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Unveiling The Influence Of Culture On Healthcare Delivery In Sub-Saharan Africa

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Abstract: ***Historically, health practitioners used to work in communities with clients who had similar or same cultural and ethnic backgrounds to their own. However, with the changing dynamics of the world, the ethnic and cultural compositions of communities have now become cosmopolitan. Different cultures have different systems of health beliefs to explain what causes illness, how it can be cured or treated, and who should be involved in the process. The extent to which patients perceive patient education as having cultural relevance for them can have a profound effect on their reception to information provided by health practitioners, and their willingness to use that information. The question that then arises is: of what socio-cultural factors must a healthcare provider be aware when entering a community in contemporary sub-Saharan Africa? This article focuses on redirecting the mind of the health practitioner to how culture can - directly or indirectly - affect healthcare delivery. The paper proposes that medical practitioners should be willing to participate in lifelong learning that helps integrate the principles of orthodox medicine with the many beliefs and values of their clients.***

Keywords: Influence, Culture, Healthcare, Tradition, Herbal Medicine, sub-Saharan African

I. INTRODUCTION

Health is multidimensional. It is comprised of biological, mental, emotional, spiritual, and social components. Living a healthy life can be compared to living a good life: not because the two lifestyles are synonymous but rather because the lifestyles often depend on societal and individual's perceptions. And so we can also say that health is subjective; it is greatly influenced by human behaviour. Dhiman (2009) indicates that; whether it is intentional or not, human behaviour affects health promotion and disease prevention activities, in some instances increasing risk and in others reducing it. According to Heggenhougen, Hackethal and Vivek (2003), nothing can be accomplished without positioning the problem in social, economic, and political contexts as well as in a cultural one. People's behaviour and how socio-cultural factors affect their lives are equally crucial and constitute underlying risks for the spread of infection. Consequently, culture will inevitably shape the interpretive framework through which individuals and communities analyze health and healthcare. Culture has a very great impact on the health of the people. Human groups have often unwittingly facilitated the spread of infectious diseases through culturally coded patterns of behaviour (Inhorn and Brown, 1990). Sub-Saharan Africa offers a wealth of examples illuminating the importance of cultural considerations in the field of healthcare. And so I ask: of what socio-cultural factors must a healthcare provider be aware when entering a community in contemporary sub-Saharan Africa?

II. METHODOLOGY

This write-up is situated in the context of The Health Belief Model (HBM). The model was developed in the early 1950s by a group of social psychologists at the U.S. Public Health Service in an attempt to understand the widespread failure of people to accept disease preventives or screening tests for the early detection of asymptomatic disease (Rosenstock, 1974). It was later applied to patients' responses to symptoms (Kirscht, 1974), and to compliance with prescribed medical regimens (Becker, 1974; Kirscht, 1974). This indicates that the model is flexible enough to contain post-sickness afflicted health beliefs at the community or societal level. The model is made of the following constructs: Perceived susceptibility, Perceived severity, Perceived benefits, Perceived barriers, Self – Efficacy, Cue to action and Modifying Variables.

A. PERCEIVED SUSCEPTIBILITY

Individuals vary widely in their feelings of personal vulnerability to a condition (in the case of medically-

established illness, this dimension has been reformulated to include such questions as estimates of re-susceptibility, belief in the diagnosis, and susceptibility to illness in general'). Thus, this dimension refers to one's subjective perception of the risk of contracting a condition (Nancy and Marshall, 1984).

B. PERCEIVED SEVERITY

Feelings concerning the seriousness of contracting an illness (or of leaving it untreated) also vary from person to person. This dimension includes evaluations of both medical/clinical consequences (e.g., death, disability, and pain) and possible social consequences (e.g., effects of the conditions on work, family life, and social relations) (Ibid).

C. PERCEIVED BENEFITS

While acceptance of personal susceptibility to a condition also believed to be serious was held to produce a force leading to behaviour, it did not define the particular course of action that was likely to be taken; this was hypothesized to depend upon beliefs regarding the effectiveness of the various actions available in reducing the disease threat. Thus, a sufficiently-threatened individual would not be expected to accept the recommended health action unless it was perceived as feasible and efficacious (Ibid).

D. PERCEIVED BARRIERS

The potential negative aspects of a particular health action may act as impediments to undertaking the recommended behaviour. A kind of cost-benefit analysis is thought to occur wherein the individual weighs the action's effectiveness against perceptions that it may be expensive, dangerous (e.g., side effects, iatrogenic outcomes), unpleasant (e.g., painful, difficult, upsetting), inconvenient, time-consuming, and so forth (Ibid).

E. SELF – EFFICACY

Self–efficacy (Rosenstock *et al.*, 1988) is a person's belief in how capable he or she is of performing certain behaviour. It is correlated with different health–related outcomes such as headache reduction, weight management, substance use prevention and reduction, relapse prevention, reduction of anxiety, and contraceptive use (Bandura, 1990). In addition, research has demonstrated that manipulation of self–efficacy is an effective strategy for reducing health risk behaviours (National Institute of Mental Health, 2001). If someone believes a new behaviour is useful (Perceived benefit) but does not think he or she is capable of doing it (perceived barrier), chances are that it will not be tried.

F. CUE TO ACTION

Besides the four major models, HBM also suggests that behaviour is also influenced by cues to action. These are events, people or things that move people to change their behaviour. This so-called "cue to action" might be internal (i.e., symptoms) or external (e.g., mass media communications, interpersonal interactions, or reminder postcards from healthcare providers).

G. MODIFYING VARIABLES

The major constructs are modified by other variables, such us culture, past experience, education level, skills, motivation and diverse issues like, demographic, socio-psychological, and structural variables, which might in any given instance, affect the individual's perception and thus indirectly influence health-related behaviour.

III. WHAT THE HEALTHCARE PROVIDERS SHOULD EXPECT

The foremost consideration of any healthcare provider must be to determine how potential beneficiaries conceptualize health. Definitions of health and illness will in turn colour views on prevention and treatment. The belief system of people forms the basis of categorization of illnesses into serious, mild or mundane which in turn determines the promptness with which care is sought, withheld or even withdrawn; the type of care sought — home, traditional or modern; and the social network that will be involved in decision making for treatment seeking (Mwenesi *et al.*, 1995; Blaxter, 1983). The matter is complicated further by the fact that issues of health are woven into the social fabric of a community. They impact, and are impacted by a host of other factors. Health cannot be separated from class, religion, politics, or gender. A healthcare provider, especially one coming from outside the community, should be aware that simply making someone well is not always quite so simple. I will turn first to the ways in which health is defined in some sub-Saharan African societies, paying particular attention to the way those definitions shape attitudes towards treatment. Then, I will use the encounter between indigenous and Western medical systems in the colonial and post-colonial eras to highlight the fundamentally social nature of health and healthcare.

I begin this inquiry - as many inquiries into sub-Saharan Africa do - with gross overgeneralization. Sub-Saharan African societies are more likely than Western societies to place strong and explicit emphasis on the social dimensions of health and illness. Stressing the social aspects of health means that when an individual falls sick, the matter concerns not just the individual, but the community as a whole. A society's reaction to illness is directly connected to its perception of the cause or causes and the severity of the illness. Many African societies recognize not only natural causes of diseases, but also preternatural and mystical or magico-religious causes (Erinosho 1998: 19; Twumasi 1975:30). Sickness is not regarded exclusively as the product of a chance encounter between a human being and a malicious microorganism. In some cases, the affliction may be said to spring from the ill-will of an enemy witch, or the ire of the ancestors incurred by the sick person's own immoral actions. According to conventional wisdom among the Dagbamba of northern Ghana, "because the disordered body is the expression of

disordered social relations, healing consists of reunifying and reordering the entire group, of which the sick person is only an individual expression".

This social definition of health manifests itself in some African societies through aspects of the sick role, or the social norms regarding duties of, and towards an individual deemed to be unwell. For an Asante of Ghana to be considered sick for instance, the certification of an elder was required. Assignment of the sick role represented a commitment on the part of the patient's kin to support his treatment and on the part of the patient to return to work when better (Twumasi, 1975: 35). It is also asserted that *zâr* possession among women in Northern Sudan is essentially the instrumental assumption of a sick role on the part of a disgruntled wife. She makes a claim to illness as a way of expressing dissatisfaction with her husband, and because her assumption of the sick role is socially recognized, it generates social pressure for the husband to rectify the grievance (Boddy, 2001: 403).

Another instance in which health is located at the level of the community rather than at the level of the individual is offered by anthropologist Allen Roberts, who worked amongst the Tabwa of Zaire. Roberts examined the execution of two thieves who had burnt down a chief's home during a botched robbery attempt. He identified the execution as an instance of ritual medicine. The executioner - a prominent village medicine man - and the method of execution (being burnt alive) both reflected the community's utilization of symbolic means to restore a metaphorical balance to society, a balance which the thieves had disrupted with their crime (Roberts, 1997: 224).

Socio-cultural variables may also influence health priorities. One survey of women in the Volta Region of Ghana found that respondents cited psychological strains resulting from marital strife and economic insecurity as their most pressing health concerns (Avotri and Walters 2001). At the extreme, culture can mould biology. Conceptions of beauty which are closely related to conceptions of health are culture-bound labels. In the West, thinness represents health and beauty, but many African societies, such as the Yoruba, take the opposite view and see 'obesity' as a sign of good health. Menopause, to a certain extent, is also socially constructed. In Europe and North America, the end of menstruation is associated with stress and the manifestation of certain physical symptoms. In Africa, however, where post-menopausal women often enjoy more respect and liberty, menopause is characterized by much less physical discomfort (Erinosho, 1998: 209).

Like definitions of health, healthcare is also deeply embedded in cultural norms. Indigenous medicine, like Western medicine, tailors treatment specifically to diagnosis. A society's taxonomy of disease is closely related to its understanding of the causes of illness and appropriate treatment. Twumasi relates an anecdote from Ashanti in which a traditional healer traced the cause of a man's impotency to his sister, with whom he had been quarrelling. Upon further investigation, the sister confessed to stealing her brother's testacles and burying them in a cigarette tin beneath an anthill. The tin (and supposedly the testes) were recovered, and perhaps more importantly the brother and sister were reconciled. A year later, the brother's wife gave birth to their first child (Twumasi, 1975: 32).

The story is instructive for its portrayal of both diagnosis and treatment by a traditional healer. First, the close connection between individual and family health is especially apparent. Also of note is the versatility of the traditional healer. He needed to assume the roles of both physician and family counsellor to achieve a successful outcome. In societies where health is defined along multiple socio-cultural axes instead of being compartmentalized as strictly biological, the medical practitioner must draw upon a variety of different skill sets. In a study conducted in Kibaha district in Tanzania, severe malaria is often referred to as *degedege*. Most of the mothers avoid mentioning it because there is a cultural belief that it is a bad omen. They simply refer to it as childhood disease. On the perceived causes, three views emerged, the dominating one being that it is caused by the *shetani* (evil spirits) (Comoro et al., 2003). In Masaka, Uganda, *Omusujja* (Malaria) is believed to be caused by what is eaten or drunk and other environmental conditions (Kengeya-Kayondo et al., 1994). Similarly, inappropriate etiologic attributions of malaria in Ghana translate to certain preventive modalities, as respondents claimed that *Asra* (Malaria) caused by heat will continue to remain with them as far as sun continue to shine. However, *Asra* caused by food can be prevented by eating good food (Ahorlu et al., 1997). In the same study, some respondents reported that malaria couldn't be prevented as we are all born with it. Cerebral malaria is commonly classified as a distinct condition attributable to supernatural forces (Winch et al, 1996).

The examples indicate that an appreciation of social psychology coupled with an intimate knowledge of the lives of community members are essential tools of the traditional healer. A traditional healer may also be consulted for his or her medicinal knowledge. The definition of medicine in many sub-Saharan societies is inclusive, encompassing more than just substances ingested to alter the body's bio-chemistry. For instance, the Hausa of Northern Nigeria consider anything that serves to improve or to repair to be *magani* (medicine). Consequently, witchcraft is also regarded as a form of medicine in many African societies. Acoording to the Asantes of Ghana, there are two types of non-human powers, *suman* and *aduo*; the latter roughly translates as "medicine" and includes both pharmaceutical and herbal medicine (McLeod, 1975: 107-8).

Indigenous medicine may benefit from a considerable placebo effect, because the patient believes that the healer is mobilizing transcendental forces. As Twumasi notes, "the whole weight of the community - its religion, myths, history, and spirit - enters into the therapy" (Twumasi, 1975:35). The religious faith of people seeking the assistance of Christian and Islamic healers can be as potent a medicine as any prescribed in a hospital (Erinosho, 1998: 53). Indigenous healers have more than faith at their disposal. The herbs used by indigenous healers, though not researched, produced, and packaged by pharmaceutical companies, may still contain chemical compounds which work to physically prevent or suppress illness. Among the Hausa, laboratory testing has shown that many of the herbs used by traditional healers to

treat malaria have oxidative properties which inhibit the multiplication of the *Plasmodium* parasite in the body.

As the above examples have demonstrated in an impressionistic manner, the landscape of community health, from the vocabulary with which it is described to the paths by which community members navigate it, is profoundly shaped by socio-cultural considerations. I now seek to trace the implications for a practitioner of Western medicine coming into an African community. In this endeavour, I start from the beginning; from the first encounter between what I have been referring to as Western and indigenous medicines. I begin with colonialism.

As was characteristic of the colonial experience generally, where the indigenous and the Western medical systems met, the indigenous system was scorned, disrupted, and disarticulated. Through rapid urbanization, migrant labour, and the introduction of foreign diseases, colonialism triggered broad changes resulting in the deterioration of public health in sub-Saharan Africa (Vaughan, 1991: 301). Under the pressure of social change, indigenous healthcare systems became less viable. The deleterious effect of colonial policies might have been softened somehow had Africans been granted equitable access to Western medicine. The fruits of European medical science were, however, reserved primarily for Europeans, especially in the early colonial period (*Ibid*, 300). Where Western medicine was made available to Africans, access was uneven and provision emphasized curative methods, which were more expensive and less effective than preventative methods (*Ibid*, 308).

The effects of colonial political, economic, and social policies often had complex and unexpected effects upon public health. For instance, the colonial administration in Uganda conducted a sanitation campaign in Kampala focusing on the extermination of rats. Those rats, it turned out, had a high rate of resistance to the bubonic plague. Reducing their numbers opened an ecological niche for a new species of rat, one less resistant to the plague, which had entered the country on ships, engaged in the trade of cotton, a cash crop introduced by colonialism. The epidemiological consequence produced by the conjunction of these economic, political, and zoological phenomena was an outbreak of the bubonic plague in Kampala in 1920 (*Ibid*, 302-3). Our hypothetical health worker should take the lesson of that plague to heart: few are the aspects of community life that exist in isolation, that are wholly discrete, and that can be changed without influencing something else. Pull one thread, and the whole garment may unravel. Health is a social fact, and as such it is interlinked with all the other processes that enable a community to function.

IV. MODERNITY AND HEALTHCARE DELIVERY IN AFRICA

The "modernization" of African societies, including their health systems, which occurred during the late colonial and post-colonial periods has had similarly unexpected and at times unfortunate consequences. Diet, which we might also call a people's 'food culture', plays a key role, though often underappreciated, in sustaining health. The pepper common in West African dishes has been shown to have antiviral properties. Changes in diet, which often result from contact with a new culture, can affect public health. One study showed that grain offered as famine relief to one African country coincided with a sharp increase in malaria infection. The grain was enriched with Vitamin E, an antioxidant, which decreased the population's natural immunity. Before determining to bring local diet into line with a preconceived notion of healthy eating, our hypothetical health worker should first realize that local dishes can be repositories of community wisdom. He or she should not regard attitudes towards non-biological causes of illness as mere superstition which will fade with education. Even Twumasi (1975: 119), predicted that the spread of Western education would result in "an eclipse of traditional cosmology". Quite the contrary, in much of the region today, both traditional and Western medicine are regarded as legitimate. Beliefs in traditional medicine persevere through even high levels of Western medical education. A majority of Nigerian medical students in their final year of study expressed belief in a connection between mental illness and witchcraft (Erinosho, 1998: 45).

Unlike many proponents of Western medicine, many Africans do not regard Western and indigenous medical systems as mutually exclusive. Neither should our hypothetical healthcare worker. A nuanced understanding of community health will take note of the variety of factors which incline an individual to seek care from either the indigenous or Western medical establishment, or both. The therapeutic milieu, or the environment in which care is provided, may be a consideration in people's decisions. A traditional healer may be closer and therefore more accessible than a clinic. The patient may feel more comfortable in the home of a fellow community member than in the antiseptic waiting room of a strange doctor. Alternatively, Western medicine may be viewed as more effective because of its higher cost and distant location. A patient may turn to one type of medicine when the alternative has failed to deliver the desired results. This is particularly common in the case of mental illness in Ghana, where the Western medical establishment because of insufficient capacity and inferior methods could not often match the effectiveness of traditional healers in resolving such complaints (Twumasi 1997: 106-8).

Public health interventions must take account of a diversity of cultural issues. Different health issues have different meanings in different contexts. Witchcraft provides a good example of the inter-sectionalism of health with religion, class, gender, and politics. Prosperous older women lacking strong kinship networks are especially vulnerable to accusations of witchcraft. McLeod has argued that antiwitchcraft cults became more frequent in Asante after the British weakened the Asantehene's political power, and by extension, his ability to prevent such cults from intruding into the kingdom. British political manoeuvring thus created an opportunity for spiritual entrepreneurs to turn a handsome profit in an early African version of the health industry (McLeod 1975: 110-2).

Public health interventions addressing women's sexual health also attest to the interdependent nature of health. Distributing condoms to women as a means of AIDS prevention presumes that those women have the power to

negotiate for safe sex with their partners. Many African women simply do not have that power. Western medical practitioners can lecture at length on the adverse medical effects of female circumcision, but any effort to put an end to the practice that fails to take into account its religious and cultural underpinnings is doomed to failure.

V. CONCLUSION

Since individuals are the building blocks of a society, the perception of those individuals constitutes the perception of the society. A society's perception of the susceptibility to an illness will depend on the perceived causes of that illness. This is what will influence their attitude towards the illness and those who are affected by it. The perceived severity of illness also urges the society to put up a particular behaviour towards that illness. Perceived severity leads to the categorization of illnesses into serious, mild or mundane which in turn determines the promptness with which care is sought, withheld or even withdrawn; and the social network that will be involved in decision making for treatment seeking. A society may believe it is susceptible to some illness; they will only change their behaviour to ward off that sickness if they believe that change of behaviour will be efficacious (perceived benefits). Based on this, a society may maintain its traditional mode of dealing with illness or change a modern one. Also, if a society believes a particular sickness is caused by evil spirits or witches, they may then look for appropriate means of handling it instead of attending modern health facilities. In some instances, a society may perceive attempts to introduce new behaviour to it as a threat to its values. This will inevitably hinder behavioural changes towards a medical established effective treatment (perceived barriers). A society may perceive itself to be capable of absorbing certain new behaviour into its norms and values, such a society is said to posses self-efficacy. It will be easy to penetrate such society with acceptable modern health programs. What is most important to change human behaviour is education. For health education to be effective and efficient, it must be culturally acceptable (Cue to action). In some situations, social change may occur to modify the society's perception. The social change may be due to pervasion of formal education, migration, colonisation or population explosion. This can bring about a change in perceived susceptibility, perceived severity, perceived benefits, perceived barriers and Self – Efficacy.

Given this review, we can conclude that the primary virtue of our hypothetical health worker must be humility and cultural competency. As Brach and Fraser (2000) indicated; providing culturally competent services has the potential to improve health outcomes, increase the efficiency of clinical and support staff, and result in greater client satisfaction with services. Cultural ignorance or, even worse, cultural hubris is not compatible with the provision of sound healthcare.

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