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Culture Matters in Global Health

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Foreground

Every global perspective begins with somebody's local perspective. This reality does not invalidate the reach and relevance of the 'local' and its place on the global landscape. However, it does allow one to examine the location of the local and its global vantage point. The privileging of individual power to change behavior regardless of the context of such a behavior is an example of somebody's 'local' becoming global. Individual preeminence over its environment is a cultural experience that may find relevance in many settings but should be located in its cultural vantage point of departure. In health and psychology, individual focused health behavior change has been recognized by many scholars as limiting and/or unsustainable even when a change does occur. It is the context of behavior known to influence health that should be the focus of health psychology and public health. Thus, what is absent, however, is a strategy to address the contexts of health behavior rather than focusing on individuals. One contextual factor that most scholars agree is central to understanding health behavior is culture. In culture, we learn to appreciate community assets and liabilities rather than focus only on the liabilities and hence the following declarations that have resulted from my research.

I contend that when you arrive in a community to address a health issue, you should begin with something positive that the community does correctly - their assets. If you cannot identify something positive, then you should not remain in the community, otherwise you are likely to focus only on their problems and may in fact become a part of their problems. This value in beginning any community project with identifying their assets and what is positive about the community has become a core of my health and culture mission over the past years. It illustrates what has become my mantra, signaling my point of departure on locating culture, especially positive aspects of culture, at the core of effective community health intervention programs.

The Journey

Research on the role of culture on health behavior has gained unprecedented attention. Earlier

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studies on culture typically focused on behavior of Africans and ethnic minorities in the West that have been 'Otherized' by representing them as problems for which their identity has become coupled. Over the years certain sub-groups in these populations have been targeted for global health efforts. For example, children are represented as those needing to survive and hence child survival, mothers needing to be saved and hence safe motherhood. It is as though children and adults in these cultures are of interest for the problems with which they have been identified and from which some international agencies must 'rescue them'. The primary lens through which these problems are defined and solutions advanced are based on individual psychology. This is premised on the notion that individuals have preeminence over their environment and they alone can change problems regardless of their contexts, hence we must teach them to gain power (read: empowerment) to change their behavior. In my earlier research in public health, I drew lessons from a variety of disciplines and from contributions offered by scholars whose identity is tied to those of men and women framed as having problems. What became evident was that the contexts that frame and nurture the humanity of Africans have been totally ignored in public health and psychological literature. Moreover, even though research reports and papers may focus on health, the scholarly convention in pro-

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moting a diseased 'Others' assumed a disciplinary normalcy in fields like psychology. It is from this earlier epistemic foundation that health psychology emerged as a field of specialization. The challenge of a culturally anchored health psychology project, therefore, is to erase these impoverished representations by unpacking the biases in their professional logic. Health psychology offers possibilities for promoting culture-centered ways of knowing to advance a strategy that allows one to engage 'Others' in understanding themselves from the perspective of their culture. Thus locating identity at the intersection of health and culture was the birth of the PEN-3 cultural model, which was first published over 20 years ago (Airhihenbuwa, 1989). PEN-3 is used increasingly in different cultures of the world to address a range of health problems, particularly in sub-populations that are 'Otherized' by being consigned to the margins of society.

To understand and appreciate the value of culture, one could recall the value of a Native American Indian expression that says 'the longest journey you will ever take is the journey between your head and your heart.' To engage in this journey is to begin the process of walking towards yourself, which is the beginning of knowing who you are without what you do. By 1988, at the beginning of the HIV and AIDS epidemic, Africa was again thrust into the doomsday lime light in attempts to frame either the origin of or who is to blame in what would come to be known as the pandemic of modern time. First was the blaming of the continent for the beginning and spread of HIV. What follows was and continues to be attempts by many to monotonize the continent as a single entity even though HIV incidence in some African countries is less than that in some Western countries. Moreover, some areas with the highest cases, like Botswana and South Africa, also represent areas with a stable economy and model governance. Yet response to HIV goes along the line of blaming cultural practices or ineffective governance.

The Point of Departure

The PEN-3 cultural model has been described in detail as a model used to understand the intersection of health and culture (Airhihenbuwa, 1995, 2007a, 2007b). PEN-3 prepares researchers to respond to the question which asks: do you know who you are without what you do? The single most unspoken tension between those developing interventions and the population for whom the intervention is developed is the inability to connect with the population at the human level. Academics and professionals are quick to cite their professional identity (read: professors, directors,

supervisors, etc.) without ever engaging in self -reflections of who they are without their professional title. After all, it is at this level of who they are that they ought to engage the community.

In PEN-3, we approach a community to conduct studies on a given issue. In South Africa, for example, we examined the meaning of HIV and AIDS related stigma (Airhihenbuwa, et al., 2009). There are four basic steps to PEN-3. First, begin with a qualitative study (e.g., focus group) to generate community response to an issue, making sure that probes include perspectives on the issue that are positive, unique, and negative. Second, results (which may include findings from subsequent surveys) are then grouped into 9 cells of PEN-3 by crossing the domains of relationships and expectations with cultural empowerment. Third, return to the community to share with them the comments generated and ask the community to group them into the same groups as the researchers. Once the community has completed grouping this into categories, the fourth and final step is for the research team to share with the community how they grouped theirs. Points of convergence and divergence become the focus of discussion to better understand the logic employed to reach the groupings of both community and research team. Collectively, the researchers and community can decide and prioritize what intervention is needed and where to begin.

Since PEN-3 was first published (Airhihenbuwa, 1989), revisions have been made and the model has been used to address several health problems including cancer (Erwin, et al., 2007), hypertension (Walker, 2000), diabetes (Goodman, Yoo, & Jack, 2006) smoking (Scarinci, Silveira, Figueiredo dos Santos, & Bettina, 2007), food choices (Underwood et al., 1997), and obesity (Kumanyika & Obarzanek, 2003). The development and revision/strengthening of PEN-3 over the years has drawn from the wisdom of many scholars of diverse background. Generations of African writers have taken up the challenge of raising issues with the notion of a monolithic African. The writer Chimamanda Adichie cautioned about 'the danger of a single story' by challenging her audience to move beyond the simple construction of one dimension of an African to one where Africans are understood to have several stories, some good, some uniquely African and others not so good. The PEN-3 model, therefore, was developed to offer a cultural lens for those who are committed to addressing health issues and problems amongst Africans and 'Others' by beginning with the positive aspects of the culture. This is a bottom-up approach. A bottom-▶

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up approach argues that the limitations observed in intervention outcomes are often the result of using models and theories that focus on individual problems, rather than locating the problem within its context.

PEN-3 also helps us to filter noise about culture that is not based on empirical evidence. Certain practices might go against the social goal of closing the gender inequity gap, for example, but the practice cannot be erroneously linked to the spread of HIV when available data suggest otherwise. An example is data that shows that polygyny is a risk factor for HIV when the reverse is supported by research (even though polygyny is not what we necessary want to promote). The notion of the hyper-sexed Africans has led to various interventions focused on how to desexualize Africans. Yet a study published in the Lancet (Wellings, et al., 2006) on sexual behaviors globally shows that Europeans have more sex than Africans yet Africans are portrayed as hyper-sexed. At a recent meeting convened by UNESCO to examine ways to anchor HIV prevention on culture, a participant wondered why donor agencies have not addressed how messages coming from their 'Western' cultures promoted some of the cultural practices that are being questioned today. Some of these practices believed to prevent HIV today where once proscribed by missionaries. For example, male circumcision was once denounced by missionaries in some cultures as 'immoral'. Home based care was once considered retrogressive but now it is promoted. Communities want to historicize the contradictions being advanced for Africans, and thus, question the question.

Questioning the question: From tobacco to obesity

Smoking prevention represents an example of the importance of changing the context of smoking before any reduction can be observed. Indeed, the gains made in smoking reduction are in large part due to program and policy interventions that addressed the contexts of smoking. It started by first restricting smoking in confined spaces beginning with airplanes, then restaurants and finally public buildings and spaces. Conversely, the growth observed in many countries with increases in smoking is in large part due to absence of related policy and context-based interventions. The next frontier for global health that now demands public health attention is obesity. It is quite evident that like smoking, the success of obesity will be measured by the degree to which cultural and contextual factors are taken into account. This is perhaps even truer in obesity than it was in smoking because individual weight management programs have failed to achieve sustained reduction in weight through diet and other individual based interventions. Indeed, the contexts that have established and nurtured obesity are systemic and structural, hence the need to turn to culture. Take the issue of food portion size in the United States, for example. Today's convention of larger portion size may have been introduced by fast food industries, but sustaining large portion size owes as much credit to family and mainstream restaurants as it does to fast food ones. Not only do the average family restaurants pride themselves at serving with individual meals more portion than they can finish at a seating, plate sizes have also significantly increased from what they were two decades ago. In fact the size of the plate for serving the main dish two decades ago is now the size of salad or desert plates. The size of the main meal dish has increased significantly and families have adapted to offer their family with enough meal to fill the plates. This system increase in not only the meal, but dishes, utensils, cups and other parts of serving the meal requires a systemic change that cannot happen at the level of the individual.

There are suggestions that the success of changing the context of smoking holds strong promise for strategies to reduce the global pandemic of obesity. The only problem is that unlike smoking, we all need to eat to survive. Smoking is not needed for human survival, and therefore, has no benefit for health. Eating on the other hand does. We all need to eat for our daily nourishment. Eating, or better yet, what is eaten is the primary cause of obesity. At the core of what we eat, how we eat and with whom we eat is culture. Eating becomes a form of expressing cultural identity whether or not it is intentional. Thus, while the context of a behavior like smoking played a major difference in smoking reduction by using policy to enforce certain changes in behavior, eating and the resulting obesity is better understood within the context of food production and distribution, and the culture of food. Obesity may very well be the first example of a chronic condition that offers insight into why certain water borne diseases remain endemic in countries of the Southern hemisphere. Obesity and the link to identity may offer insight into why certain water borne diseases persist in poor resource areas for decades. Food and water represent basic human needs. Left with a policy to regulate their content, value, quality and quantity, the outcome is obesity from food and diarrhea from water. Thus to understand the nature of obesity, like water borne diseases, one needs to begin at the level of the community to understand the role of culture in food and water consumption rather than focusing solely on the individual behavior. ■

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