



<http://www.diva-portal.org>

Postprint

This is the accepted version of a paper published in *The Australian journal of rural health*. This paper has been peer-reviewed but does not include the final publisher proof-corrections or journal pagination.

Citation for the original published paper (version of record):

Ge, L., Wikby, K., Rask, M. (2016)

‘Is gestational diabetes a severe illness?’: exploring beliefs and self#care behaviour among women with gestational diabetes living in a rural area of the south east of China.

The Australian journal of rural health

<http://dx.doi.org/10.1111/ajr.12292>

Access to the published version may require subscription.

N.B. When citing this work, cite the original published paper.

Permanent link to this version:

<http://urn.kb.se/resolve?urn=urn:nbn:se:lnu:diva-52899>

1 **“Is gestational diabetes a severe illness?” exploring beliefs and self-care behaviour among**
2 **women with gestational diabetes living in a rural area of the south east of China**

3
4 **Abstract**

5 **Objective:** This study explores beliefs about illness and health and self-care behaviour among women
6 with gestational diabetes living in a rural area of the south east of China.

7 **Design:** A qualitative exploratory study using semi-structured interviews and qualitative content
8 analysis.

9 **Setting:** A hospital located in the outskirts of a city in the south east of China.

10 **Participants:** Seventeen women with gestational diabetes in 34-38th pregnant weeks.

11 **Results:** The beliefs about gestational diabetes among the women in the present study were found to
12 be bidirectional. Some of them feared the illness and its negative influence on health, while others
13 believed that it was not a severe illness and disbelieved the diagnosis of gestational diabetes. They
14 related their illness and health to the individual, social and natural factors. They mainly sought help
15 from the professional sector, but did not fully comply with the professionals' advice. Diet control and
16 exercise were their main self-care measures, but none of them self-monitored their blood glucose.
17 They demonstrated their misunderstanding about diet control and self-monitoring of blood glucose.

18 **Conclusions:** This study highlighted the serious lack of knowledge, lower level of risk awareness and
19 poor self-care behaviour among women in this group. Health professionals were found to be the most
20 important source of knowledge about gestational diabetes for these women. The influence of Chinese
21 culture was demonstrated. Gestational diabetes among these women can most likely be improved by
22 training the health professionals and by health education involving individuals, families, and the rural
23 communities.

24
25 **KEY WORDS:** gestational diabetes, beliefs and behaviour, health education, rural, China.

26
27 What is already known on this subject:

- 28 ● The prevalence of gestational diabetes is 4.3% and is increasing in China.

29 ● Some individual beliefs about illness and health may lead to inadequate self-care behaviour and
30 thus fail to meet health targets.

31 ● Beliefs about illness and health among urban Chinese women with gestational diabetes could
32 affect self-care behaviour, and thus influence health.

33

34 What this study adds:

35 ● The beliefs about gestational diabetes among the women in the present study were found to be
36 bidirectional. Some of them feared the illness and its negative influence on health, while others
37 believed that it was not a severe illness and even disbelieved the diagnosis of gestational diabetes.

38 ● This study highlighted the serious lack of knowledge, lower level of risk awareness and poor self-
39 care behaviour among the women in this group.

40 ● Gestational diabetes among these women can most likely be improved by training the health
41 professionals and by health education involving individuals, families, and rural communities.

42

43 **Introduction**

44 The prevalence of gestational diabetes mellitus (GDM) is 4.3% and is increasing in China.¹ GDM is
45 independently associated with adverse pregnancy outcomes and between 30% to 70% of women
46 manifesting GDM will go on to develop type 2 diabetes mellitus (T2DM).² GDM can be adequately
47 controlled with dietary modifications and increased physical activity², which will change the lifestyles
48 of women with GDM. A study showed that women's ability to follow a healthy lifestyle was
49 influenced by their beliefs and was embedded in the socio-cultural contexts of their lives.³

50 The transition between illness and health exists in the fundamental life patterns of human being.
51 Beliefs about illness and health are closely tied to beliefs about treatment and health-related
52 behaviour⁴, which is a central cognitive structure of every health care system.⁵ A recent metasynthesis
53 showed that women feared GDM and believed themselves to be likely develop T2DM over time,
54 while others believed GDM to be temporary and were unaware of any future risk.⁶ Native Swedish
55 women^{7,8} with the former beliefs more frequently searched help and advice from professionals and
56 used medications against pregnancy-related complications than Middle-Eastern-born women⁷ and

57 African-born women⁸ living in Sweden with the latter beliefs. Chinese urban women feared the
58 negative influence of GDM, but some of them believed in “letting nature take its course” and “living
59 in the present”. They sought a balance between following professionals’ advice and avoiding practical
60 difficulties.⁹

61 In China, according to the division regulation of the urban and rural area used by National Bureau
62 of Statistics, the rural area refers to the area out of the whole administrative area of city with district
63 establishment, city without district establishment, town, and township,¹⁰ which is designated by the
64 State Council of the People’s Republic of China.¹¹ The health system development in rural areas has
65 lagged behind that of urban areas nowadays.¹² There are also deficiencies in the quality and quantity of
66 the medical workforce in economically less developed areas, especially at the village level.¹³
67 Socioeconomic differences¹⁴ and differences in health care provider⁵ can influence patients’ beliefs
68 and self-care behaviour. It could thus be hypothesised that the beliefs and self-care behaviour of
69 women with GDM living in the rural areas are different from those of women living in the urban areas
70 in China. However, to our knowledge, no previous study has explored those among women with GDM
71 living in rural areas in China. The aim of this study was thus to explore beliefs about illness and health
72 and self-care behaviour among women in this group.

73

74 **Methods**

75 A qualitative exploratory study was conducted with semi-structured individual interviews. The
76 study was approved by the Ethics Committee of a university in the south east of China, and was
77 conducted according to the Declaration of Helsinki.¹⁵ The interviews were carried out at a hospital
78 located in the outskirts of a provincial capital city in the south east of China. Women with GDM from
79 rural areas were in the catchment areas of the obstetric clinic or ward at this hospital.

80 The study used purposeful sampling¹⁶ seeking women from high, medium and low educational
81 backgrounds.¹⁷ Inclusion criteria were age \geq 16 years, diagnosis of GDM¹⁸, 34-38th gestational weeks,
82 living in a rural area, and speaking Mandarin Chinese without speech impediment. Seventeen
83 participants accepted the invitation and were interviewed whose median age was 27.5 (range 21-37)

84 years, comprising six women with a high educational level, five with a middle educational level and
85 six with a low educational level (Table 1).

86 ---INSERT TABLE 1 HERE---

87 Data were collected between April and July of 2013 by using an interview guide that had been used
88 in a previous study⁹ (Table 2). The first author (a native female Chinese who is a teacher of maternal
89 care with bilingual skills) interviewed these women in a room at the hospital after the written informed
90 consents were obtained. The interviewer was not involved in the work of the obstetric clinic and ward.
91 Each interview lasted between 40~60 minutes and was documented with a digital audio recorder, and
92 then was transcribed verbatim in Chinese and translated from Chinese to English by the first author.

93 ---INSERT TABLE 2 HERE---

94 Data were analyzed by using qualitative content analysis¹⁹, which includes inductive category
95 development and deductive category application. Firstly, during the process of inductive category
96 development, each sentence of the text was read several times. Categories were formulated and then
97 were condensed into main categories by combining similar meanings. The main categories were
98 summarized in order to gain a holistic picture. Secondly, the categories from the lay theories of illness
99 causation⁴ and the model for care-seeking behaviour⁵ were used as the categories of the text analysis
100 during the process of deductive category application (See examples in Table 3 and Table 4). The
101 analysis process and the cultural issues were discussed between authors.

102 ---INSERT TABLE 3 and 4 HERE---

103

104 **Results**

105 **Beliefs about illness and health**

106 In the present study, some women felt fear when they received the GDM diagnosis, and especially
107 concerning the potentially negative influence of the illness on the health of their babies such as
108 abnormalities, large babies, neonatal hypoglycemia. A woman cried when she was interviewed
109 because she felt stigmatized from her family because of GDM: “My mother-in-law phoned relatives
110 and told the villagers that my baby was not healthy because I had GDM...” However, some of them
111 doubted the diagnosis because they did not have any symptoms and they and their babies were

112 “normal” after conventional prenatal checks. They said that GDM was not a severe illness.

113

114 I discussed with my colleagues who’d been pregnant after I came back from hospital. All of them
115 felt the illness wasn’t severe, and so I took it easy and didn’t ask the doctor until the next visit for
116 antenatal care.... My sister-in-law had GDM, but she and her baby didn’t have any problems after
117 she gave birth, so I’m not feeling tense.

118

119 The women believed that the causes of GDM emanated from the individual world (IW), such as
120 incorrect dietary habits and heredity, while some also believed that stress (social world, SoW) and
121 medications (natural world, NW) were among the causes (Table 3). Most of the women did not have
122 any knowledge about the pathogenesis of GDM, while a few women spoke of limited knowledge
123 about hormones, insulin and blood glucose.

124 In prognostic terms, almost all women thought that they would recover after delivery, but more than
125 half of them thought that they would suffer from T2DM in the future. On the other hand some spoke
126 of not knowing about any future influence of GDM. Some did not expect their future health to be
127 affected by GDM, while others did not think about it because they let nature take its course or tried to
128 live in the present.

129 In terms of the beliefs of health, these women attributed health to the IW and SoW, such as
130 “money” and well-being (IW), as well as quality of life and “having energy to work and taking care of
131 family” (SoW). These women generally believed that diet control, exercise and having a good mood
132 (IW) were good for their health, and the NW in terms of a clean and quiet environment as well. They
133 also believed in the negative factors for health such as high blood glucose and unhappy mood (IW), as
134 well as the NW in terms of the polluted environment and food.

135

136 **Self-care behaviour**

137 All the women in the present study believed in the importance of the health professionals for their
138 GDM and mainly sought help from the professional sector - obstetricians. Their care-seeking behavior
139 varied between the professional sectors and the popular sectors such as colleagues. None of the

140 women sought help from the folk sector such as a folk healer (Table 4).

141 More than half of these women were satisfied with the professionals' advice, and thought that this
142 was the most important source of knowledge to help them reduce their blood glucose. Almost all
143 women used diet control and exercise in order to attain glycemic control. Some thought, however, that
144 the advice was too elementary and not sufficient. Half of them could not fully comply with the
145 professionals' advice due to such as the customary diet habit and the thoughts of "GDM was not a
146 severe illness". Some women feared that the diet control would lead to a nutrition deficiency for the
147 fetus, and thus influence the growth and development of the fetus. One woman talked about her diet
148 control, "I only eat cooked rice and vegetables".

149 None of the participants conducted self-monitoring of blood glucose, and most of the women said
150 that the obstetricians had not mentioned it at all. All of the women checked their blood glucose only
151 when they received conventional antenatal care. One woman demonstrated her thoughts about self-
152 monitoring of blood glucose:

153
154 I don't dare to do self-monitoring of blood glucose. I don't have enough knowledge about it...I test
155 my blood glucose in the hospital. The measurement by drawing blood from a vein is more accurate
156 than when pricking a finger. ...The result of the blood glucose monitor is not correct because it is
157 an electronic thing.

158
159 Furthermore, some women used individual measures to maintain health such as maintaining a
160 relaxed mood. Some spoke of using spiritual measures such as prayers, burning incense and
161 worshipping Buddha. While some used natural cures such as nutritional supplements and traditional
162 Chinese medicine. A few used household remedies such as chrysanthemum tea, soups based on plant
163 roots or some special foods.

164
165 **Discussion**

166 The present study added new knowledge that was the bidirectional beliefs about GDM among the
167 women with GDM living in a rural area in China. Some of them feared the illness and its negative

168 influence on health, while others believed that it was not a severe illness and even disbelieved the
169 diagnosis of gestational diabetes. The study also highlighted the serious lack of knowledge, lower
170 level of risk awareness and poor self-care behaviour among women in this group. They attributed
171 illness and health to the individual, social and natural factors. They believed that the professionals
172 were the important resources for their health and mainly sought help from the professionals, but they
173 did not fully comply with the professionals' advice. Diet control and exercise were their main self-care
174 measures, but none of the women used self-monitoring of blood glucose. They demonstrated their
175 misunderstanding about diet control and self-monitoring of blood glucose. The influence of Chinese
176 culture was demonstrated.

177 In the present study, women feared GDM and its negative influence on their own and their babies'
178 health. The result was similar to other studies, for example, north American indigenous women with
179 GDM had significant fear and anxiety surrounding the health and well-being of the unborn child and
180 the use of insulin injections.²⁰ The women in the present study attributed illness and health to the
181 individual factors such as wrong dietary habits, which demonstrated a belief in their own
182 responsibility for their illness and health⁴. This implied that it was possible for these women to take
183 the responsibility for controlling their GDM⁴. They also related their illness and health to the social
184 factors, especially the well-being of their babies and families. A study carried out in contemporary
185 China showed that family collectivism and mutual dependence were preferred to individualism and
186 continued to be the dominating family values.²¹ Another systematic review study showed that
187 husbands, partners and families play a vital role in facilitating GDM self-management.²² These women
188 in the present study also attributed illness and health to the natural factors such as the polluted food
189 and environment. It showed that it is necessary to provide information about how to reduce the
190 negative influence from the natural factors to these women during GDM education.

191 A study in Sweden showed that the stigma from GDM resulted in women hiding their condition and
192 even carrying out unhealthy behaviour in order not to attract other people's attention.²³ One woman in
193 the present study also experienced stigma from GDM. Health education about GDM in rural
194 communities might thus be necessary to make people understand women with GDM and provide
195 support rather than generating feelings of being stigmatized.

196 However, some women in this study doubted the diagnosis of GDM they had received and thought
197 that GDM was not a severe illness even after being informed by professionals about the harm to
198 themselves and to their babies. The reasons for this were that they did not perceive that they had any
199 symptoms, that they and their babies were “normal” after being checked in hospital, and that they had
200 seen other women with GDM and whose neonates did not have any problems generated by GDM.
201 Some similar views were also found in a study about the experiences of Australian women with GDM,
202 where the women’s disbelief regarding their diagnosis and the uncertainty in their perception of the
203 serious nature of GDM were described.²⁴ A lower level of risk awareness about GDM have been found
204 to be related to limited knowledge about the body and GDM,⁸ which was perhaps the reason why these
205 women in the present study believed that GDM was not a severe illness and even disbelieved the
206 GDM diagnosis.

207 All the women in the study believed that the professionals were the important resources for their
208 health and most of the women mainly sought help from the professionals. The need for the
209 professionals’ support among women with GDM was also highlighted in a systematic review article.²²
210 However, some women in the present study thought the advice from the professionals was not
211 sufficient, and most of women had not been informed about self-monitoring of blood glucose by the
212 professionals. A study showed that lower levels of health literacy and risk awareness of GDM might
213 relate to a risk for poorer self-management of GDM.²⁵ A similar finding could be seen in the present
214 study. For example, some women in this study lacked knowledge about GDM and thus believed that
215 diet control for GDM would affected their health and resulted in a nutrition deficiency in their babies,
216 so they did not well control their diet; some women controlled their diet by only eating cooked rice
217 and vegetables.

218 Gestational diabetes among these women can most likely be improved by training these health
219 professionals and by health education involving individuals, families, and rural communities. During
220 the process of health education about GDM, some misunderstandings about GDM diet and self-
221 monitoring of blood glucose need to be clarified; the information about how to reduce the negative
222 influence from the polluted food and environment also needs to be provided.

223 The present study is unique in terms of providing a voice for the disadvantage populations in

224 maternal health in China, i.e. women living in a rural area who are probably in the shadow of the
225 Chinese mainstream society. However, there are limitations in the study. The present qualitative study
226 used small sample size, so the findings can only represent these women in this study, not all women
227 living in rural areas in China. It is possible to transfer the findings to similar contexts,²⁶ and to be
228 served as a base for the further larger studies.

229

230 **Conflicts of interest**

231 The authors declare no conflict of interest.

232

233 **References**

- 234 1. Chinese Diabetes Society. China guideline for type 2 diabetes prevention and treatment in 2013.
235 Chinese Journal of Diabetes Mellitus 2014; 6(7): 447-521. In Chinese.
- 236 2. World Diabetes Foundation. Diabetes, Women, and Development: meeting summary, expert
237 recommendations for policy action, conclusions, and follow-up actions. International Journal of
238 Gynaecology and Obstetrics: The Official Organ of The International Federation of Gynaecology
239 and Obstetrics 2009; 104(Supplement): S46-S50.
- 240 3. Razee H, van der Ploeg H, Blignault I, Smith B, Bauman A, Wah Cheung N, et al. Beliefs, barriers,
241 social support, and environmental influences related to diabetes risk behaviours among women
242 with a history of gestational diabetes. Health Promotion Journal of Australia 2010; 21(2): 130-137.
- 243 4. Helman C. Culture, Illness and health. CRC Press, Taylor & Francis Group: Boca Raton, 2007.
- 244 5. Kleinman A. Patients and Healers in the Context of Culture. London: University of California Press,
245 1980.
- 246 6. Parsons J, Ismail K, Amiel S, Forbes A. Perceptions among women with gestational diabetes.
247 Qualitative Health Research 2014; 24(4): 575-585.
- 248 7. Hjelm K, Bard K, Nyberg P, Apelqvist J. Swedish and Middle-Eastern-Born women's beliefs about
249 gestational diabetes. Midwifery 2005; 21(1): 44-60.
- 250 8. Hjelm K, Berntorp K, Apelqvist J. Beliefs about illness and health in Swedish and African-born
251 women with gestational diabetes living in Sweden. Journal of Clinic Nursing 2012; 21(9/10), 1374-

- 252 1386.
- 253 9. Ge L, Albin B, Hadziabdic E, Hjelm K, Rask M. Beliefs about illness and health among urban
254 women with gestational diabetes in the south east of China. *Journal of Transcultural Nursing* 2015;
255 1-10. [Cited 30 Jan 2016]. Available from URL:
256 <http://tcn.sagepub.com/cgi/reprint/1043659615594677v1.pdf?ijkey=bzHqppAeBIrSpNC&keytype>
257 =finite
- 258 10. National Bureau of Statistics of the People's Republic of China. The division regulation of the
259 urban and rural area on statistics, July 2008. [Cited 1 Feb 2016]. Available from URL:
260 http://www.stats.gov.cn/tjsj/tjbz/200610/t20061018_8666.html
- 261 11. The State Council of the People's Republic of China. The rules of the State Council about the
262 management of administrative partition, March 2009. [Cited 1 Feb 2016]. Available from URL:
263 http://www.gov.cn/guoqing/2009-03/30/content_2617928.htm
- 264 12. Chen Z. Launch of the health-care reform plan in China. *Lancet* 2009; 373(9672): 1322-1324.
- 265 13. Anand S, Fan V, Zhang J, Zhang L, Ke Y, Chen L, et al. China's human resources for health:
266 quantity, quality, and distribution. *Lancet* 2008; 372(9651): 1744-1781.
- 267 14. Cai L, Dong J, Shu ZK, Lu YC, Tao J. Socioeconomic differences in diabetes prevalence,
268 awareness, and treatment in rural southwest China. *Tropical Medicine & International Health* 2011;
269 16(9): 1070-1076.
- 270 15. World Medical Association. World Medical Association Declaration of Helsinki: ethical principles
271 for medical research involving human subjects 2013. [Cited 30 Jan 2016]. Available from URL:
272 <http://www.wma.net/en/30publications/10policies/b3/index.html>.
- 273 16. Patton MQ. *Qualitative research and evaluation methods*. London: Sage Publications, 2002.
- 274 17. Ministry of Education of the People's Republic of China. Education Statistic Data in 2012. [Cited
275 30 Jan 2016]. Available from URL:
276 <http://www.moe.gov.cn/publicfiles/business/htmlfiles/moe/s7567/201309/156896.html>
- 277 18. Medical Service Specialty Standard Committee of Ministry of Health, China. Diagnosis criteria for
278 gestational diabetes mellitus (WS331-2011). *Chinese Medicine Journal* 2011; 125: 1212-1213. In
279 Chinese.

- 280 19. Mayring P. Qualitative Content Analysis. *Forum: Qualitative Social Research* 2000; 1(2): 105.
281 [Cited 30 Jan 2016]. Available from URL:
282 <http://www.qualitative-research.net/index.php/fqs/article/view/1089/2385>
- 283 20. Carson L, Henderson J, King K, Kleszynski K, Thompson D, Mayer P. American Indian Diabetes
284 Beliefs and Practices: Anxiety, Fear, and Dread in Pregnant Women With Diabetes. *Diabetes*
285 *Spectrum: a Publication of the American Diabetes Association* 2015; 28(4): 258-263.
- 286 21. Anqi X, Yan X. The Changes in Mainland Chinese Families During the Social Transition: A
287 Critical Analysis. *Journal of Comparative Family Studies* 2014; 45(1): 31-53.
- 288 22. Keygan J. The impact of gestational diabetes mellitus on the pregnant woman, her infant(s) and
289 family, midwifery practice and the health care system. *Nuritinga* 2013; (12): 12-23.
- 290 23. Persson M, Winkvist A, Mogren I. 'From stun to gradual balance'- women's experiences of living
291 with gestational diabetes mellitus. *Scandinavian Journal of Caring Sciences* 2010; 24(3): 454-462.
- 292 24. Morrison M, Lowe J, Collins C. Australian women's experiences of living with gestational
293 diabetes. *Women & Birth* 2014; 27(1): 52-57.
- 294 25. Carolan M, Steele C, Margetts H. Attitudes towards gestational diabetes among a multiethnic
295 cohort in Australia. *Journal of Clinical Nursing* 2010; 19(17/18): 2446-2453.
- 296 26. Polit DF, Beck CT. *Nursing research: generating and assessing evidence for nursing practice*, 9th
297 edn. Philadelphia: Wolters Kluwer Health/Lippincott Williams & Wilkins, 2012.

TABLE 1: *Characteristics of the interviewed women with GDM (n=17)*

Variable	Median (range)	Number
Age (year)	27.5 (21-37)	17
Recurrence in GDM		
Yes		1
GDM symptoms such as thirstiness and uorrhagia		
Yes		2
Present treatment for GDM		
Diet+exercise		15
Diet		2
Current medication such as		
Multivitamin, minerals, protein power		16
Nulliparous		11
Parous		6
Educational level[†]		
Junior Secondary Education (9 years)		6
Senior Secondary Education (12-13 years)		5
Higher Education (\geq 15 years)		6
Present working condition		
Employed		5
Unemployed		11
Sick leave		1
Family circumstances		
Married		16
Unmarried		1

[†]The classified standard of educational level is according to the education statistic data in 2012¹⁷

TABLE 2: *Questions in the interview guide*[†]

Beliefs about illness	1. What did you think when you were informed about having GDM?
	2. What do you think has caused GDM?
	3. What do you think about your own/your baby's future health related to GDM?
Beliefs about health	4. What does health mean to you?
	5. What factors are good for your health/your baby's health being as you have GDM?
	6. What are the negative factors for your health/your baby's health being as you have GDM?
Health-related behavior	7. Who did you seek advice or care from?
	5. What do you do for your health-related to GDM?
	6. Do you follow the advice you get? If not, why?

[†]The same interview guide as Ge et al.⁹

TABLE 3: *Beliefs of what causes GDM among Chinese women (n=17)*

Categories [†]	Definition [†]	Examples	<i>n</i>
The individual world (IW)	The origin of illness is mainly malfunctions within the body. The responsibility for the illness is mainly on the patients themselves.	Incorrect dietary habit Hereditiy Overweight Pregnancy Inactivity Pancreatic disease Imbalance between Yin and Yang	17 17 16 15 12 12 1
The social world (SoW)	The illness comes from interpersonal malevolence, or physical and psychological injuries.	Stress	7
The natural world (NW)	This includes aspects of the natural environment, both living and inanimate.	Medications	9
The supernatural world (SuW)	The illness is ascribed to the direct actions of supernatural entities, such as gods, spirits, or ancestral shades		

[†] In accordance with the lay theories of illness causation by Helman⁴

TABLE 4: *The care-seeking behaviour of Chinese women living in a rural area in China*

Categories [†]	Definition [†]	Care-seeking behaviour among Chinese women (n=17)	
		At first time	At second time
Professional sector	This comprises the organized, legally sanctioned healing professions. It includes not only physicians of various types and specialties, but also the recognized paramedical professions such as nurses, midwives and physiotherapists.	Obstetrician (15 cases)	Obstetrician (1 case) Medicine textbook (2 cases)
Popular sector	This is the lay, non-professional, non-specialist domain of society. It includes all therapeutic options that people use, without any payment and without consulting either folk healers or medical practitioners.	Colleague (1 case) Internet (1 case)	Friends (1 case) Relatives (3 cases) Internet (4 cases)
Folk sector	Certain individuals specialize in forms of healing that are either sacred or secular, or a mixture of the two. These healers are not part of the official medical system, and occupy an intermediate position between the popular and professional sectors.	(0)	(0)

[†] According to the model for care-seeking behaviour by Kleiman⁵