


The neglect of culture in global health research and practice

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INTRODUCTION

In a village in southern Senegal, Grandmother Tobo proudly states that ‘Culture is the most important thing for an individual. Culture is the foundation for life’. Culture’s far-reaching influence on human existence is also suggested by Airhihenbuwa, ‘Culture is a system of interrelated values active enough to influence and condition perception, judgement, communication and behavior in a given society’¹ (p 3). Related to global health and development, Cameroonian psychologist Nsamenang asserted, ‘to intervene appropriately is to ground theory, research and practice in the local culture and context’² (p 75). We posit that congruity between global health interventions and cultural context increases community engagement and subsequently contributes to programme effectiveness.

CULTURE: A MISSING ELEMENT IN GLOBAL HEALTH

For many years, the need for global health research and practice to give greater attention to culture has been articulated. In early development programmes in Latin America, anthropologist Paul analysed unsuccessful health programmes and attributed their failure to inadequate understanding of cultural context.³ In 1984, renowned medical anthropologist, Foster, evoked the urgent need for research on ethnomedical studies to inform community health interventions.⁴ Echoing Foster’s concerns, Airhihenbuwa proposes the centrality of culture in health programmes while critiquing the Eurocentrism of these programmes in the Global South. And in 2008, the United Nations Population Fund (UNFPA) asserted, ‘International development agencies ignore culture—or marginalize it—at their own peril’⁵ (p 7).

In 2014, a National Institutes of Health expert committee concluded that ‘culture is an overlooked and misused concept in health research’⁶ (p 20). Their key conclusions were

Summary box

- ⇒ The impact of global health strategies is constrained by the incongruity between critical facets of cultural context, global health practitioners’ inadequate understanding of the culturally-grounded worldview of communities and the strategies they develop to promote family and community well-being.
- ⇒ For many years, in the field of global health, anthropologists have articulated the need for greater attention to be given to culture, however, this critical parameter continues to be neglected in research and practice.
- ⇒ Predominant conceptual models of health and illness at the global level reflect Euro-centric values of individualist societies and overlook the structure and dynamics of family and community systems in non-western, collectivist cultures in the Majority World.
- ⇒ Decolonization of global health requires reframing of research and interventions to ensure that they reflect the structure, roles and resources of indigenous cultures in the Global South.
- ⇒ Global research and funding institutions should support more culturally-grounded research and programs to increase their relevance to local communities, their effectiveness and subsequent impact. For many years, the need for global health research and practice to give greater attention to culture has been articulated; however, this critical parameter continues to be greatly neglected.

published in an important article, ‘Culture: the missing link in health research’, calling for more culturally grounded research to increase its relevance to public health programmes.⁷ In this regard, historically, the World Health Organisation (WHO) has given limited attention to the cultural dimensions of health but the 2017 policy brief *Culture Matters* boldly states that ‘the systematic neglect of culture is the biggest barrier to the advancement of health and health care worldwide’⁸ (p viii).

In Global Health discussions, it is frequently stated that *culture must be taken into account*; however, often only lip service is paid to this critical parameter. Two flagrant examples illustrate how cultural context is overlooked



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in global health. In all cultures, families have strategies for caring for newborns involving culturally defined gendered roles and experience. There is an extensive body of evidence on the culturally defined role of grandmothers in newborn care across the Global South. However, most research and interventions on newborn care in the Global South focus only on mothers of young children, thereby ignoring the structure of non-western families where caregiving is collective and intergenerational.⁹ A second example, related to child marriage, concerns the gap between the culturally determined role of elders in perpetuating this practice and the fact that most programmes do not actively involve them while primarily targeting girls and sometimes their biological parents.¹⁰ In both cases, programmes blatantly overlook the structure and strategies of family systems to promote the well-being of newborns and adolescents by acknowledging and building on the culturally designated roles of influential family and community members.

WHY IS CULTURE NEGLECTED IN GLOBAL HEALTH?

In spite of numerous appeals, mainly from anthropologists, to accord greater importance to culture in global health, it continues to receive scant attention by major organisations, donors and academics working in this field. We identify a series of factors that contribute to this persisting oversight.

1. There is no consensus on either the concept, or parameters, of culture. And most definitions, emanating mainly from academics in the Global North, are Eurocentric.
2. Anthropologists often emphasise the uniqueness of each culture. This can convince health planners to conclude that it is impossible to design culturally adapted interventions for an infinite number of different cultural contexts.
3. Many definitions of culture narrowly focus on cognitive or psychological factors, that is, the knowledge, attitudes, customs and habits, while ignoring the culturally determined social context in which they are embedded. Many studies investigate knowledge, attitudes and practices (KAP), providing only superficial understanding of complex cultural systems.
4. The combined influence of epidemiology and the behavioural sciences, especially psychology, contributes to the narrow focus on individuals at risk, and the assumption that individuals can make rational and autonomous decisions on health-related issues irrespective of culture. This orientation reflects western individualist values and conceals the influence of others on the individual in non-western social environments.⁶
5. Culture is frequently perceived to be a negative factor in the health sector. Global health publications frequently refer to *cultural barriers, obstacles* and *constraints* while ignoring positive cultural features.
6. Presumed universality of cultural values, structure and life stages across the globe, grounded in those from

the Global North.⁶ Examples of the erroneous notion of universality include the assumption that all societies address key life stages, for example, pregnancy, in the same way, and that nuclear family structure is a global norm. Assumptions regarding universality occult the significant differences between cultures thereby limiting the imperative to understand cultural specificities.

7. Many powerful institutions, including WHO, UNFPA, US Agency for International Development and the Gates Foundation, give limited attention to culture in their policies and programmes. This highlights the gap between the importance accorded to culture by communities and by influential funders and policy setters.

NEGLECTED FACETS OF CULTURE

There are two inter-related concepts from anthropology that shed light on fundamental facets of health culture that are particularly relevant in the Majority World. Both have been given limited attention in global health research and practice: Weidman's two-dimensional framework for health culture; and the contrasting structure and values of western and non-western cultures.

While many conceptual frameworks on culture related to health focus narrowly on KAP, medical anthropologist Weidman¹¹ proposed a broader concept of health culture with two inter-related dimensions: (1) the cognitive and conceptual facets; and (2) the social system in which health issues are embedded. In her schema, the *cognitive dimension* refers to the KAP, values, norms, beliefs, traditions, etc, related to different health issues. The *social system dimension* includes the roles and influence of both family and community-level actors, their strategies, health-seeking patterns and social networks of relationships that influence health status and health behaviour. Weidman asserted that understanding health-related behaviour 'requires that individual behavior be understood within the context of health culture from both a cognitive and a social system point of view'¹¹ (p 272). According to her, social norms are products of those culturally constructed social contexts. Unfortunately, most discussions of health culture overlook the social system dimension. Addressing the inadequacies of past conceptualisations of culture, we believe that Weidman's framework represents a decisive tool to engender greater understanding of cultural context and, in turn, more cultural-grounded global health initiatives.

A second facet of culture, related to Weidman's discussion of social systems, and also generally ignored in global health, deals with the profound differences between the structure and values of western and non-western, or indigenous, cultures. Many anthropologists¹² and cultural psychologists¹³ discuss the two contrasting models of social organisation and values in families and communities. Different scholars use different terms to describe these contrasting cultural systems. Many refer to a continuum between *individualist* and *collectivist cultures*¹²

while others refer to societies that prioritise *autonomy* versus *relatedness*.¹³

The core contrasting feature of the two types of societies is the relationship between the individual and others in the social environment. In individualist societies the concept of the individual is an autonomous, self-contained entity. In non-western societies, emphasis is on the interdependent relationships between people, where interdependency is valued more than independence. The African concept of Ubuntu, implying that *a person is only a person through others*, exemplifies the importance of connectedness to others, a foundational value in all non-western cultures. According to Henrich *et al*,¹⁴ more collectivist cultures make up approximately 88% of the world's population, that is, the Majority World.

Related both to the social system facet of Weidman's health culture framework and to Ubuntu, a fundamental characteristic of endogenous collectivist cultures relates to the influence of the extended family. The nuclear family, composed of biological parents and children, is atypical across the Global South, however, this western construct is deeply embedded in the concepts and methods used globally in the social and health sciences.

An outspoken critic of the Eurocentric orientation in the social sciences worldwide, psychologist Nsamenang clarifies that 'The African does not think of the family in its nuclear form'¹⁵ (p 70). He asserts that while the extended, or joint, family has mutated in African contexts, it retains its function as the primary social structure. Predominance of the extended family structure across the Majority World has many implications, too often overlooked, in the design of health research and interventions.

Conceptual models of health and illness based on Eurocentric individualist values and the nuclear family overlook numerous culturally determined facets of family systems in non-western cultures, namely multigenerational caregiving, by extended family members and kin when faced with health issues; gender and age-specific roles of men and women; culturally designated roles of family advisors and caregivers based on age and experience whose roles are intensified at critical times, for example, during pregnancy or when mental health issues arise; the experience of older family members, especially older women, plays a central role in both preventive and curative health behaviours at the family level; related to all health issues, including maternal and child health and reproductive health, younger women are expected to follow the advice of more experienced, usually older women around them; on family health issues there is a collective decision-making process in which age and experience are recognised; younger family members are discouraged from making independent decisions; in all communities there are recognised *cultural authorities* on key aspects of family health and development, for example, maternal or adolescent health; and even when formal health services are accessible all families have their own strategies for promoting the health of their

members. To increase the cultural relevance of health research and interventions all of these facets of health culture should be taken into consideration.

GROUNDING GLOBAL HEALTH IN CULTURAL CONTEXT

We believe that the impact of global health strategies to promote family and community well-being is severely constrained by the incongruity between critical facets of cultural context and global health practitioners' limited attention to the culturally grounded worldview of communities. Therefore, transforming global health programmes to ensure their cultural relevance should be a priority. Cultural contexts, too often overlooked in the past, need to be more comprehensively investigated, and hegemonic global health concepts, frameworks and methods revisited and decolonised.

Nsamenang¹⁶ asserts that culture should not be viewed merely as a parameter of development, but rather as the foundation for all development. A vocal critic of Eurocentric development values and frameworks, he argues that the starting point for all development initiatives should be to understand culturally constructed family and community systems including the cultural resources that they embody. While elders are often assumed to be an obstacle to adoption of improved health-related practices, some innovative programs view elders, specifically grandmothers, as a cultural resource. In Zimbabwe, in the Friendship Bench strategy, local grandmothers were identified as a resource to provide therapy for common mental disorders from park benches across the country, building on their innate capacity to empathize.¹⁷ In Senegal, a grandmother-inclusive approach has contributed to improving maternal and child nutrition,¹⁸ and to decreasing child marriage, teen pregnancy and female genital mutilation.¹⁹

CONCLUSION

Several current conceptual lines of thinking support the need for transformation in global health research and practice to give greater attention to cultural context, namely *systems science*, *socioecological models*, *family systems* and calls for *decolonisation*. In addition, there is growing awareness of the need for health researchers and practitioners to recognise their own positionality, that is, the interface between their own cultural backgrounds, values and training, and the cultural contexts in which they work.

Increasing the attention given to cultural parameters and their inclusion in global health research and practice will require commitment, open-mindedness and courage on the part of global health practitioners both from the North and South to question entrenched Eurocentric frameworks and methods and to create alternatives. Recognising the complexity of the task, Abimbola and Pai²⁰ argue that *radical transformation* will be required at various levels to decolonise global health to make it more

culturally relevant to communities and thereby increase its contribution to more equitable health development.

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