan, thereby facilitating the progression to the subsequent stage in the healthcare journey.

Stage 9: Treatment

The ninth stage marks the commencement of the treatment phase, during which the agreed-upon treatment plan is diligently executed by both the healthcare providers and the patient. This phase is crucial, as it involves a mutual commitment to the prescribed regimen designed to restore the individual's health. The patient is expected to adhere strictly to the treatment protocol, which may encompass a variety of interventions ranging from medication adherence to participation in specific therapeutic practices intended to promote recovery.

During the execution of this treatment phase, two distinct outcomes may arise. Firstly, there exists the potential for a tragic outcome in which the patient may succumb to their illness, effectively terminating the health-seeking process. Such an event would not only denote a loss for the individual and their family but could also resonate through the community, impacting collective perceptions of health and treatment efficacy. Alternatively, it is hopeful that the treatment will yield positive results, leading to the patient's recuperation and eventual return to health. This underscores the vital importance of empathetic care, comprehensive communication between care providers and patients, and the necessity of addressing both physiological and psychological dimensions of the illness. Thus, the treatment phase serves as a critical intersection between medical intervention and patient compliance, ultimately determining the trajectory of the patient's health and wellbeing.

Stage 10: Assessment of the Effects of Treatment on Symptoms

In the treatment process, Stage ten represents a critical phase that runs concurrently with the treatment stage itself. As the treatment regimen is administered, it is imperative for the patient's family members, caregivers, and healthcare professionals to closely monitor the patient's response to the prescribed therapy. This vigilant observation serves a dual purpose: it enables the identification of any improvements in the symptoms expressed by the patient, and it provides crucial feedback regarding the effectiveness of the chosen treatment strategy.

The primary objective of this assessment phase is to determine whether the treatment is achieving its intended outcomes. If the implemented treatment plan demonstrates a positive impact marked by a reduction or complete alleviation of symptoms, the patient is then considered ready to advance to the subsequent stage of recovery and rehabilitation. This transition is pivotal, as it signifies not only an improvement in the patient's health status but also an opportunity to reintegrate into normal life activities with enhanced well-being.

Conversely, if the assessment reveals that the treatment is failing to produce the anticipated results or if the patient experiences a worsening of symptoms, a reevaluation of the treatment strategy is necessitated. In such cases, the process will revert back to Stage 7, which involves a critical assessment of the treatment's probable efficacy and the appropriateness of the selected therapeutic modalities. This reexamination is particularly prevalent in instances of chronic illnesses, where treatment effectiveness may fluctuate over time and necessitate the development of a new treatment protocol.

During this stage of re-assessment, healthcare providers collaborate with the patient and their support network to undertake a comprehensive review of the treatment plan. This evaluation may lead to the identification of alternative therapeutic options or adjustments to the current regimen that better align with the patient's unique medical profile and treatment response. The iterative nature of this process highlights the importance of patient-centered care, where the subjective experiences and cultural backgrounds of patients are taken into account when formulating a revised treatment approach.

Ultimately, this ongoing cycle of assessment and adaptation ensures that patients receive the most effective and appropriate care possible, reflecting a commitment to optimizing health outcomes in a manner that respects individual experiences and cultural perspectives. This adaptive methodology not only aids in addressing immediate health concerns but also in fostering long-term wellness and resilience among patients navigating the complexities of chronic illnesses that leads to the next stage.

Stage 11: Recovery and Rehabilitation

In this pivotal stage of the health-seeking behaviour model, the individual grappling with illness begins to experience a substantial positive shift in their overall health status as a result of the treatment received. It is during this phase that the patient typically starts to exhibit discernible signs of recovery from their condition, which may manifest in various forms, such as a reduction in symptoms, an increase in energy levels, or an overall sense of well-being. As the healing process unfolds, the sick individual often reaches a point where they no longer experience any lingering symptoms associated with their illness.

Upon achieving complete recovery, the individual is able to resume their social roles and responsibilities, often reintegrating into their personal and professional spheres with renewed vigor and capability. This successful return to daily life signifies the closure of the recovery cycle within the context of the health-seeking behaviour model proposed by A.U. Igun in 1979, which meticulously delineates the various stages encountered during an episode of illness.

It is essential to underscore that the progression through the stages of this model does not always occur in a linear or chronological fashion. In fact, some illness episodes may conclude prematurely at the self-treatment stage, where individuals independently attempt to manage their symptoms without seeking professional medical intervention. Others may terminate at the stage of expressing concern, wherein individuals acknowledge their health issues but may not take decisive action to obtain treatment.

Moreover, in the case of chronic illnesses, it is not uncommon for individuals to experience regressions to earlier stages of the health-seeking behaviour model. Such reversals can occur at various points throughout the illness episode due to fluctuating symptoms or changing personal circumstances, necessitating a reevaluation of treatment strategies until satisfactory corrective measures are identified and implemented.

Discussion

The General Appraisal of the Model

The appraisal is made under the following themes: cultural/structural dimensions and iterative nature.

Cultural/Structural Dimensions

Igun's model situates health-seeking within the broader social and cultural structure. It assumes that individuals act as rational but socially embedded agents whose decisions are shaped by communal values, kinship obligations, and religious beliefs. Health-seeking is therefore both an individual and collective process. Moreover, Igun's framework integrates structural constraints such as distance to healthcare facilities, gender roles, and economic resources that influence care trajectories (Isiugo-Abanihe, 1994; MacKian, 2004).

Iterative Nature and Feedback Mechanism

A distinctive feature of Igun's model is its iterative nature. Unlike Suchman's linear model, Igun's stages allow for back-and-forth movement depending on treatment outcomes and changing illness perceptions. This iterative process better represents real-life experiences in rural African settings, where patients may oscillate between biomedical and traditional systems before achieving recovery (Oberoi & Kaushal, 2016).

Applying Igun's Model of Health-Seeking Behaviour in the Understanding of African Communities HSB Rationale

Igun (1979, 1987) provides one of the most influential models explaining African treatment pathways. His work reveals that individuals do not seek healthcare randomly but follow structured and predictable patterns, shaped by the perception of illness causation, expected efficacy of the provider, accessibility and affordability, social legitimacy of the healing option, advice from family or community actors

Generally, the authors extracted the following as key ideas from Igun's model. First are the sequential treatment

pathways that sees the patients as often start treatment at the most accessible or culturally appropriate provider and shift to others only if recovery fails showing the weak efficacy of the treatment regimen. This is a commonsense risk-reducing strategy normally employed by African traditional societies. Second is medical pluralism where both modern and traditional systems coexist, and individuals strategically combine them with the belief of seeking care. Combining many treatments at a time is not confusion or illiteracy but a rational choice based on preconceived schema, health seeking determinants and existing illness knowledge strictly derived from the indigenous setting.

Third is the availabilities of socio-culturally rational guided choices. Decisions are often influenced by kinship networks, elders, neighbours, and healers (significant others). This reflects African communalism, where illness is interpreted socially, not individually. Fourth, there is a trial-and-error logic attached to treatment efficacy. If a treatment fails, it is commonsensical to try another option available. People move along the therapeutic continuum until the illness is resolved. Fifth, illness interpretation determines provider choice. If a child convulses at night, many parents due to the cultural belief (cultural knowledge) interpret it as spiritual attack. Common sense in this worldview says: Go to a traditional healer first, not a biomedical clinic. Sixth, comparative cost and accessibility shapes sequential care. People initially use cheaper, familiar remedies from the first attempt to health seeking. If symptoms persist, they subsequently escalate to a more expensive, sophisticated or specialized care providers. This strategy is economically rational which culminates most nature of African HSB.

Seventh, there is the issue of social validation of treatment choices. Treatment options and choice were never spontaneous but African extended families commonly influence decisions guided by existing cultural evaluation of the illness episode. It is general cultural norm in African communities for a person to follow and respected elders' suggestions most especially when rooted in experience and knowledge. Eighth, there an intended therapeutic mobility in African societies that ensures and prevents resource wastage. This is done by trying multiple providers until one works is practical. Igun observed that individuals in Africa rarely abandon treatment entirely, they continue seeking help until relief is achieved. Thus, Igun's Model demonstrates that African HSB is neither primitive nor uninformed—it is logical, structured, and culturally grounded.

CONCLUSION

This paper examined health-seeking behaviour through the lens of U. A. Igun's (1979) descriptive model, situating it within broader theoretical frameworks. Igun's eleven-stage process remains a seminal contribution that

contextualizes illness behaviour within African social realities. More so, the paper was able to show that HSB in traditional African societies is a complex process influenced by cultural beliefs, perceived causes of illness, social relationships, economic realities, and expected treatment outcomes. In African traditional settings, HSB is shaped by a holistic worldview and often follows predictable pathways explained by Igun's model. The model rationalizes how individuals move between traditional, spiritual, and biomedical providers using commonsense reasoning that reflects lived realities. Understanding these conceptual foundations is crucial for designing valuable culturally sensitive health interventions insights for sociologists, public health researchers, and policymakers seeking to understand pluralistic health systems. By emphasizing the iterative and socially embedded nature of health decisions, the model challenges reductionist biomedical views and highlights the need for culturally sensitive health interventions as mostly in applicable to African traditional societies.

RECOMMENDATIONS

1. *Integration in Health Research:* Future sociological and public health research should incorporate Igun's model to analyze complex healthcare utilization patterns in plural systems.
2. *Policy Application:* Policymakers should design culturally grounded interventions recognizing iterative and multi-provider care-seeking pathways.
3. *Cross-Model Synthesis:* Scholars should explore hybrid models combining Igun's descriptive stages with contemporary explanatory approaches, enhancing both theoretical and practical relevance.
4. *Educational Use:* Incorporating Igun's model into medical sociology curricula can deepen students' understanding of socio-cultural determinants of health most especially in complete traditional societies whom were closely attached to their traditional healthcare systems.

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