

## In Search of Models for Healthcare Delivery in Multi-Cultural Africa

Abdullahi Ali Arazeem<sup>1</sup> and Moshood Issah<sup>2</sup>

**Abstract:** Africa is said to be one of the most diseased regions in the world. With mere 13% of the world's population, Africa carries 24% of the global burden of diseases as there are more people living with HIV/AIDS in Africa than anywhere in the world. Malaria also kills more children than anywhere in the world as there are no less than half a million children younger than the age of five that die from malaria every year. Cardiovascular diseases are beginning to kill more people in Africa more than ever before. It is crystal clear that the rate at which diseases are killing people in Africa is alarming and catastrophic and this has attracted the attention of health policy makers in the continent. Africa has adopted and implemented different health policies to tackle health challenges ravaging the continent. However, many of these policies have failed perhaps, owing to the fact that the designers of health policies failed to recognize the role of culture in their design as well as implementation. In this paper, we make a case for the recognition of cultural factors in the design and implementation of health policies in Africa. Appropriate models have been reviewed in this paper to guide the design and implementation of health policies.

**Keywords:** Healthcare; Delivery system, Cultural care model, Sub-Saharan Africa

### Introduction

The continent of Africa is faced with huge burden of health problems proportionately far beyond Africa's share of the world's population. With mere 13% of the world's population, Africa carries about 24% of the global burden of diseases (World Health Organization, 2005). For example, Africa is rated highest in infectious and parasitic diseases. WHO (2011) reported that about 67% of the people living with HIV/AIDS worldwide reside in Sub-Saharan Africa (SSA) and 75% of annual global deaths from AIDS occurs in SSA. The reports further showed that 90% of new infections of HIV/AIDS among children occur in SSA countries. Although Southeast Asia had the highest number of new tuberculosis (TB) infections annually, SSA had a TB incidence rate that doubles that of Southeast Asia (WHO, 2011). Specifically, South Africa and Nigeria had the fourth and fifth largest number of new TB cases annually respectively, while Zimbabwe

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<sup>1</sup>Corresponding author, Department of Sociology, University of Ilorin, Nigeria and Department of Sociology, University of Johannesburg, South Africa. E-mail: [kwaraeleven@yahoo.com](mailto:kwaraeleven@yahoo.com); cell: +2348069696844

<sup>2</sup> Department of Sociology, University of Ilorin, Nigeria and Department of Sociology, University of FortHare, South Africa. Email: [issahmoshood80@gmail.com](mailto:issahmoshood80@gmail.com)

and Mozambique ranked second and third respectively (WHO, 2011). According to Crawley et al. (2010), malaria represents 10% of SSA's overall disease burden and more than 70% of malaria-related deaths occurred in SSA. Maternal mortality was also high in SSA because Reports had shown that one in seven women in Niger Republic and one in eight in Sierra-Leone would ultimately die of pregnancy-related infections and complications (WHO, 2012). Other neglected tropical diseases such as Dracunculiasis, Trypanomiasis, Leishmaniasis, leprosy, Lymphatic filariasis, onchocerciasis and schistosomiasis had also continued to threaten human existence in SSA (WHO, 2012).

Indeed, the existence of these diseases have adversely affected socio-economic life as well as general process of development in Africa, as they sap energy, creativity and productivity of over 67 million people in the continent (WHO, 2002; Von-Schirnding, 2002). Life expectancy on the continent, which is one of the lowest in the world, has been reduced further to an average of 52 years by the existence of many of these diseases. Women and children carry a disproportionate share of Africa's heavy disease burden, with 4.8 million children dying annually, mostly from preventable diseases (WHO, 2014).

It is crystal clear from these narratives that the continent of Africa is diseased and this has attracted the attention of stakeholders resulting in high-level inter-sectoral actions for healthcare provisions. For instance, most SSA countries are signatories to global health initiatives such as Alma Ata Declaration that led to the birth of Primary Health Care in most African countries in 1978; the 1987 Bamako Initiative on Healthcare Provision; the 2001 Abuja Declarations on Health Expenditure; the 2008 Ouagadougou Declaration on Primary Healthcare and Health Systems in Africa; the Libreville Declaration on Health and Environment in Africa in 2008; and the Brazzaville Declaration on Non-communicable Diseases in 2011. The spread of disease and illnesses like the HIV/AIDS and tuberculosis despite initiatives to curb them is an indication that most of the health initiatives in Africa have failed.

Perhaps, one of the reasons health initiatives in SSA had failed to tackle incidence and control of diseases and illnesses ravaging the continent was because cultural context of disease and illness has not sufficiently taken into consideration in the designs and implementations of health policies. Existing studies have shown that there is a gap between cultural construction disease and the design and implementation of health initiatives in SSA (Lipson & Dibble, 2005; Giger & Davidhizar, 2004). For an example, in most African countries, diseases and illnesses are usually attributed to supernatural and mystical forces including witchcraft or evil machination. Extant literature has shown that determinants of health and illness across Africa have socio-cultural origins that are beyond the direct influence of the health sector and health policies (Arnold & Glenn, 2007). Thus, Purnell & Paulanka (2005) observed that health care providers and organizations must take and consider cultural diversity as a priority in the design and implementation of health initiatives in SSA as well as ensuring that the healthcare providers are culturally competent in handling health challenges of culturally and ethno-linguistically diverse people in the region. In most African

societies, diseases and illnesses are, sometimes, seen as punishment as a result of being disobedient to the spiritual forces (e.g. the ancestors) (McElroy & Townsend, 2009). Consequently, several deaths often take place before getting to health facilities (Taylor & Taylor, 2002). In this article, we make a case for the recognition of cultural factors in the design and implementation of health initiatives in Africa. The paper is structured into six sections.

### **The Nexus between Culture and Health**

The concept of culture has been at the centre-stage of academic debate in sociology and anthropology, hence, finding a singular universally accepted definition has been very problematic. In this section, attempt is made to define culture from the point of view of scholars and connect these definitions to the concept of health. Historically, some scholars have maintained that the 'scientific' explanations of culture started with the work of Blumenthal in 1940 when he conceptualized culture in terms of symbols, ideas, personality, and functional relationships (Aina, 2007). This was said to have laid the foundation for a kind of scientific engagement in the concept of culture and this had inspired many scholars to follow suit. Barely one decade after Blumenthal's (1940) definition, several other authors had attempted to add more flesh to the debate; what culture means, what it stands for and its universality as well as relativity. As at 1952, the American anthropologists, Kroeber and Kluckhohn, had compiled and reviewed more than 164 different definitions of culture. Despite these, there was still consensus among scholars that not much was done in the scientific conceptualization of the concept of culture (Aina, 2007). Even, it was argued, Blumenthal's definition, which he claimed to be scientific, was non-inclusive and faulty in some respects. This position was demonstrated when Apte (1994: 2001) noted that 'despite a century of efforts to define culture adequately, there was in the early 1990s no agreement among anthropologists and sociologists regarding its nature and dynamics'.

Prior to Blumenthal's definition, a ground-breaking definition of culture had been conceptualized by Edward Burnett Tylor. According to Tylor (1871), 'culture... is that complex whole which includes knowledge, beliefs, arts, morals, law, customs, and any other capabilities and habits acquired by man as a member of society'. This definition is considered highly inclusive because it encapsulates various components and dimensions of human culture. Tylor's definition was ground-breaking and appears to encapsulate the main components of culture and what it means to be cultured. Tylor deviates from previous scholars who defined culture based on biological traits. Tylor was perhaps the first who specified that culture is learned and acquired, as opposed to being a biological trait. Such a perspective to culture was perceived by many as revolutionary against the backdrop of colonialism, racism, and social evolutionism that dominated the ideologies of the 19th century.

Others have also attempted to define culture. For example, Schwartz (1992) defines culture as 'consisting of the derivatives of experience, more or less organized, learned or created by the individuals of a population, including those images or encodements and their interpretations transmitted from past

generations, from contemporaries, or formed by individuals themselves'. For Morris & Maisto (2005), it is everything that describes individuals design for living. According to Coakley (2007:5), 'culture consists of the ways of life that people create as they participate in a group or society'. Spencer-Oatey (2008:3), sees culture as 'a fuzzy set of basic assumptions and values, orientations to life, beliefs, policies, procedures and behavioural conventions that are shared by a group of people, and that influence (but do not determine) each member's behaviour and his/her interpretations of the 'meaning' of other people's behaviours'.

From the foregoing, it is evident that the concept of culture is complex and dynamic in both theory and practice and that it influences and determines every aspect of human existence, including health. How a group of people perceive health, disease and illness is largely influenced by their culture. According to Iorvaa (2013), all humans, irrespective of ethnicity and creeds, behave in the context of a specific culture that profoundly influence reactions to the world, such as their beliefs, attitudes and predispositions towards health and illness. Conceiving culture as related to health dynamics of a people, Cunningham (2007) observes that culture includes ethnicity as well as the health belief system of the people of a particular area or region. The connection between culture and health is pervasive and widespread in Africa. In these societies, general medical practices and specific health belief systems are culturally embedded. Therefore, the diversity of health belief system can be explained in terms of the diversity in the socio-cultural dynamics of diverse nations.

### **Cultural Diversity in Sub-Saharan Africa (SSA)**

There is no widely acceptable definition of the term 'diversity'. Most scholars would agree that diversity refers to differences between individuals, but there is disagreement concerning which different attributes should be included within the scope of the concept. According to Patrickson & O'Brien (2001), diversity is a subjective phenomenon, created by group members themselves who, on the basis of their different social identities, categorise others as similar or dissimilar. Loden & Rosener (1991), defined diversity as that which differentiates one group of people from another along primary and secondary dimensions. From this perspective, on the one hand, primary dimensions of diversity are those aspects of differences that have primary influences on human social identities as well as fundamental world-views and they include gender, ethnicity, race, and age. On the other hand, secondary dimensions of diversity appear to be comparatively less conspicuous, and which exert influence on personal identity. They include social attributes such as educational background, geographic location, religion, and first language. In advancing the frontier of knowledge, Arredondo (2004) added culture, social class and language to the primary dimensions; and healthcare beliefs and recreational interests to the secondary dimensions. Table 1 shows the categorizations further.

**Table 1: Categorizations of Diversity**

Primary	Secondary	Tertiary
<ul style="list-style-type: none"> <li>a) Race</li> <li>b) Ethnicity</li> <li>c) Gender</li> <li>d) Age</li> <li>e) Disability</li> </ul>	<ul style="list-style-type: none"> <li>a. Culture</li> <li>b. Sexual orientation</li> <li>c. Thinking style</li> <li>d. Geographic origin</li> <li>e. Family status</li> <li>f. Lifestyle</li> <li>g. Economic status</li> <li>h. Political orientation</li> <li>i. Work experience</li> <li>j. Education</li> <li>k. Language</li> <li>l. Nationality</li> <li>m. Religion</li> </ul>	<ul style="list-style-type: none"> <li>a) Assumptions</li> <li>b) Perceptions</li> <li>c) Attitudes</li> <li>d) Feelings</li> <li>e) Values</li> <li>f) Group norms</li> <li>g) Health</li> <li>h) Belief</li> </ul>

Source: Rijamampinina& Carmichael (2005:109)

From table 1, the categorization most relevant to this paper is cultural diversity. Thus, what is cultural diversity? Cultural diversity is increasingly employed and defined in relation to social and cultural variation in the same way as biodiversity is used when referring to biological and ecological variations, habitats and ecosystems (Brewster *et al.*, 2002). Technically, cultural diversity is the quality of diverse or different cultures, as opposed to monoculture. Vertovec & Wessendorf (2004) expanded the scope of the conception of cultural diversity when they argued that the term cultural diversity is often used to mean the variety of human societies or cultures in a specific region, or in the world as a whole. The importance of cultural diversity has been enunciated by the UNESCO in its Article 1 of the Universal Declaration on Cultural Diversity in 2002 that, which stipulated that cultural diversity is as necessary for humankind as biodiversity is for nature.

Sub-Sahara Africa (SSA) is one of the most culturally diversified regions in the world in terms of ethno-linguistic compositions and divergent belief systems (Ahlerup& Olsson, 2012; Michalopoulos, 2012). Datasets on ethno-cultural diversity in SSA showed that standard deviation in the number of ethnic groups

per country is more than 35%, higher than any other region in the world (Fearon, 2003). Another dataset from Alesina *et al.* (2003) shows that the standard deviation in ethno-cultural diversity per country as measured by the Ethno-Linguistic Fractionalization (ELF) index is largest in SSA. Indeed, in a continent with high levels of diversity (for example, Liberia, Nigeria and Uganda) it is also striking to find largely homogenous countries like Burundi and Comoros.

For the purpose of comprehensiveness and systematization, it is imperative to adopt region by region analysis of the ethno-linguistic compositions of SSA using language as a yardstick. Language is used as the basis of classification because it represents one of the most important and visible components of culture. In other words, within the context of this work, the diversity of culture is reflected in language variability. This has been demonstrated by previous researchers and authors. To start with, Central Africa is a region of Africa that is primarily inhabited by *Bantu* and *Pygmy* groups (Heine & Derek, 2000). In the sub-region, *Bantu* languages predominate. *Chadic* and *Nilo-Saharan* languages were also spoken in some areas in the sub-region (Epstein *et al.*, 1998). More specifically, the African Great Lakes region is primarily inhabited by *Bantu* and *Nilotic* who speak *Bantu* languages, especially *Chichewa*, *Luhya*, and *Luganda* tribes and *Nilotic* languages among the *Luo*, *Dinka* and *Maasai* tribes (Lyle & Mauricio, 2007). In Southern Africa, *Bantu* peoples as well as some *Khoisan*, who speak *Bantu* languages and *Khoisan* languages primarily inhabited the sub-region (John, 2011). There are also numerous Afrikaners and other Africans of European descent who speak a Germanic language as a first language, namely Afrikaans and English respectively (Heine & Derek, 2000). It is currently believed that speakers of *Khoisan* languages were the first inhabitants of Southern Africa (Grimes & Barbara, 1996).

In West Africa sub-region, people who speak Niger–Congo languages mainly occupy the area, Niger–Congo tongues spoken locally include the *Kwa* languages, *Mande* languages, *Fulani* languages, *Wolof* languages, *Yoruba* languages and *Igbo* languages (Lyle & Mauricio, 2007). West African *Bantu*-speaking communities are found almost exclusively in Cameroon, the purported homeland of the *Bantu* languages (John, 2011). In addition, some *Chadic* languages, including *Hausa*, are spoken in areas bordering the *Sahara*, and the *Nilo-Saharan Zarma*, *Songhai* and *Kanuri* languages are spoken in the areas bordering Central Africa (John, 2011).

From the foregoing, it is undisputable that SSA is culturally diverse, and this has implications on the conceptions and constructions of health and illness in the region. This is because the health belief is one of the critical components of SSA's culture, and people of the region are embedded within cultural contexts, which defined and shaped their beliefs, attitudes and understandings of health and illness.

### **Culture and the Conception of Health and Illness in Sub-Saharan Africa: Empirical Evidence**

Empirical studies have shown that culture plays a central role in health related behaviours (Omu & Reynolds, 2012; Legg & Penn, 2013). Different cultural groups have vastly different perceptions of the causes of disease and these perceptions influence their health seeking behaviours (Pronyke *et al.* 2001). Many ethnographical studies, such as Helman (2001) have shown that cultural factors have both positive and negative influences on health behaviours. For an example, the escalation and spread of HIV/AIDS, especially in Southern Africa, is culturally rooted. Studies have shown that attitudes towards condom use in Southern African countries are partly influenced by cultural factors (Mulatu (2000). Culturally, in most Southern African countries, condom use is seen as a 'waste' of sperm (Oke, 2001). Also, for many Africans, polygamy is celebrated where most men believe they have a cultural right to have multiple partners (Epston *et al.*, 2003).

More so, in South Africa, male circumcision has some cultural undertones. Traditional male circumcision among indigenous communities such as *Xhosa*, *Ndebele*, *Pedi*, *South Sotho* and *Venda*, are culturally embedded (Connolly, *et al.*, 2008). In some cases, the newly circumcised young men are encouraged to engage in sex soon after initiation with a woman whom they do not intend to marry and it has been observed that these cultural practices had aided the spread of HIV/AIDS among the general population. Some studies among the *Swazi* people of South Africa have found that the causes of illness are culturally categorized under two fundamental categories: proximate and ultimate causes (Gluckman, 1955). Proximate causes are believed to be infections from pollutants while the ultimate cause accounts for why a disease is contracted by a particular person in the midst of many. For instance, Green (1994) reported that a *Swazi* mother may accept that her child has diarrhea because flies settled on its food (proximate cause), but she might also want to establish who *sent* the flies to harm her child (ultimate cause). In the *Swazi* community, witchcraft, sorcery and ancestral vengeance are culturally believed to have the capacity and spiritual powers to inflict pains and illnesses on people. These spiritual agents are collectively believed to be the major determinants of illnesses even in the modern world.

Lyons (1999) documented the erroneous early search for explanations for the earliest AIDS-related deaths among the *Haya* of Tanzania. His findings showed that among the *Haya* people of Tanzania, the emergence and spread of the HIV was attributed to the distribution of the *Juliana Shirt* from Uganda at that time. The shirts were thought by the *Haya* as containing infectious substances, and were believed to have been contaminated by Ugandan traders. Also, among the *Haya* people of Tanzania, witchcraft and sorcery is another ultimate explanation for the outbreak and spread of diseases (Green, 1994). The slow sapping of strength and vitality of the affected members of the community and the fact that illness may spread from mothers to their unborn children make the *Haya* people to attribute the illness to witchcraft and sorcerers (Lyon, 1999). Also, among the *Chagga* of Tanzania, illnesses and diseases are believed to be the

consequences of breaking the communion with the ancestors (Amat-Roze, 1999). Thus, emergence and resurgence of illnesses and diseases are seen as the manifestations of ancestral wraths.

Amuyunzu-Nyamongo et al. (1999) reported that illness is frequently seen as traditional curse in East African societies. Studies carried out in rural areas of Malawi and Zambia by Edginton, Sekatane, & Goldstein (2002) reported that TB is commonly conceptualized as a disease which has its origins in the breaking of sexual taboos. Similarly, Among the *Dinka* people in *Amb* societies, they believed that witches are the ultimate causes of ill-health. Among the *Bira* of *Mobala* and the *Nande* of *Mukulia*, of the Democratic Republic of Congo the etiology of ill-health could be attributed to seven different causes. These ranged from natural causes to transgression of cultural taboos (e.g. eating forbidden food) to witchcraft (Oke, 1982).

In West Africa, among the *Akan* people of Ghana, illness is attributed to witchcraft (Mensch, Hewett & Erulkar, 2003). In Nigeria state capitals, 10-12% endorsed the view that cultural factors are critical in health and illness (Orubuloye & Oguntimehin, 1999). Studies in Nigeria have also shown that certain childhood diseases are attributable to the anger of the gods, especially when taboos had been broken (Oke, 1982). Some diseases were attributed to the evil machinations of certain persons who seemed to bear certain grudges against the sufferer. Studies in Nigeria showed that the *aje* (the witches) and the *oso* (sorcerer) can inflict diseases on people through their mystical powers. In a study conducted among the *Yoruba* speaking people of Southwestern Nigeria, 96.5 % of the respondents indicated four etiological perspectives on illness causes: enemies (*ota*), which include witchcraft (*aje*) and sorcery (*oso*); gods (*orisa*) or ancestors (*ebora*); natural illness (*aare*) and hereditary diseases (*aisanidile*) (Jegade, 1998). A study conducted by Omorodion (1993) among the *Esan* communities in Nigeria illustrated that even diseases and illnesses such as diarrhea, malaria, small pox, chicken pox and minor headaches may be attributed to witchcraft and sorcery.

Empirical studies have also shown that in most SSA countries, women with breast cancer hardly go to the hospitals because of the fact that the health care systems in most parts of the region are male-centered, which goes contrary to the cultural provision of most countries in the region (Facione, *et.al.*, 2002). More precisely, cultural norms in some SSA countries may make some females to be feeling reluctant to allow male physicians to examine them (Facione et al., 2000). This might be because once a woman is married, only her husband has the socially approved authority to touch her, particularly her sensitive parts. The presence of cultural beliefs is much more felt in maternal and infant care. There are certain cultural beliefs which determine the health seeking behaviors among African pregnant women. In Tanzania, for example, some cultural taboos prohibit the intake of some foods during gestation, which may be much more needed at the period. Culturally, most indigenous African people strongly believe in the use of 'health' herbs during pregnancy and the perinatal period as the best options to food supplements (Erinoso & Oke 1994). The maternal situation among the *Ogu* people of Badagry, Lagos State in Nigeria has been exacerbated by

cultural beliefs (Isiugo- Abanihe, 2003; Ajiboye & Adebayo, 2012). The influence of cultural practices could also be seen in the attitude to anti-natal attendance and the actual delivery. According to Evjen-Olsen et al. (2008:7), 'about 50% of the pregnant mothers prefer to see traditional midwives or relatives for both antenatal care and delivery in Tanzania'. In studies conducted by Maimbolwa et al. (2003) on the cultural childbirth practices and beliefs among the women who accompanied pregnant women to the modern health center during labour (*Mbusas*) in Zambia. The *Mbusas* were advisors to the women regarding appropriate traditional practices and childbirth. They encouraged pregnant women to use herbs as they believed that these may help to precipitate labour and widened the birth canal. Any complication during labour is usually attributed to witchcraft or seen as punishment for misdeeds committed by the pregnant woman. Studies by Kyomuhendo (2003); Atuyambe et al. (2009) in Tanzania and Zambia showed that maternal death was seen as a 'sad but normal event', and mostly the work of 'evil doers'. This belief could have accounted for the high level of maternal and infant mortality in both Tanzania and Zambia.

Similarly, treatment modalities of health and illness is conditioned and determined by culture. Prior to Western civilization, diseases and illnesses were usually (and are still) handled by traditional doctors. More than 70% of people in Africa use traditional medicine at some point in their lives (WHO, 2012). Among indigenous African communities, the traditional doctors are well known and are important players in health care delivery whether approved or not. In many of these communities, traditional healers often act, in part, as an intermediary between the visible and invisible worlds; between the living and the dead, sometimes to determine which spirits are at work and how to bring the sick person back into harmony with the ancestors. In South Africa, for instance, traditional medicine is practiced in accordance with the philosophy of *Ubuntu* (An African ethical or humanist philosophy focusing on people's allegiances and relations with each other). *Ubuntu* philosophy requires traditional healers not to provide services for material gains, but for the benefits of humanity. The cultural taboo imposes on the practitioners a strong code of moral ethics in the provision of health care services to which they should always abide. The cultural tradition of *Ubuntu* symbolizes the uniqueness of SSA's culture on health and illness and most practitioners seem to uphold this moral code in the treatment of their patients, and they often have higher patronage, especially in rural communities.

Kleinman (1980) pointed out what he called the 'core clinical functions' in traditional SSA's countries within the cultural context. In his conception, the term 'clinical' represents treatment modalities in SSA's countries, and it has five constructs. These are: (1) *Cultural hierarchies of health values*, (2) *Experience of illness*, (3) *Cognitive response*, (4) *Healing activities* and (5) *Potential outcomes*. The clinical functions of traditional herbalists in most SSA's countries follow these patterns of treatment modalities and constructs. By and large, what could be deduced from the discussions under this sub-section of the chapter is that socio-cultural factors play prominent role in the general dynamics of health and illness as well health care seeking, utilizations and general health care delivery system in SSA. It is important to note that many of these medical conceptions are indigenous with the people and it has been part and parcel of their medical lives for

centuries and despite the advent of orthodox medicine, many still believe in the tradition and hence are influenced by such. Thus, there is the need to always consider this factor in the making and implementations of health policies in the region.

### **Models for Healthcare Delivery in Multi-Cultural Sub-Saharan Africa**

In order to ensure functional and effective healthcare delivery in SSA, the models of cultural care and cultural competence are suggested for healthcare providers in Sub-Saharan African societies.

#### ***Cultural Care Model***

The cultural care model was developed by Leininger (1970) to explain the prominence of environmental and cultural factors in determining health dynamics of a group of people, this include events, meanings and interpretations given to diseases or illnesses in particular cultural settings, in the understanding of disease and decision on treatment options. According to Leininger (1991), treatments should be more individualized and the socio-environmental and cultural context of the patient should be properly taken into consideration in his treatment. Leininger (1990) further argued that the historical and experiential conditions and incidents preceding illness or ill-health as well as patients' interpretations and definitions of health conditions should be contextualized in deciding treatment options and modalities. The biggest challenge, according to Leininger (1990) is how healthcare providers could gather information about the historical and experiential conditions, interpretation and definitions of patients' ill-health. Consequently, Leininger (1995) suggested the use of 'ethno-history on health belief', which explains human health concepts within particular cultural contexts. The collection of data on the ethno-history of health belief of the patients by the healthcare providers is fundamental and critical in treatment options divisions. This is important because, for instance, assuming an individual had a threat two days back from a perceived enemy (evil-doers, witchcrafts, sorcerers, herbalists etc.) and then today has this mysterious pain that would not go even with drugs and injections. This individual may narrate to healthcare providers that his pain cannot go with the administration of drugs and injections. A provider who has no or (limited) knowledge of ethno-history or health belief of the people may think that the patient might have been mentally or psychologically derailed and this may adversely affect the treatment outcomes. Ajiboye & Adedayo (2012) have documented the challenges the healthcare providers faced in treating patients who are believed to have been possessed by a spirit.

*I had been employed at a construction site. In the evening when I was sleeping, I saw something like a bomb coming to hit me, then I heard someone in my sleep telling me to wake up, not sure who the person is but I think it was God strength (grace), and when I woke up something that could not be seen hit my body. I went to the medical doctors; they examined me but they could not identify the problem. Whenever I went to work, I would cry and complain because of pain, but no one could understand. So I went to a traditional healer who said that someone had sent to me a 'jini' (spirit). We looked for chicken, a goat, and some herbal roots. I was given some to use while bathing and the other to drink. The timing for using the medicine was just like the hospital one i.e. morning and evening; and with God's help I now feel alright (Ajiboye & Adebayo, 2012:143).*

Leininger's culture care model has strong arguments, which should form the basis for the formulation of policies and programmes on healthcare delivery in multi-cultural societies such as SSA. In other words,

cultural care model perfectly fits into the cultural diversity and complexity of the SSA. However, the theory has been criticized for placing too much emphasis on the patient's culture, which is capable of undermining and compromising the modern medicine. Hence, the need for an alternative supportive approach.

#### *Cultural Competence Model*

Another model that could be considered to tackle the challenges of health and illness in a culturally diversified society such as SSA is the cultural competence model. The model is connected to the cultural care model. The model is premised on the notion that, to provide an effective and culturally responsive health care service to a multi-cultural population such as SSA, healthcare providers need to be apprised of general and specific socio-cultural elements and components that are directly and indirectly connected to several health and medical issues as conceived by the people in diverse socio-cultural environment, proponents of the model assume that it is only such knowledge that could make a care giver be competent enough to provide useful and relevant health care service to people. Prominent among the proponents of this model are Campinha-Bacote (1998), Cross et al. (1989) and Carroll et al. (2007).

Cross et al. (1989) define cultural competence as a set of congruent behaviours, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency or professionals to work effectively in cross-cultural situations. Campinha-Bacote (2002: 181) views cultural competence as 'an ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client'- individual, family or the community. According to him, in order to meet the needs of culturally diverse groups, healthcare providers must engage in the process of understanding the cultural dynamics of the people in order to become competent of providing reliable healthcare services to them especially as such a health care provider can take the cultural elements related to the health issue into consideration, conducting culturally sensitive assessments relating to cultural desire, cultural awareness, cultural knowledge, cultural skill and cultural encounters (Campinha-Bacote, 2002).

Cultural awareness is the self-examination and in-depth exploration of one's own cultural background (Campinha-Bacote, 1998). This process involves the recognition of one's biases, prejudices, and assumptions about individuals who are different. Without being aware of the influence of one's own cultural values, there is risk that the healthcare providers may engage in cultural imposition; the tendency to impose one's beliefs, values and patterns of behavior upon another culture (Leininger, 1978; Treloar, 1999). Cultural knowledge is the 'seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups' (Campinha-Bacote, 2002: 182). Obtaining cultural knowledge about the patient's health-related beliefs and values involves understanding their world-view. The patients' world-views will explain how they interpret their illness and how it guides their thinking, doing, and being (Campinha-Bacote, 2002). Health

care professionals' lack of cultural awareness may lead to cultural imposition (Campinha-Bacote 2002). In other words, a practitioner must develop the desire to understand cultural dynamics of the people in order to be effective in the management of disease and illness. Cultural desire is defined as the motivation of the healthcare providers to 'want to' engage in the process of becoming culturally aware, culturally knowledgeable, culturally skillful, and seeking cultural encounters (Campinha-Bacote, 1998). In applying the cultural desire in healthcare provisions and delivery in SSA countries, healthcare providers should be motivated by the government through health care policies and programmes in such a way that they would be encouraged to engage in the process of becoming culturally aware and knowledgeable. In other words, they would be having the desire to learn various or divergent cultures of their locality or operating environment. For instance, healthcare providers in National Hospital, Abuja as well as healthcare providers in other places should have the desire to learn about people and their cultures. More precisely, they should demonstrate determinations to learn and understand the subjective interpretations and conceptions of illnesses as well as their cultural treatments as conceived by their patients.

### **Conclusions**

This paper has examined the connections among cultural diversity, disease, illness and the implications of same on workability of health initiatives in SSA. The paper shows that health and illness dynamics in SSA are culturally embedded, and since there is diversity in cultural components among various groups that made up the region, the cultural conceptions, constructions and interpretations of health and illness are diverse and divergent across the region. The paper observed that SSA is bedeviled with many health challenges and in a bid to control and manage the incidence of diseases and illness in the region, several efforts have been made in this regard. However despite the enormous time and resources dedicated to these initiatives, little has been achieved in the region in terms of disease control and incidence of ill health among the teeming population of the people in SSA. The position of this chapter is that the palpable failures of health declarations and programmes could be linked to non-consideration of socio-cultural elements and less regard of cultural diversity of the people in their formulations and implementations.

Consequent upon the above, the paper suggested that there is the need for the awareness of the patients' health beliefs by healthcare practitioners. This will enable the policy-makers and the healthcare providers to domesticate, situate and contextualise their practice within communities. In order to achieve this, traditional healthcare providers should also be formally incorporated and included in some relevant areas of health care provision because they are the custodian of traditional medical knowledge which form an important part of culture and tradition. This is theoretically buttressed by the positions of the cultural care and cultural competence models discussed in the paper.

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