Original Article

Culture and Biomedical Care in Africa: the influence of culture on biomedical care in a traditional African society, Nigeria, West Africa.

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ABSTRACT

BACKGROUND: Biomedical Care in Africa and the influence of culture on the health-seeking behaviour of Africans can not be underestimated; many African cultures have different understanding of the causes of disease which more often affect our public health system, policy, planning and implementations. The traditional African healer unlike a doctor trained in western biomedicine, looks for the cause of the patient's ailments as misfortune in relationship between the patient and the social, natural and spiritual environments. The complexity of African society with different cultural and religious practices also reflects on the people's attitude and understanding of their health matters. This paper is an overview of the cultural influence on biomedical care in a traditional African society, Nigeria, West Africa.

METHODS: A research on the patients' health seeking behaviour and Primary Health Care service organization in 10 health centres in the five eastern states of the Federal Republic of Nigeria was carried out using a multistage cross-sectional study. A semi-structured questionnaire was administered to the health care providers and patients while an in-depth semi- structured interview was also conducted.

RESULT: We observed there is underutilization of health care services at the primary level because most people do not accept the model of health care system provided for them. Most people believe diseases are caused by supernatural beings, the handiwork of neighbours or vengeance from an offended god as a result of transgressions committed in the past by an individual or parents. This group of people therefore prefers seeking traditional medicine to seeking orthodox medicine and often ends up in the hands of witch doctors who claim to have cure to almost all the diseases.

CONCLUSION: Biomedical care in Africa is influence by culture because of different understanding of what ailment is and also due to limited knowledge of health matters, poverty and ignorance. There is a need therefore to focus on health out-reach programme, communication and enlightment campaign in Africa especially in the rural areas that are more vulnerable and are burdened with many of these diseases.

KEYWORDS: Biomedical Care; influence of Culture; Africa; Nigeria

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INTRODUCTION

Primary Health Care (PHC) is accepted as the model for delivering basic health care to low income populations in developing countries such as Nigeria[1]. Since the strength of a country's primary health care system is associated with improved population health outcomes for all-cause mortality[2], Nigeria in 1988 adapted PHC as the cornerstone of its national health policy till date. Despite all the efforts and strategies adapted, Nigeria still has a high level of morbidity and mortality from the diseases that PHC is expected to control. Comparisons between communities on health status indicators can reveal the extent of any differences that exist, including the dynamic changes which may be helpful in characterizing the role of modifiable risk factors to the development of these preventable diseases [3].

PHC programme in Nigeria at present appears to have a theoretical framework which practice possess new challenges for understanding and securing the health of our population. Achieving health for all in Nigeria is a process that is more than a simple stretching of health issues, health problems and provision of basic health facilities. In order to ensure effective implementation of PHC in Nigeria, the programme should take a look at the complex dynamics involved in the process considering not only the wider socioeconomic context but also the cultural and religious meanings and practices through which the individual and group engage in health seeking behaviour. Therefore, to achieve the objectives of PHC as stated in the Alma Ata Declaration in 1978, our primary health system must be directed towards the provision of health services that is shaped around the health needs of individuals, their families and communities taking into consideration the socio-cultural construct in Nigerian. The health system should therefore be responsive to individual differences, cultural diversity and preferences.

In Nigeria, as it is often the case with most African countries, understanding of health problems and their causes differ from community to community, society to society within the community, from religion to religion and from culture to culture. Most people believe diseases are caused by supernatural beings, the handiwork of neighbours or vengeance from an offended god as a result of transgressions committed in the past by an individual or parents. These groups of people therefore prefer

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seeking traditional medicine rather than orthodox medicine. Unlike a doctor trained in western biomedicine, the traditional African healer also looks for the cause of the patient's misfortune in the relationship between the patient and the social, natural and spiritual environments [4] and some of these healers claim to specialize in one or more biomedical aspects, such as herbalism, midwifery or even surgery [5,6,7]. Most of our rural dwellers more often find succor in the hands of these local healers who are readily available because they live within the community. Priority in these situations should therefore be focused on educating and creating awareness on proper health-seeking attitude among our rural populace and these can be supported with not only ensuring the existence of health centres in these areas but also provision of adequate infrastructure and health care services that will meet the needs and demands of the people. There is a need therefore to assess the health seeking behaviour of Nigerians as well as service organization of the PHC providers.

Culture, Religion and Health Care in Nigeria

As a secular state, the Nigerian constitution guarantees religious freedom. Consequently, many religions are practiced in Nigeria. Christians predominantly live in the southern part of the country which comprises of South West, South-South and South East whereas Muslims live predominantly in the northern part. Native religions in which people believe in deities, spirits and ancestor worship, are spread throughout the country.

Many Muslims and Christians may also intertwine their beliefs with more unorthodox indigenous ones. Nigeria has the largest population in Africa with over 250 ethnic groups and more than 510 languages[8]. This has made the country a complex society with different cultural and religious practices which also reflects on the people's attitude and understanding of their health matters within the same country. Extended families are still the norm and in fact remain the backbone of the social system in Nigerian. Grandparents, cousins, aunts, uncles, sisters, brothers and in-laws all work as a unit through life. Family relationships are guided by hierarchy and seniority (*Familismo*). Individuals turn to members of the extended family for financial aid and guidance, and the family is expected to provide for the welfare of every member even in time of ill health.

Therefore, individual that benefited from the family structure is expected to owe allegiance to the system in return and in certain situation, do not have autonomy to decide on his or her health matters without the family input. However, in most urban areas these days, with the proliferation of western culture, the role of the extended family system is gradually diminishing but a strong tradition of mutual caring and responsibility among the members still remains.

The health care systems of Nigeria and most African countries emerged from colonial medical services that emphasized costly high-technology, urban-based, curative care[9] When Nigeria became independent in the 1960, she inherited health care systems modeled after the systems in industrialized western nations that colonized them. Public health programs of international development agencies during this period were also largely targeted at eradicating specific diseases such as smallpox, yaws, and malaria[10] Each disease eradication program operated autonomously, with its own administration and budget and very little integration into the larger health system[11].

There were some successes during this period such as eradication of smallpox, chickenpox and yaws. However, these short-term interventions were not addressing poor populations' overall disease burden[12]. The situation worsened into the early 1970s, as populations continued to expand and experiencing failing health outcomes necessitating the changes in health policy and emergence of Alma Ata Declaration in 1978 and Nigeria in 1988 adapted PHC as the cornerstone of its national health policy till date[13].

Health Seeking Behaviour and the influence of culture

Several factors play a role in shaping the health-seeking behaviour of individuals and they include predisposing variables such as age, gender, culture, religion, occupation, prior experiences with illness, level of education, general attitudes towards health services and knowledge about the presenting illness. Others are the enabling factors such availability of health services, financial resources, social network and support services, perception of the severity of the disease. Behaviours cannot be deduced from one or various isolated factors. For example, a certain practice can be correlated with aetiology, but in the illness models, aetiologies often have moral implications that give meaning to behaviour. Identifying key factors relevant to the health-seeking behaviour is helpful for planning health policy interventions.

But in order to correctly understand behaviours, these factors need to be contextualized [3]. Health-seeking behaviour studies acknowledge that health control tools, where they exist, remain greatly under or inadequately used. Understanding human behaviour is prerequisite to change behaviour and improve health practices. Experts in health interventions and health policy became increasingly aware of human behavioural factors in quality health care provision which in African is often influenced by culture. In order to respond to community perspectives and needs, health systems need to adapt their strategies, taking into account the findings from cultural disposition of the community which may some

cases may be centered on behavioral studies[3]. Culture and personal beliefs play very important role to the health-seeking behaviour of the people especially in most rural areas. Some believe that most of the health problems are spiritually related and therefore do not need the attention of an orthodox medicine.

This belief is not exceptional to Nigerian situation; in Tanzania for example, Hausmann-Muela et al.[14] described how malaria and witchcraft can be interrelated in illness interpretations. According to them among the Tanzanian population, the belief that witchcraft can impede biomedical treatment from working or malaria parasites from being detected in the blood is the fact that witchcraft hides the parasites by putting a veil between the body and the outside. This examples show sadly how concepts from different knowledge sources could amalgamate and give rise to new, syncretistic interpretations, rather than how new knowledge would replace existing concepts.

The logic of interacting concepts explains much of treatment-seeking behaviour, as becomes clear in the case of malaria and witchcraft. An individual suffering from malaria who believed he or she has been bewitched will seek treatment from a traditional healer who can remove the witchcraft prior to attending the hospital for malaria treatment if at all. Typically, observed treatment sequences with alternating use of traditional and biomedical resources follow logic of interpreting and re-interpreting illness, using merged concepts from biomedicine and local beliefs in witchcraft [15].

In conclusion the misconception that most diseases are supernatural and do not need orthodox treatment thereby exposing individual to the lure of witch doctors who claim to have a cure to almost all the diseases, and lack of awareness on the part of the communities about their own health needs are chain reaction that leads to under utilization of Primary Health Care Services in Nigeria. Therefore, to increase the health-seeking behavior of Nigerians and for the effective implementation of PHC in Nigeria, the service organizations should among other things be properly structured to understand and appreciate the need for health outreach programme especially in the rural communities. The local government and the health caregivers should also collaborate with private and public health providers and establish a communication network linking health care institutions and other care-giving systems like traditional healers to ensure access to quality health care.

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