Examining the Relationship Between Culture and Perception of Illness

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Introduction to East African Culture

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**Introduction**

 In the early 70s, the worldwide recession from oil prices affected the economies of many African countries. Tanzania responded to the recession by transitioning from socialist to capitalist which resulted in drastic cuts to the national spending on the health system. The transition indirectly produced an increase in international health programs working in Tanzania. “There are about 1500 national or local NGOs operating in Tanzania” (S&A 2011). Many of these NGOS are ran by foreigners, usually white Europeans or U.S. citizens. It is beneficial, for everyone, if the foreign health workers obtain familiarity with Tanzania culture through ethnographic fieldwork. Ethnographic field works is “a period of observation and involvement with the people whose lives an anthropologist hopes to study” (S&L 2014).

The purpose of this essay is to outline the importance of health interventions in Tanzania using a cultural reflexive approach. Perception of illness is shaped by your location, family, genetics, cultural beliefs, social practices, and more. As a result, perception of illness in Tanzania deviates from the Western medical paradigm. “Culture affects beliefs about health status—about the perceptions and meanings of illness, the definition of disease” (Skolnik 2012). Foreign health aid implementing projects in Tanzania must complete a comprehensive analysis of the population and culture.

The chosen interviewees for this research paper were Mr. Andrew, Rogers Swalee and Annie Kisiri. Mr. Andrew is a mid- forties aged male from the U.K. He is part of the Emmanuel International Water/ Sanitation Project. Mr. Andrew provided a foreign NGO personnel perspective. He was asked about the process for selecting village projects and about the implementation of their global health agenda. Rogers Swalee is a 23-year-old male, Tanzanian born, and student at PHCI. He was asked questions about the health care system and his mother’s work as a medical doctor. Annie Kisiri is an early twenties aged female, Tanzanian born and student at PHCI. She was asked questions about female health, the health care system, her views on foreign NGOs, and ways she thought the health care system could be improved.

**Literature Review**

*Cultural anthropology a perspective on the human condition*.provided definitions, examples, and relevant quotes on culture. In addition, the publication explained in detail the importance of receiving primary source information including ethnographic fieldwork and a one-on-one interview. The publication provides a new perspective on the role of culture in shaping thoughts and viewpoints.

*Global Health 101, Second Edition* is a comprehensive collection of global health. The publication analyzes risk factors, health determinants, structural and systemic violence as well as environmental health. These components were all vital to the formulation of this main argument. In addition, the publication also provides real applications of health interventions including the resulting statistics and suggested improvements.

Africa: A Practical Guide for Global Health Workers was a supplemental publication to *Global Health 101, Second Edition.* This publication provides definitions, solutions, and personal accounts as well. However, this publication was referenced mainly for the in-depth tips for global health workers completing health interventions in many African countries including Tanzania. The publication provided health statistics for Tanzania which also included regional disparities.

*Fresh fruit, broken bodies migrant farmworkers in the United States* provided a medical anthropologist perspective on health interventions. The author shares the account of his ethnographic fieldwork and his analysis of a foreign heath system. The publication was vital in providing information on how to minimize situated knowledge. The publication emphasized personal interactions with the studied population in order to complete meaningful work as a foreigner.

“Ethnomedicine” analyzes the field of medical anthropology while offering formal definitions and novel recounts for the fairly new field. The publication provides a scientific account for the numerous new sectors that have emerged from ethnographies completed in foreign countries. The publication emphasizes the importance of forfeiting an ethnocentric view and promoting a cultural relativistic approach when immersing yourself in a new culture.

**Argument**

International Health Organizations must evaluate the determinants of health and health equity in Tanzania. During an interview, Annie was asked, “What efforts do you think would be most effective for improving the health of people in Tanzania?” She replied, “Improve the medical personnel in villages giving education to the people” (A. Kisiri, personal communication, June 7, 2017). It benefits the health of the public if the message is conveyed in a manner which the Tanzanian population can aptly understand.

Miscommunication frequently occurs in health interventions between the health professionals and the treated population. This confusion is a result of the two parties unequally communicating the health issue. ‘Western culture views mind and body as distinct, other cultures rarely do. In most cultures, people are simply sick, not physically ill or mentally ill” (Quinlan 2011). The Western medical paradigm and health approach utilizes etic terms. Emic terminology includes a term for the local illness whereas etic terminology is often the biomedical definition. Emic and etic terminology have varied degrees of overlap, however, there can also be no degree of overlap. When discussing health issues, the people of Tanzania commonly utilize emic terms. Emic terms are often characterized by the produced symptoms. If there is no degree of overlap between emic and etic terms, health interventions become difficult. For example, ‘Hepatitis C’ is a biomedical definition or the etic term, however, there is no local term for ‘Hepatitis C’. The ‘Hepatitis C’ disease does not have local connotations because it is difficult to diagnose, requiring specific laboratory tests. If there is no emic term, Tanzanians often will regard the disease as inapplicable and novel with a perspective similar to ‘only *you* *foreigners* get that’. However, foreign aid can easily dismiss Tanzanian patients when they use emic terminology, as well. ‘Privileging biomedical knowledge is not only ethnocentric, but does not account for the myriad elements of healing that bioscience has yet to learn” (Quinlan 2011). Due to lack for common terms and linguistic connotations, foreign aid has the arduous task of generating concern for an uncommon disease in the local population.

Tanzanian language and cultural connotations should be integrated into the implemented treatments and programs. Let’s analyze a hypothetical disease, ‘X’, and the associated treatment, ‘Y’. ‘Standard of efficacy’ evaluates the question: ‘Do people in Tanzania think that ‘Y’ can prevent ‘X’’? Health interventions must analyze the etiology of the targeted disease. Etiology examines the question: ‘What do the people in Tanzania believe cause ‘X’’? Tanzanians associate diseases, illnesses and medical terminologies with different connotations than the foreign aid will.

Etiology, or causation of illness, is shaped by culture and the resulting perception of illness. “I have become interested also in the ways in which social and economic structures affect **health professionals**, the **lenses** through which they perceive and respond to their patients, and the **care** they are ultimately able to offer” (Holmes 2014). Communication of illness, within Tanzania, will utilize cultural specific language. It is in the best interest of the treated population and the health intervention to vocalize these cultural associations in order to prevent assumptions and the deleterious results. ‘There is a link between someone’s ethnomedical conceptions of the nature and cause of an illness and what he or she does to prevent that illness or to right the body, should illness occur” (Quinlan 2011). Anemia is a condition characterized by low levels of hemoglobin in the blood. Iron pills is an inexpensive and efficient anemia health intervention used commonly in many African countries including Tanzania. Etiology seeks to explain how equilibrium in the body was disturbed. Tanzanian belief of anemia is that there is not enough blood in the body. When both yellow and white iron supplements were given to the anemic women, they refused the pills. The Tanzanian women believed that anemia meant they do not have enough blood, as a result, the anemic women only wanted red iron pills. Red is the color of blood, a strong association in the culture of Tanzanian health. The women wanted more blood in their body so they needed to take iron pills that were the color red. The health intervention then began to distribute red iron supplement pills to the anemic women and the program was a success.

The structure of the Tanzanian heath system includes a pyramid of five levels (1-5). Number one is on the bottom of the pyramid, representing the least advanced, and number five is at the top of the pyramid, representing the most advanced. In order from one to five, or bottom of the pyramid to the top of the pyramid, the levels of the Tanzanian health care system are as such: Dispensary, health center, district hospital, regional hospital, and consultant hospital. The least advanced level of the system is also the least expensive and as a result, dispensaries are usually the first option chosen when people become sick. However, ‘patterns of resort’ varies by income nationally. “Affected by “cost” of services, including both financial and social costs- in which the provider treats them socially” (Skolnik 2012). Where you choose to receive health care for your family also exploits your social and financial status. Parents must find the money for their children’s health care bills. “If you bring your sick child to the hospital, they will treat your child but you are forced to stay inside the hospital until you pay for the treatment” (R. Swalle, personal communication, June 13, 2017).

Location and environment influence your ‘Order of health seeking’, also known as the ‘patterns of resort’. As stated earlier, advancements and quality of care improves as you ascend from bottom of the health system structure to the top. Key determinants of health equity are; “Access to health services, including Geographic availability, Availability, Financial accessibility, Acceptability, Coverage of health services, [and] Protection from financial risks of health costs” (Skolnik 2012). Quality of care can be assessed by; the vaccinations available, number of laboratory diagnostic tests, present medical treatments, whether treatment is by a medical doctor or a medical officer, and more. Although quality of care is more improved at a high tier health facility, order of health seeking is determined most by your location and your finances.

 The ‘patterns of resort’ in rural Tanzania can be contrasted with the ‘pattern of resort’ in urban Tanzania. A medical dispensary in Kilolo, a rural town in Tanzania, included an exhausted staff and their exhausted resources. There was one medical officer on site at the dispensary. The medical officer gave a tour of every room in the facility, including the areas under construction, as patients waited to receive care. The ideology of many Tanzanians is a relaxed view of time. However, as stated by the tour guide, many patients travel to the clinic from far either by foot or by pikipiki. It is important to note that your health status also influences your amount of productivity at work. The medical officer ignored the waiting patients because of another cultural aspect as well: respect for visitors. Visitors/ foreigners are revered in Tanzanian culture and special circumstances are enacted to accommodate the visitors. As a result, the medical officer prioritized a tour of the facility for twenty Mzungus over the health care for waiting patients. To reiterate a previous point, medical dispensaries are in no way comprehensive and their range of care is limited. Medical dispensaries cannot adequately treat many of the patients that arrive. However, in small villages, the medical dispensary is the required first step. Patients must receive clearance documentation from the medical officer at the dispensary before traveling to a higher-tier health facility (A. Kisiri, personal communication, June 7, 2017).

The ‘patterns of resort’ of someone living in Iringa differ from those living in an urban city of Tanzania. Both of the PHCI interviewees, Rogers and Annie, stated that if you become sick in Iringa, you go straight to either Frelimo District hospital or Iringa hospital for care (R. Swalle, personal communication, June 13, 2017). “Hospitals [now] have the best care, doctors, and examinations. The dispensaries have Mrdts (Malaria rapid diagnostic tests) but they only detect a few parasites…. Specialist hospitals have more tests for malaria. The Mrdts can be negative but the blood smear test reveals that the patient has malaria” (A. Kisiri, personal communication, June 7, 2017). There is a strong distrust for dispensaries and clinics. Since the 70s, there has been a growing prominence of local healers or Waganga. The progression of traditional healers has been strongest in villages of rural areas. There is a stigma against traditional healers in urban areas. Annie replied, “Oh no!” to a question about the use of traditional healers. She then added, “Many Christians are not allowed to go to traditional healers” (A. Kisiri, personal communication, June 7, 2017). There is a high external locus of control in rural Tanzania. Someone with a high external locus of control will perceive their health status as out of their control. An example perception is, ‘witchcraft is the reason I’ve been cursed, that’s why I got HIV’. Culture also establishes moral elements of your health status; you got a disease because you were doing something bad. Moral elements of diseases produce stigma which deters people from using preventative methods and receiving proper treatment.

Implementation of interventions by heath professionals must take in to account the familial ties, social norms, and influence of the community. These factors establish what health practices are decent “[Culture] when acted upon by the members, produce behavior that falls within a range of variation that members consider ***proper*** and ***acceptable***” (Skolnik 2012). Global health programs working in Tanzania must understand that community is rooted in the culture. The community of each patient has a vocal, influential, and monetary role in the decision of whether or not to receive treatment. Successful programs work to give autonomy to individuals in the community. In an interview, Mr. Andrew explained how the village water project facilitates the implementation of community health funds. People in the village each contribute approximately 1000 shilling a year to build a savings fund. If there is an illness in your family or you need tuition for your child’s school fees, you can take a loan from this savings fund. (Andrew, personal communication, June 13, 2017). The role of the NGO was to instruct the community members on how to create the fund and manage the money with established conditions to secure viability of the fund.

 When NGOs use a hands-off approach, they abdicate power to the community while monitoring their success. “Regular, scheduled, and ongoing communication is key…weekly conference calls to discuss the daily operations of projects, anticipate critical issues, and solve problems. All Tanzania-based directors and staff of the programs are Tanzanian” (S&A 2011). Observation of the treated population is consequential for the creation of an efficient intervention. ‘Involve end users, especially women, to asses needs [and] design approaches” (Skolnik 2012). If the project idea is shared with the population under study, the project is more likely to be exerted effectively. The Emmanuel International Water/ Sanitation Project implements a clean water project but the people in the village dug the holes for the pipes and also purchased their own concrete slabs. This gave the slabs and pipes value and as a result, people were more likely to maintain them because they have invested their own money (Andrew, personal communication, June 13, 2017).

A successful health intervention in Iringa, Tanzania produced an increase in hand hygiene. The project targeted farmers in rural Tanzania. The call to action of the health message was for farmers to wash their hands with water and soap after dealing with chickens. The program targeted zoonotic diseases spread from chickens to humans. Originally, the program was unsuccessful because the foreign aid did not effectively communicate to the farmers that chicken residue remained on their hands after contact. Farmers could not visually see the chicken poop and bacteria on their hands. Because they could not see the alleged germs, they continued to practice poor hand sanitation. “[Culture encompasses] the predominating attitudes and behaviors that characterize the function of a group or organization” (Skolnik 2012).

The foreign aid listened to the farmers and observed their daily practices. Soon the aid realized that hand washing after animal contact is enrooted in western medical practices but it is not a component of the Tanzanian farmers’ culture. The foreign aid altered their approach to visualize their message to the farmers rather than explain it with language that the farmers did not value. The health program put glowing blue dye in the food for the chickens. This altered approach worked: A few days later, everything in the farm, including the people, was glowing blue. “We acquire culture through our parents’ and teachers teaching, through the subtle processes of acculturation and socialization, and through learning particular ways of talking and communicating” (S&L 2014). The adjusted intervention was able to give the farmers visual evidence which influenced the farmers to believe the necessity for hand washing. The health program resulted in more farmers washing their hands with water and soap. Visual evidence and ‘treating the symptoms’ are components of the Tanzanian culture attitude towards health. The hand washing program was later successful because they incorporated both symbolic and empirical language to propel their scientific efficacy agenda.

**Conclusion**

In conclusion, the goal of this essay is to provide real examples of health interventions in Tanzania with hopes that they emphasize structural and cultural competency. Involving the end users is a paramount component of becoming structurally competent while offering foreign aid. Often, health interventions take the public health approach over the moral or ‘Rights-Based Approach’ because of cultural differences and indecencies. Successful health projects carry out to completion but also provide maximum comprehensive human health benefits.

As stated earlier, health in Tanzania is affected by your location, age, gender, income, social status, and more. “Almost 80 percent of healthcare facilities in the country offer basic child health services… [but, these] children’s health services vary across the country” (S&A 2011). Structural violence then results in health inequity unevenly across the country. Foreign aid must immerse themselves through conversation to learn about the culture, daily lives, and most used scientific inventions in Tanzania. This, ethnographic fieldwork, will provide the foreign aid with the necessary information to create a health project specific to the population. Perception of illness is cultural specific. However, culture varies even within a country. Cultural aspects including gender norms, views on family planning, societal decencies, and emic terminology vary across the country with visible differences between the urban regions of the country and the rural regions. Although it is often associated with location, your financial status is another crucial determinant of your health which must also be examined by foreign aid. Foreign aid must take into consideration the uneven distribution of wealth and access to services when formulating health projects because these factors influence the perception of illness.

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