Cultural Issues in Health and Health Care: A Resource Book for Southern Africa

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Metatheoretical and Theoretical Perspectives on Cultural Studies

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Learning Outcomes

After studying this chapter, you should be able to conceptualise the foundations of cultural studies by:

- Explaining the meaning of the concept of world view and how world view influences people’s behaviour;
- Illustrating the notion of world view with ethnographic information from the Southern African region;
- Demonstrating the relevance of the concept of world view for understanding the processes of health care;
- Applying the principles of ubuntu to health-care practice; and
- Applying the theoretical foundations of culture-competent and culture-congruent care to health-care practice.

1. Introduction

People’s world view represents their overall mindset and their unique way of looking at the world. Their value systems, beliefs and behaviour are determined by their world view. It is necessary to understand a cultural group’s world view if one wishes to make sense of their values, beliefs and practices. In this sense, world view forms part of the metatheoretical foundation of cultural studies. Various theories and models on aspects of culture and the relationship between culture and health issues have been
developed. These theories and models provide a conceptual framework according to which we study and interpret cultural issues. Cultural theories and models are regarded as the theoretical foundation of cultural studies. In this chapter, we introduce the reader to the metatheoretical and theoretical foundations of cultural studies. We discuss the concept of world view and selected theories or models that underlie cultural studies applied to health care. The reader is advised to take the content of this chapter into consideration when reading the chapters that follow.

2. World View

2.1 Defining and Understanding World View

To survive, people must relate to the circumstances of their lives, and they do so by positioning or adapting themselves in time and space in relation to the environment in which they live. Anthropologists call this environment the sociocultural environment because, besides the natural or physical environment, it also includes the realm of the supernatural, as well as other people. People therefore position themselves in the environment according to their culture, which implies that adaptation is a cultural, and therefore group, phenomenon, and accordingly, a topic for anthropological investigation. To describe the way in which people relate to their world, anthropologists use the term ‘world view’, which, of course, literally means the way in which people look at the world, or their total outlook on life. This is a rather simplistic description of a complex concept, however, and on closer investigation we note that logical patterns and relationships can be identified in people’s world view (Lewis 1985:105). As a set of ideas about the universe and the place that people have created for themselves within it, world view indicates how people conceptualise and explain issues that are both threatening and non-threatening, moral and immoral, and that impact upon their lives, thereby imposing order on or disrupting their world.

There is a dual meaning in the concept of world view. Firstly, it embodies a system of beliefs and ideas about nature and the supernatural, the sources of misfortune and danger, and about existence in general. Secondly, it is concerned with the manifestation of such ideas and beliefs in the ordinary lives of people, indicating that it also constitutes a system of action (Hammond-Tooke 1974a:319). From this, we deduce that people’s behaviour is in line with the principles of their world view.

The term ‘world view’ originated from the German concept of Weltanschauung, which is based on the idea that societies live in totally distinct worlds. From this arose the idea that, with due regard for individual differences, the members of a society basically share the same world view, and, therefore, also share attitudes, norms, values and a set of cultural and psychological beliefs. Therefore, world view is a general conception of the nature of the world, particularly insofar as it concerns a system of
values that underlies and shapes people’s behaviour. From a society’s world view we can discern something about the way its members think and behave, conceptualise the existential problems of their lives, and, ultimately, what it takes to be human. Stated differently, world view is a conceptual phenomenon, but by studying people’s beliefs and behaviour, we can determine the nature of their world view (Hammond-Tooke 1981:xi, xii).

Because of their common cultural orientation, members of a society share a world view. Through the process of enculturation, people learn categories of thought from childhood and they think in particular ways, but this does not suggest that the world views of individuals are identical. They may share belief and thought systems, values and norms, but individual experiences and personality are unique and, accordingly, a degree of uniqueness is imposed on a particular individual’s world view. Nevertheless, a person’s world view will always be more like that of other members of his/her own society than of persons in other societies.

Various characteristics of a society make it possible to characterise its world view in specific terms. For example in non-specialised (mainly traditional) societies, where people regard economic activity as a means of recognising their dependence upon the natural environment, world views are characterised by the image of ‘limited good’, which means that all the desired things in life exist in limited quantities, and economic activity is determined by built-in limits, such as fixed wants, limits to property ownership and wealth-levelling principles. In contrast, the world views of specialised (mainly Western) societies are characterised by the principle of ‘unlimited good’. This means that the good things in life can be increased as more resources become available and more widely as the generations pass (Bodley 2001:56).

Although aspects of traditional systems of beliefs and behaviour are likely to occur in all world views, like all aspects of culture, a society’s world view changes as the environment in which it is located changes. This means that in line with culture change, a society’s world view must be extended to incorporate new concepts, experiences, values and orientations. In traditional terms, a world view tends to comprise a closed system of ideas based largely on a religious system, but as people are incorporated in the modern world, they broaden their frames of reference in order to understand and explain increasingly complex issues, so that their world view becomes more open and includes non-mystical ideas to cope with their new experiences. Other people, new religious and political ideas, scientific theories, and new conceptions of time and modes of subsistence, amongst other issues, must be accommodated in people’s ongoing attempts to position themselves in the changing sociocultural environment (Hammond-Tooke 1981:xii, xiv).

Some anthropologists have equated the notion of world view with religion, and although the world view of some more traditional societies does reveal an orientation towards the supernatural, the concept of world view is actually more comprehensive,
and includes all the cognitive (thoughts) and affective (emotional) ways in which people conceptualise and classify their world. This is evident in categorisation in terms of kinship terminology, species of plants and animals, ideas about nature and treatment of sickness, colour shading, and conceptions of time, amongst other issues. This means that through categorisation of phenomena around them, people attempt to understand their world, thereby imposing order on it (Hammond-Tooke 1989:24). Both religious and secular issues are therefore part of a world view (Hammond-Tooke 1981:xiii), and, in essence, it is a cognitive attempt by people to understand and to find meaning in the world.

Nonetheless, there is a significant correspondence between world view and religion, which should be considered more closely. To illustrate, we refer to some ethnographic details from South Africa's black societies. Among them, ideas relating to categories of supernatural beings are applied in attempts to explain various types of phenomena. For instance, the Supreme Being is associated with nature, in particular its more spectacular aspects such as lightning, thunder, hail and drought, as illustrated by the conception among the South and North Sotho that these elements are manifest in or personified by Modimo, their Supreme Being. More significant, however, is the idea that most problems experienced by people emerge from their relationships with others rather than from phenomena in the natural environment. For example, hostilities develop among people who live together in various units, or as a result of competition over scarce resources such as cattle and land. To prevent conflicts or tensions from getting out of hand, such issues must be dealt with, and this is often done through application of religious or moral authority, specifically by invoking the influence of the ancestral spirits (Zulu: amadlozi; Tswana and Pedi: badimo; and Xhosa: izinyanya) in the lives of people. The ancestral spirits are the spirits of deceased members of the larger kinship groups, such as a lineage or a clan, and retain an important influence on the lives of their living descendants. They are regarded as benevolent and protectors of their descendants' well-being and fortune. By implication, this means that when misfortune does occur, it is interpreted as the disfavour or anger of the ancestors. Therefore, the ancestral spirits are conceptualised as the guardians of a society's norms and values, and because people are dependent upon them for their well-being, they are invoked whenever the natural order is disrupted. Further, since the ancestors are regarded as jealous of their descendants and are easily offended, they must be placated through rituals such as sacrifices, which ensure that their anger is kept at bay. This accounts for the significance of the ancestor cult in the lives of many black South Africans and in the ways in which they view their world.

While the ancestors are associated with the incidence of misfortune, they are not linked to the presence of evil in the world, manifest in things or situations that are bad, dangerous, abnormal or immoral. Such issues are explained with reference to the
existence of witchcraft and sorcery. Witches and sorcerers (Zulu and Xhosa: abathakathi; Sotho: baloi) are supernatural beings who manipulate their powers to harm people in various ways. Sorcery is believed to occur through procedures such as uttering spells, manipulating medicines to poison people, or by obtaining body parts such as nail parings and hair clippings, mixing them with medicines and administering them to a victim to harm him/her. Witchcraft is linked with cannibalism, sexual problems and the activities of familiars, for example, thikoloshe among Nguni people (Hammend-Tooke 1974a:318–42). It is significant that in cases of witchcraft and sorcery, the perpetrator is in a position of control and deliberately engages in anti-social behaviour. In the Southern African context, therefore, belief in witchcraft and sorcery constitutes a primary way of explaining misfortune and evil in the traditional world views of people (Hammend-Tooke 1989:48). The world view of such societies is described as magico-religious, implying the reality of belief in the manipulation of powers (magical acts) and dependence on the supernatural (religious acts).

2.2 Universals of World View

In his publication World View (1984:65–107), Michael Kearney identified various universals of world view, which he refers to as cognitive categories that can be identified in all societies (without suggesting that people themselves are aware of them). As we explain in our discussion of cultural universals in Chapter 5, universals of world view are similarities in classification rather than in content, and as such, form the basis for cross-cultural comparisons.

The Self and the Other

The first of these universals is the presence of a Self, that is, the persons from whose perspective the world view is being considered and who indicates an awareness of an essential existence of him-/herself separate from the second universal, which Kearney refers to as the Other, that is, the environment, which includes objects and other people.

The notion of the Self consists of two aspects: one is the awareness of being separated from surroundings; the second is that in spite of the foregoing, a dynamic relationship exists between the Self and things that exist outside of the Self. Such relationships are not arbitrary, but are determined by specific factors, such as kinship, authority, work and religion.

The Other, which includes phenomena that are separate from or opposite to the Self, influences the Self by projecting cold, pain, affection or visual phenomena, towards which the Self reacts in culturally determined ways (Kearney 1984:68–71). It is clear, therefore, that the universals of the Self and the Other exist in relation to each other and we cannot deal with one without also dealing with the other. This is emphasised further by the fact that people never exist in isolation, but always as members of some group.
Space

Space constitutes the next category of a world view. In metaphysical terms, space concerns dimensions of height, depth and width within which everything exists and moves, that is, an expansion or area that is free or available. As regards world view, space concerns the relationship between the environmental space of a society and the images its members have of it. Conceptions of space depend upon the nature and appearance of the geographical environment and the ways in which it is perceived by people. Here we are reminded of early conceptions of the earth as being flat rather than round, and that one could ‘fall off’ its edge. However, space is delimited, as we know from people’s perceptions of boundaries, the ideas of centre, above and below, left and right, and from technological innovations such as the compass, maps and ratar, which are used to orientate location in space. Information regarding conceptions of space can be determined from the ways in which people establish their settlements, construct their buildings, arrange furniture, lay out agricultural lands and identify boundaries, as well as from their folk dances, which include action in space. For example, as regards boundaries, in non-specialised societies, division of land is not based on formalised boundaries, but on people’s ability to move over areas or on the availability of subsistence resources. Among the San, no strict territorial boundaries exist, although a hunting band does claim right of ownership over a stretch of land on which it hunts and collects food. A band’s movements in the area are regulated by water supply.

In contrast, in specialised societies, notions of space are apparent in the division of land on the basis of predetermined, often arbitrarily indicated, straight lines, and by natural geographic features such as rivers and mountains that cut across environmental regions (Kearney 1984:161), or by the construction of ‘skyscrapers’ or multi-storeyed buildings. Also, through technological developments, conceptions of space have been extended beyond the limits of the earth to incorporate the universe. Current concepts such as that of a ‘global village’ reflect an extension of people’s perceptions of space.

Time

 Nearly all societies have a conception of time, as time past, time present and time future. It consists of marking points on a linear scale, or in relation to culturally meaningful events. For instance, in contemporary history, 11 September 2001, the day of the terrorist attacks on the United States of America, has been marked as the day that ‘world history changed’ – there was a time before 11 September and a time afterwards, when the world would no longer be the same. Time, therefore, constitutes an existence and progress in the past, present and future as a whole.

We can differentiate between two main conceptions of time. Firstly, there is oscillating or cyclical time, which refers to time as something that is repetitive, based
on events that are repeated regularly, such as those of the seasons. Oscillating time is usually associated with non-specialised societies, where, for instance, people adapt their lives according to the changing seasons. Agricultural cycles of planting and harvesting crops depend upon observance of the seasons. Oscillating time is essentially related to the present, to the 'here and now', and not to some distant future, when things may be better (or worse) than they are now. This conception of time can be identified among Southern Africa’s black societies, among whom religious orientation emphasises obtaining 'the good life' in this life and not in the future, which is a principle that is fundamental to Christianity (Hammond-Tooke 1974a:318), and underlies much of the Protestant world view of the West.

Secondly, there is linear time, which is usually associated with specialised societies where a perspective of history, technological and social change, and the idea that progress and development are both desirable and to be expected, are recognised. It is future-oriented. The passing of time is revealed in calendars, clocks, history books, diaries, and insurance and investment companies. Here the obvious effects of passing time associated with changes in nature do not necessarily impact on people's activities. According to Kearney, linear and oscillating time are not mutually exclusive and both occur in the world view of a society. However, it is likely that one dimension will be dominant (Kearney 1984:95, 99, 101, 102).

Causality

The idea of causality, or the relationship between cause and effect, is found in all societies and is based on the principle that everything that takes place has a cause. In specialised societies, causes are explained in empirical (or scientific) and rational terms, although the idea of chance, which is also linked with the notion of causality, also occurs. A logical or scientific reason can be found, therefore, for incidents of misfortune, or events occur and develop without there being any obvious cause, which is 'by chance'. In contrast, in many non-specialised societies, including indigenous Southern African groups, belief in supernatural beings and powers is central to the ideas of causality. This means that, as we shall see in Chapter 6, an incidence of misfortune or sickness is explained in terms of the activities of supernatural beings, including gods and spirits, or ascribed to the malevolent activities of individuals, namely witches and sorcerers, who manipulate supernatural powers to harm people.

Number

In all societies, people count or calculate objects, hence the use of number is also identified as a universal of world view. In non-specialised societies, the use of number involves the calculation of totals of objects and depends on the type of numerical problem to be solved (Hallpike 1979:278–9). Here, methods that can be used to solve
problems mainly consist of actions in relation to a configuration such as the five fingers of a hand or a pile of stones, in a one-to-one relationship to the things that must be counted. For example, among the LoDagaa of Northern Ghana, counting bride wealth, which is valued in cowrie shells, takes place by forming collections of five cowrie shells each, which are then further grouped in collections of five, twenty and so on (Hammond-Tooke 1989:30). If a San is asked how far a waterhole is, he/she may indicate the length of the journey in terms of the number of nights (one or two) one will sleep before the waterhole is reached.

In specialised societies, the idea of number is very complex and, for instance, explains aspects of financial and commercial innovation, scientific developments, and developments in the computer industry. In biomedicine, number in terms of pulse rate, respiratory rate and blood pressure is fundamental to the identification of sickness and the distinction between ‘normal’ and ‘abnormal’.

2.3 Concluding Remarks

Although there is a close connection between world view and religious beliefs, they are not identical concepts, since besides secular phenomena, world view includes beliefs, ideas and values pertaining to the supernatural, that is, religious phenomena that people use to explain and give meaning to the world in which they live. By investigating the world view of a society, anthropologists can understand something of their way of life and patterns of thought that are based on their fundamental values. The idea of world view emphasises the complex whole of human existence and the place of human societies in the universe.

3. Ubuntu

Ubuntu is an African view of life and world view that represents African humanism. Ubuntu takes seriously the view that the individual is basically a social being, reflected by the central dictum, ‘I am because you are’ or, ‘a person is a person through other people’. It represents a collective consciousness, which implies that the individual is regarded as being a dignified social being. However, ubuntu also emphasises that every member of society should visibly participate in society and not disappear in the whole. Values such as the universal brotherhood of Africans sharing and treating other people as humans manifest themselves in ubuntu. The idea of brotherhood is reflected in a sensitivity towards the needs of others and an understanding of the frame of reference of others. Other attributes of brotherhood are respect, solidarity and loyalty. Although a strong emphasis is placed on duties and virtues, rights are also always implied. Ubuntu centres on the worthwhile, the good and the valuable in human life. It is concerned with visions of happiness and fulfilment (Makhudu 1993:40-1; Mbigi & Maree 1995:111; Prinsloo 1998:41-2, 46).
The expression of one’s humanity in African indigenous environments is defined through interactions with others and the actions of people, individually or collectively. *Ubuntu* is deeply rooted in humanness and empathy in interpersonal relationships. Particular emphasis is placed on the value of congruence, namely being oneself and being proud of and true to one’s identity. Highly regarded is the ability to foster open communication, namely to fearlessly establish direct, open and honest lines of communication, which involves getting in touch with oneself and admitting, among other things, to one’s biases and prejudices about other cultures and ethnic groups. Virtues such as warmth, sociability, hospitality and generosity are highly regarded. This is also true for patience. Human interaction is characterised by heartiness, harmonious participation and co-operation, and reciprocation that flow from a shared world view (Khoza 1993:1; Makhudu 1993:40–4; Prinsloo 1998:42). Social relations are internalised in the extended family, and family life is emphasised, as is contact with distant relatives and friends. Such relations form a closely knit social web that promotes solidarity among people.

Society is organised in terms of age and gender classes that provide a framework for orderly status distribution and social interaction. The distribution of wealth is made according to the prescriptions of status classification. The aged are respected, because an older person is regarded as being more of a person than a younger one, because he/she has more to offer by way of knowledge and experience, personal influence and power (Prinsloo 1998:43).

In *ubuntu*, the individual’s moral nature is also emphasised. Morality is acquired during a progressive process of socialisation. A notion of social morality is manifested by accepting obligations towards others and by participating in social upliftment through reconstructive development programmes. In the same vein, social and economic reconstruction and development should include moral development as well, because without such development, massive amounts of money cannot guarantee real economic and social development (Teffo in Prinsloo 1998:42). Humankind and nature are one in *ubuntu* ethics, and therefore nature conservation has a definite place in the *ubuntu* view of life.

*Ubuntu* involves compassion and social responsibility, which are expressed in caring for the less privileged, the poor and orphans. As African humanism, *ubuntu* involves being sensitive to the needs of others, alms-giving, and demonstrating an attitude of sympathy, consideration, patience and kindness. Empathy, as directed to putting oneself in the shoes of a person in need, entails that each person must be viewed holistically by focussing on his/her physical, emotional, social and spiritual needs. The ultimate expression of regard for another is by showing spontaneous concern and voluntarily assuming a self-imposed sense of duty towards the needy, destitute or bereaved. Nobody should be condemned as worthless (Prinsloo 1998:42).
Ubuntu has numerous implications for health-care delivery, which, if centred on a community-based approach aimed at community empowerment in health and health care, is likely to be congruent with the principles of ubuntu. The principles of community participation and ownership in health and development projects are likely to contribute to success in achieving healthy individuals and communities. Traditionally, the relationship between health professionals and clients is viewed as a contractual relationship. However, the principles of ubuntu dictate that clients are cared for holistically and with empathy, and that health-care delivery is characterised by co-operation among those involved. Health-care professionals ought to view clients not merely in individual terms, but rather as social beings. This implies that health-care professionals ought to utilise clients' social networks as client-support systems in health care. Health-care professionals should also take cognisance of the fact that consultations with clients on an individual basis may be inappropriate. There is a possibility that senior members of a client's social network may have to be involved in the consultation process. In conclusion, it is clear that a paternalistic attitude on the part of health-care professionals is inappropriate when dealing with clients who approach life according to the principles of ubuntu.

4. Theories Supporting Culture-Congruent Care

4.1 Introductory Remarks

This book focuses on cultural issues in health care, and the aim is to develop awareness among health-care professionals of the necessity of rendering culture-congruent care in multicultural health-care settings. In the previous section of this chapter, the metatheoretical foundations of culture-congruent care were discussed by focussing specifically on world view. In this section, selected theoretical foundations of culture-congruent care are discussed. To grasp the essence of a field of study, it is necessary to understand its theoretical foundations. These theoretical foundations also serve to underlie the content of this book. The reader is therefore advised to consider these theories and models while reading the other chapters of the book.

4.2 Leininger's Theory: Culture-Care Diversity and Universality

The first theory we discuss is Leininger's theory of culture-care diversity and universality. Leininger's theory focuses on transcultural nursing as a formal field of study, but the principles inherent in this theory are universally applicable to the health sciences (Leininger 1991:33–56). The reader is therefore advised to consider this theory keeping his/her own profession in mind.
Health Care for People of Different Faiths

G. J. A. Lubbe

Learning Outcomes

After studying this chapter, you should be able to apply the religious principles underlying cultural studies and health care while rendering health care by:

- Discussing the main characteristics of the main religions in Southern Africa;
- Discussing how culture-congruent care can be rendered to clients from different faiths; and
- Demonstrating respect and tolerance for the views and needs of clients from religions other than your own.

I. Introduction

The inclusion of a chapter on religion and health care in this collection is a tribute to the highly professional attitude of those who are involved in and committed to the health-care profession in Southern Africa. The desire to be informed about the dos and don’ts of the various religious traditions certainly echoes the spirit of the old saying ‘forewarned is forearmed’. Mistakes, miscommunications and misconceptions can be avoided if religious beliefs and practices are properly understood by all those who come into contact with the consumers of health-care services.

Southern Africa is, and always has been, a region of religious diversity. However, due to the previous (apartheid) dispensation of sociopolitical segregation in South Africa, the very fact of a multiplicity of religious traditions might not have been the
experience of all that many people in that country in particular and Southern Africa in general. Due to the gradual integration of residential areas, education and health service after the 1994 change from apartheid to democracy in South Africa, more and more people are encountering people who believe differently from the way they do. To want to know what one's neighbour believes is therefore a most natural response and is one that can only lead to sound human relations.

While it is true that many people in Southern Africa are religious, it is also true that not all people practise or even hold any religious beliefs. Even though this chapter will specifically deal with religious beliefs and practices, it should be borne in mind that there could well be patients who do not adhere to any particular religious tradition. Such people are equally deserving of respect and understanding. On the other hand, it will be wrong to assume that all those who profess to a religion on a hospital form are in fact what they have stated, that is to say, practising a particular faith. The golden rule is therefore not to assume anything when it comes to religion. If approached sensitively, the person concerned will often volunteer the required information. It will generally be seen as a gesture of courtesy if, upon admission, the patient is asked by the professional staff about any particular religious practices that should be borne in mind.

In this chapter, religious traditions prevalent in our region will be discussed in alphabetical order, namely African Religion, Buddhism, Christianity, Hinduism, Islam and Judaism. In each case, a brief account of the main tenets of each tradition will first be given. Then the particular attitude towards illness and health care will be discussed and, finally, practical matters will be dealt with.

2. African Religion

African Religion or African Traditional Religion(s), as it used to be, and still sometimes is, referred to, accommodates a great variety of concepts and practices that distinguish the religious systems of various language or cultural groups from one another. At the same time, there are a sufficient number of common features shared in sub-Saharan Africa to distinguish this religious orientation from other world religions. These features are discussed below.

2.1 Basic Beliefs

Belief in a Supreme Being

Throughout most of Africa, there is belief in a Supreme Being with one or more names to describe Him, either in terms of His activities or His place of abode. This Supreme Being created and set the world in motion. Although it could be that among certain groups the involvement of the Supreme Being in the daily affairs of life is
unwelcome, the general view states that God is never far away from an African’s thoughts or perceptions of the world. He is above all else the creator of all things and as such the basis of all that is.

In many respects, the attitude adopted towards the Supreme Creator resembles the respect that traditional African rulers are accorded. In accordance with African tradition, certain procedures need to be observed in order to gain access to a person of authority. For an ordinary person, such contact can only take place through approved mediators or councillors.

This attitude of respect for authority also holds true for spiritual matters and necessitates the intervention of intermediaries if the divine has to be addressed. However, it is important that these intermediaries be approached with respect, since respect for the intermediaries is at the same time understood as respect for God. These intermediaries are the ancestral spirits.

1 The complexities of which pronoun to use when referring to the Supreme Being or God are enormous in the modern era, especially because of the pressures from feminists. The editor decided to use the male pronoun (He, Him, His) in the discussion largely because of tradition, and for practical reasons, while acknowledging feminist objections to this usage. Interestingly, the question about the gender of God is not a problem in African Religion. God is neither exclusively masculine nor feminine. In some traditions, the divine is regarded as both male and female. In other traditions, there are male and female gods present. In the Zulu tradition iNkosi yezulu (‘Lord of the Sky’) is for instance regarded as male, while the female element is represented by uNomkhubulwana. In eastern Nigeria, God is referred to in female terms and the Akan of Ghana call God the moon goddess.

**Belief in Ancestral Spirits**

It is generally believed that only those who have married and produced offspring to remember them become ancestors when they die. Those who have not done so, rapidly fade away and are forgotten. It remains the responsibility of each family to remember its own ancestors until they fall into oblivion. The relationship that exists between the living members of a family and those who have died is a reciprocal one. While the ancestors enjoy the respect and honour of the living by being included and remembered in family functions and in decision-making processes, the living family members also rely on the ancestors for protection and prosperity. Although the ancestors are very much remembered, and at times even feared, it would be wrong to say that they are worshipped.

In addition to the ancestral spirits, Africa also knows a relatively widespread belief in nature spirits. Manifestations of spiritual force and energy are to be found in certain mountains or hills, in specific rivers or lakes, or in special stones.
Belief in the Sanctity of a Unified Community

From birth, an African is guided and trained with the purpose of achieving a full and complete life. However, in this process, people are fully conscious of the fact that they have been born as part of a community. Since life is communal, the individual almost automatically becomes integrated into a network of mutual relations with the community. Far from being looked upon as a sacrifice of individual freedom, this existence-in-community is accepted as indispensable for security and wholeness.

The performance of rituals play a major role in the life of both the individual and the community. In assisting a person to move successfully through the various stages of life, life-affirming rites are maintained and centre primarily on birth, puberty, marriage and death.

African Religion in Southern Africa

African Religion is the oldest form of religion in Southern Africa and goes back to the religious practices of the Khoi-San. This religion is certainly still very vibrant, and vivid proof of the continuing influence of African religious views is to be found in the process of cross-fertilisation between the African ethos and Christianity in Southern Africa. The result of this process has manifested itself in the emergence and growth of the so-called African Indigenous Churches, in which many Africans find comfortable spiritual homes. Several factors make it impossible to estimate the number of adherents of African Religion in Southern Africa. What can be stated with certainty, though, is that, next to Christianity, it has the largest number of adherents in the region.

2.2 Health and Healing

Health and Harmony

In Africa, good health means much more than just a healthy body. It pertains to all that concerns a person, including the perception of a harmonious, co-ordinated universe. This could be said about African people throughout sub-Saharan Africa. Health, balance, harmony, order and continuity are all key words. They do not only describe a desirable present condition for individuals and the community, but also represent the goal towards which people constantly strive. This ideal needs to be maintained not only within the visible community, but equally in relation to the invisible community, conceptualised as spiritual powers.

Pain

This holistic emphasis that is placed upon healing in African religion should not be underestimated. Recent findings seem to indicate that pain is a relative concept that differs among people. It can therefore probably be said that within the African
context, pain is not predominantly physical and individualistic, but rather psychical, with strong social dimensions.

Pain is felt when relationships are disturbed or when problems are encountered in the socioeconomic and political spheres. This truth is borne out by an increase in the number of people who consult diviners and traditional healers, as well as those who join African Indigenous Churches during times of socioeconomic and political stress.

**Western Medicine**

In the perception of African people, Western medicine is often viewed merely as a means of treating symptoms. Unless the cause of an illness is ascertained, the treatment is merely superficial. The cause, more often than not, is to be found in an initial and continuing disruption of unity, which brings stress both to a given group and to its individual members. That which disrupts the normal flow of life, either of an individual or of the group as a whole, is evil. It must be avoided if possible. If not, the cause should be ascertained and remedy sought so that the vital life force can be restored. This process of defending itself continuously against disruption becomes a major factor in binding the community together and keeping it intact.

**Diviners**

In African society, certain persons are specially selected by powers in the invisible spirit world for mediatory work. These chosen individuals are the diviners and traditional doctors. Amongst the fears that most people have are the fear of evil spirits and malicious persons known as witches or sorcerers, who use medicine to harm and destroy. Other fears are that of offending the ancestors, and fear of losing one's vital life force. In addition, anxieties are, of course, also triggered by natural disasters, drought, lack of fertility and, increasingly, by the complexities encountered by those who are living in urban areas.

**Death**

Death is traditionally conceived of as a departure to the abode of the deceased relatives, where blood ties are conceived to be stronger and firmer, since death can no longer break them. It does not seem as if the presence of death in the world is attributed to God, who is the source of life. The presence of death is rather attributed to some form of human arrogance against the divine ordinances. Thus death is an accepted reality, but not feared.

Death does not end life. Life is lived in a series of events, and death is one of these events. Death is therefore not seen as the end of life, neither is it conceived as a complete annihilation of a person. When one dies, one moves on to join the company of the departed. The dead person is remembered by the whole family and community. This remembrance centres around the ancestors, who lend support to the community.
and through whom this human life is communicated and preserved. These highly revered persons do not vanish out of existence, but enter into the state of collective immortality. Death is then not the last word. It threatens the life of the community and represents a cruel and painful parting; however, it does not signify the destruction of the person, but is merely a ‘passing away’ into a different mode of existence.

2.3 Practical Matters

Religious Affiliation

It may be quite rare that a person will openly declare him-/herself to be a practitioner of African Religion. The likelihood of a patient stating membership of a particular Christian church or denomination is much greater. Since there are several possibilities to consider in this regard, it should not be understood as an attempt at deception. One possibility is, of course, that such a person is a committed Christian and a fully fledged member of the institution referred to. Another possibility is that, in terms of historical realities in the region, many schools and hospitals in rural areas were run by church-related organisations and it was thus regarded as ‘civilised’ or proper to belong to a church. It is therefore probably fair to say that the majority of African people today still have links with the church, whether out of conviction or out of habit.

Unlike elsewhere on the continent, African Religion in Southern Africa is generally of very low visibility and only really surfaces during the so-called rites of passage, that is, curing birth, initiation, weddings and funerals, when the ancestors are revered and their blessings and benevolence requested. Rituals performed during these events are also often seen as cultural rather than religious. This fact will therefore make it possible in times of crisis for a person who genuinely belongs to a church still to resort to traditional practices and thus hold a two-fold allegiance. In general, the remark made in the introduction to this chapter, namely, not to assume that those who profess to a religion on a hospital form are in fact what they have stated, often holds true in the case of African people. To be sensitive is indeed the watchword here.

The Ominous Character of a Hospital

Probably like all others, African people are scared of going to hospital. There may be many reasons for this. One could be that a hospital is seen as a rather unnatural place, away from the guiding influence and tender care of relatives. In terms of the reality of the presence of ancestors in one’s life, another fear related to going to hospital is that the ancestors may be unaware of one’s whereabouts, which could render one outside of their protective reach. It may also be that, in terms of popular belief, going to hospital means to die. It is of course quite natural for people to fear death. However, in the African mind, serious religious concerns are linked to the notoriety of hospital as a place of death.
According to Austine Okwu (1978:5), African cosmology rules that a person dies when the spiritual part separates from the material body. Under normal circumstances, which means within the cosmic order, this should only happen because of the physical deterioration of the body resulting from old age. It is the most important rite of passage, stipulated only for the elderly who have already gone through life's other crisis rites. Deaths of young people and women during pregnancy and childbirth, homicide, suicide and all deaths due to accident and outside the normal ageing and biological weakening of the body are regarded as contrary to cosmic order. Okwu refers to such untimely deaths as 'jumping the queue of dying'. Such people are normally not given the same funeral rites as are given for the elderly, nor are they included, remembered or mentioned in the litany of ancestors.

The implications of the above is that going to hospital does not just mean to be out of reach of one's ancestors. With the possibility of not returning from hospital alive, the risk is run of becoming disqualified as a potential ancestor, and thus falling into total oblivion. The necessity for health-care professionals to create a warm and caring atmosphere in hospital, which in itself will be conducive to speedy recovery or healing, is therefore self-evident.

The Inadequacy of Western Medicine

Unlike Western society, where disease is seen as a biological phenomenon and medicine is regarded as the principal response to it, healing in the African context is composed of a combination of medicine and religious rituals. The African does not expect to be healed by Western medicine and medical procedures alone. Healing has to be associated with divinity, which is achieved in two ways, namely by means of rituals and sacrifices and by means of traditional medicines.

Another major difference between Western and African medical therapy is the fact that in the case of the former, it is generally preformulated and impersonal in dispensation. In contrast, traditional healing practices are tailor-made, so to speak. The rituals, the healing and the preventative prescriptions are designed to suit the individual's special relationships and circumstances. Consequently, such therapies are exclusively private and personal out of awe of and respect for the ancestral spirits involved. Health-care professionals should therefore be aware of the fact that, when obtaining a history of treatment that a patient has received, much more than just names of traditional medicines or descriptions of healing practices are involved. Entrance into the realm of what might be not only private but also very sacred may be at stake. Obtaining the information should be done with great sensitivity and the information received should be handled with the necessary care and respect.

In cases of serious illness or where surgery is necessary, rituals aimed at requesting ancestral protection for survival and the retention of life are performed. It is preferable to perform such rituals at home, even after a person has been admitted to
hospital. Health-care professionals should therefore understand that a person, if at all physically possible, would want to return home prior to a major operation. If the physical condition of the patient does not allow this, then relatives, and even traditional healers, should be allowed to perform the necessary rituals at the patient's hospital bed. In some cases, a family would want to perform certain rituals at the bed where a patient has died. The aim of such rituals would be to remove the spirit from that particular bed in order to prevent the spirit from being confused.

Where it is thought necessary to supplement Western medicine with traditional medicine, it would be incumbent upon health-care professionals to be fully aware of the contents of the proposed potion, as well as of the method of application. A potion would normally consist of holy water or herbs or a combination of the two. In both cases, these substances would have been acquired in special ways, from special locations and at special times. In the case of a terminally ill patient, such medicine may be used to cleanse or purify the soul of the patient in order to ensure a peaceful death. Health-care professionals should at all times have the confidence of both patient and family in order to know when traditional medicine would be applied and to oversee such a process. Where the medicinal properties of certain herbs may clash with the medication that a patient receives, the family should be tactfully requested to refrain from applying the former. Where incisions are to be made by a traditional healer to insert traditional medicine, the process, as well as the particular instruments used, should be overseen by health-care professionals.

3. Buddhism

3.1 Basic Beliefs

Buddhism began in India about 2500 years ago, during the life of an Indian prince called Siddhartha Gautama. He saw that there was suffering in the world and wanted to understand why this was and how to end it. By meditation he found the answers to his questions. After this, he became known as the Buddha, which means 'the enlightened one'. For the rest of his life, he travelled through India, teaching people about what he had learned and how they could leave suffering behind.

Buddhists are people who follow the Buddha’s teachings. They do not worship the Buddha as a god, but see him as the guide for their lives. Today, there are over 400 million Buddhists all over the world. Many live in Asia, in countries such as Japan, Sri Lanka and Thailand.

The Four Noble Truths

In his first sermon after his enlightenment, the Buddha explained the human condition in terms of the Four Noble Truths. This is what he taught about these truths:
Principles of Cultural Assessment
L. de Villiers and A.A. Tjale

Learning Outcomes
After studying this chapter, you should be able to conduct cultural assessments and interpret the data collected by:

- Integrating and applying your knowledge about culture and health to conduct cultural assessments of clients in a multicultural health-care setting;
- Demonstrating awareness of and sensitivity towards the culture of patients during assessment and planning of health-care plans; and
- Designing culturally appropriate health-care plans for culturally diverse clients and their families.

I. Introduction
Culturally and educationally, health-care settings are very complex and the need to understand cultural differences is even more obvious today, since most societies are multicultural, to a greater or lesser degree. Health-care professionals collaborate with individuals and groups of different cultures from across geographical and cultural boundaries. They are faced with cultural differences between themselves and their clients, and amongst themselves. As cultural environments continue to diversify, the need for specialised guided knowledge increases. Competence in cultural assessment will provide the health-care professional with appropriate tools to construct culture-competent health-care plans. Cultural assessment is an integral part of culture-competent health care. Health-care professionals who are skilled in
conducting culture-relevant assessments will demonstrate sensitivity to cultural differences and similarities during their interactions with clients when delivering health care.

2. Cultural Assessment

In health care, assessment is done to determine physical, psychological, spiritual and social characteristics of clients in order to identify their health problems and health needs. This forms the basis for rendering care to solve clients’ health problems and meet their health needs. Traditionally, health-care professionals are taught how to gather biopsychosocial assessment data from the client. However, it is imperative that, once the traditional biopsychosocial assessment data has been gathered in culturally diverse settings, the focus ought to shift towards cultural data. This is to ensure that the health care rendered is consistent with the cultural prescriptions and practices of clients. Cultural assessments are also done to determine the cultural context of health problems and health-care needs. Cultural assessment is done on clients (individuals, families, groups, communities and organisations) in order to identify cultural characteristics of clients; their views and expectations on health, sickness and care; as well as their expectations and preferences with regard to health-care practices.

Cultural assessment occurs on the micro level and is done to gain insights into clients’ contexts and their perspectives on health care. According to Leininger (1984:44), cultural assessment is an essential prerequisite for rendering holistic, humanistic and meaningful health care to clients. Health-care professionals must be able to conduct cultural assessments in the clinical setting and plan their care delivery according to the cultural characteristics and needs of their clients.

Before we continue with this chapter, we must first remind you of what you have read in previous chapters, as most of those aspects are relevant to this section as well. We have introduced you to some theories and models pertaining to culture and health in Chapter 2. Although these are nursing models, the principles are applicable to the health sciences in general and you should approach them with your own profession in mind.

The models that are applicable for this chapter are Leininger’s theory on cultural universality and diversity, Spector’s views about the client within a culturally unique heritage, and Giger and Davidhizar’s transcultural assessment model. You should revise these models and use them to structure your own notes on cultural assessment. There are other relevant topics in the various chapters of this book and you must read this chapter within the context of the information in the other chapters. Pay specific attention to world view, society and culture, intercultural communication, religion and the anthropology of health.
We shall now proceed with guidelines for how to integrate and apply your cultural knowledge to cultural assessments. The discussions that follow provide explanations about what kinds of data should be gathered and why the data is important.

Cultural assessment occurs in two phases, namely determining the general cultural characteristics of clients and also determining their culturally influenced perspectives about health and sickness.

3. Cultural Characteristics of Clients

3.1 Differences in Perceiving the World

World view was addressed in Chapter 2, and the reader is advised to read the discussions on world view again before continuing with this section. Members of a particular culture share a world view (mindset) that is the result of how they were reared and the circumstances under which they grew up. This world view is concerned with the way in which they look at the world and solve problems that they encounter. A people’s world view remains intact for a longer time than some of the customs, beliefs and aspects of their culture (Malan, 1980:10). It would be advisable, therefore, to consider differences in world view when you function in culturally diverse health-care settings, for reasons that will become apparent as you work through this section. Two major categories of world view are the mechanistic and the supernatural perspectives.

The Mechanistic World View

The mechanistic perspective is typically held by those cultures that adopt a scientific approach to life. Members of such a culture typically believe that nature (and disease) can be conquered through experimentation and by applying the principles of science. Values such as self-reliance, self-reliant and proactive behavior to prevent predictable problems from occurring are proclaimed. Those who have adopted this perspective may use the use of analytical thought processes. Health care differs from a Western perspective in accordance with the mechanistic world view, i.e., sickness and disease is viewed as a physical entity that can be treated or removed. Health education aimed at responsible, preventive behavior will have a greater effect on clients with a mechanistic worldview than on those with a supernatural world view.

The Supernatural World View

The supernatural perspective is typically held by cultures that are more traditional and religious. This perspective is characterized by a belief that one does not have much control over one’s destiny and therefore a more fatalistic approach is adopted. Like
occurrences are viewed as being the result of supernatural forces or influences. This perspective generally allows for a value system that supports looking for causes and solutions outside the individual. Traditional healers and religious institutions are prominent in the lives of these cultures, especially in their quest to secure prosperity or to recuperate from adversity. Holistic thought processes are typically practised. It should be noted that many people from more traditional cultures, though having basically a supernatural world view, are also prepared to accept some degree of health care from Western health-care professionals trained in the context of the mechanistic world view.

When conducting cultural assessments, health-care professionals should take differences in world view into consideration, as this knowledge will help them to interpret the cultural data that they have obtained. It is also important to consider that the cultural values that people adopt may be varied. Values, together with world view, shape people’s views about health, sickness and care, and these views influence their health-care practices and health-care delivery expectations.

3.2 Faith

In Chapter 6, we discussed the health-care implications of various religions, and the reader is advised to read this section in conjunction with that chapter. In this section, we stress the importance of assessment of clients’ religion and their associated health-care needs and expectations.

Health-care professionals ought to gather data about clients’ religious affiliation, as well as practices that influence health-care delivery, and incorporate it in the health-care plan in the interest of culture-congruent care. Clients’ needs with regard to prayer and other religious rituals to be performed while in the care of health-care professionals need to be identified and provided for. This also applies to prescriptions and practices involved in death and dying. Religious leaders or other community members are often involved in performing prayer and other rituals or are expected to visit or counsel the sick. Health-care professionals ought to identify these persons and involve them in client care. Clients often participate in religious festivals and adhere to religious prescriptions associated with holy days. It is imperative to note clients’ needs and to assist them in participating in such religious activities.

Religious affiliation often influences how health-care professionals meet the basic needs of clients. It is important to develop a dietary plan specific to the health problem of each client that is also congruent with the prescriptions of his/her religion. Assessment data to be gathered therefore also includes data about food preferences, prescriptions and taboos that are associated with the client’s religion. Clients are often required to expose their bodies because of some diagnostic procedures and health interventions, or while their hygiene needs are being attended to. This may be in
conflict with the modesty prescriptions of some clients' religions. Health-care professionals ought to determine what is expected of clients in terms of modesty and dress, and develop strategies to render health care while also respecting clients' wishes.

3.3 Communication

Intercultural communication is dealt with in Chapter 7, and therefore we will not discuss this issue again. When we conduct cultural assessments, the issue of communication is relevant and therefore you are advised to refer back to that chapter.

Assessment data related to communication includes language spoken, verbal and non-verbal communication styles, and cultural prescriptions and practices associated with communication. Attention should be given to the meanings that clients attach to, for instance, physical touch and the appropriateness of physical touch while engaging in conversation with health-care professionals. While some clients may regard physical touch as part and parcel of interpersonal interactions, others may regard it as inappropriate. Other important factors to assess include practices, meanings and restrictions associated with gestures, and eye contact associated with communication. For instance, while some clients show respect by maintaining eye contact with health-care professionals, others may do so through avoidance of eye contact. The context of speech, such as the relationship between tone of voice and emotions, is also important. Clients express their emotions uniquely and the absence of emotion in tone of voice or in the content of messages communicated does not necessarily mean that a client's emotions are under control (Anderson 1987:12; Giger & Davidhizar 1999:22–38).

The implications of diversity with regard to communication are numerous. For instance, in health education, teaching and learning are, in essence, processes involving interactions between health-care professionals and clients, and among clients themselves. It is therefore necessary that health-care professionals take cognisance of aspects such as communication patterns and the significance of some non-verbal behavioural patterns to prevent unnecessary misunderstandings and conflicts in the health-care setting. Have you ever considered the fact that some clients come from an oral-communication tradition, while others come from a written-word tradition? The implication is that health-care professionals ought to develop skills in rendering health education in verbal, written or visual formats. Some clients will particularly respond to messages that are communicated through song or visual representations.

Communication is the key to successful health-care delivery. Clients and health-care professionals communicate differently with one another for specific reasons. Clients who maintain a collective consciousness have a high-context communication style, for example, people from Africa, Asia and Latin America (Ghyoot 2000:133).
while people from an individualist consciousness have a low-context communication style. In high-context communication, much information is implied in context, and a substantial portion is not explicitly stated and remains unsaid. In low-context communication, information is made explicit in frank, detailed discussions. When assessing clients that have a collective consciousness, it is sometimes difficult to get to the core of the problems that they present with. This can be attributed to high-context communication in which the problem is implied in the client’s responses. It is not explicitly stated. An example of low-context communication can be seen in the wording to obtain written consent for a surgical procedure. In consent forms, the procedure to be performed and the possible consequences are explicitly stated. This is done to avoid misunderstandings. With high-context communication in general life, a verbal decision that is taken in the presence of witnesses is binding.

3.4 Space

The issue of cultural differences in perceiving space is discussed in Chapter 2, and the reader is referred back to those discussions. During cultural assessments, perceptions by clients about personal space are explored to enable health-care professionals to create a therapeutic environment without inappropriately intruding upon the space that is reserved for intimate friends and family. It is important to recognise that there are cultural differences about the physical and emotional spaces that are reserved for different people in different situations.

Giger and Davidhizar (1995:51; 1999:52) describe three primary dimensions of space in Western cultures. All health-care recipients or providers do not necessarily share similar perceptions of space. Health-care professionals must assess and be sensitive to a particular client’s preferences in this regard. The intimate zone is reserved for comforting, protecting and counselling and is reserved for those that are closely related to the client, for example, family members. Interaction with friends and some counselling interactions take place in the personal zone. The social zone is often reserved for impersonal business or interactions with colleagues (Giger & Davidhizar 1995:51).

Health-care professionals should assess clients’ perceptions and preferences about their personal space by asking them about it and attending to their non-verbal behaviours. Aspects to attend to are physical space, the issue of touch and privacy of information.

Health-care professionals must be careful not to infringe on the boundaries set by clients. For instance, some clients may move their chairs further away from other clients in a health-education setting or draw the curtains around their beds in clinical settings. They may even shy away from physical contact with strangers, including health-care professionals. Such professionals should recognise such non-verbal
behaviour as an attempt to secure appropriate distance from others. Similarly, some clients may be reluctant to share their belongings with others. Health-care professionals should refrain from forcing clients to share things that they do not want to share. Similarly, they should also refrain from verbalising private matters of clients within hearing distance of those who need not know the detail of an individual’s private matters.

If health-care professionals ignore cultural values with regard to space, the client may experience inner cultural conflict. Failure to render culture-congruent care could arise if clients feel that health professionals who do not hold similar views on space are inappropriately invading their personal and intimate zones by touching them inappropriately or handling private matters inconsiderately.

3.5 Social Organisation

Social organisation refers to cultural group affiliations such as the nature of the family or kinship networks. The nature of interpersonal relationships and power relationships within a client’s culture should also be determined during cultural assessments. This provides clues about the social needs of clients and how to utilise available social support systems. For instance, clients who have a collective consciousness must be viewed and approached within the context of their kinship structure, while clients with an individualistic consciousness have to be approached on a one-to-one basis.

Collectivism versus Individualism

Ubuntu is a metaphor that describes the significance of group solidarity on survival issues. Ubuntu philosophy implies that African people tend towards a community inclusivis: orientation. This reflects a cultural heritage of traditions, customs, beliefs and value systems. Ubuntu is a unifying social vision enshrined in the proverb ubuntu ngumuntu ngabantu, which, literally translated, means ‘I am because you are; you are because we are’. The group is regarded as being more important than the individual. Ubuntu is ideally expressed through a person’s relationship with others, and others in turn through recognition of their humanity. The essence of ubuntu is humanism, and therefore human values, namely dignity, safety, welfare, health, beauty, love, respect and development, come first before all other considerations, such as economics, and financial and political factors. The principles of ubuntu include co-operation, respect and supportiveness (Khoza 1993). Members of the group are interdependent and collective democracy is exercised by, for instance, reaching collective consensus and exercising collective decision-making. The implication for health care is that clients may be required to make decisions on health-care interventions in consultation with family or relevant community members. This is problematic when decision-making must occur swiftly to pave the way for urgent health-care interventions.
An individualistic consciousness is characterised by individualism, autonomy, independence, self-reliance and personal accountability. In the relative absence of a struggle to survive in Western societies, a focus on survival is replaced by a focus on self-actualisation, which is individualistic and self-driven. Individual autonomy and self-reliance is proclaimed. Decision-making is done on an individual basis (Kotze 1993). It is therefore sufficient for health-care professionals to ask a competent person to decide on health-care interventions pertaining to his/her body.

In health education, clients who have a collective consciousness will flourish in educational settings where organising clients into learning groups applies the principles of collaborative or co-operative learning. Those with an individualistic consciousness may prefer one-to-one educational sessions or even to take pamphlets home to read privately. It is therefore important that health-care professionals offer a variety of teaching strategies to their clients to ensure that they meet the learning styles of clients, who will certainly be from various cultural backgrounds.

**Family**

There are cultural differences in how the term ‘family’ is defined, the nature of family structures and relationships among family members. The term normally conjures up visual images of adults and children living together. A family can be defined biologically, legally, or as a social network that has been constructed by larger social networks and philosophical ideologies. When performing cultural assessments, health-care professionals must determine how their clients define family and whom they regard to be part of their family or their next of kin. While some clients define their next of kin in terms of members of a nuclear family, others may include a wider network of people, such as members of an extended family or clan members.

It is important that health-care professionals understand that the family structure and the roles of family members differ from culture to culture. Over the years, basic family structure has been changing from extended family to nuclear family and single-parent family. The adult members of the nuclear or single-parent family enjoy relative autonomy with regard to decision-making about matters concerning the family and its members. Decision-making may be regarded as an individual matter or may result from negotiations between partners.

However, on the African continent, broad kinship structures continue to define family in terms of extended families. Senior members in an extended family are accorded decision-making responsibilities. For example, within lay care, recognition and diagnosis of health-care symptoms are often delegated to an elder in the extended family. During hospitalisation of a child, women often find it difficult to consent to an operation because a decision-making role has not been assigned to them. For health-care professionals, this often causes unnecessary delays in interventions that are required immediately, as the mother is not keen to take up the
responsibility of making a decision without prior consultation with the father of the child or the family member who is designated with such authority within the extended family.

Relationships and the power balance in families differ culturally. There are differences with regard to beliefs about who is the primary person responsible for making important decisions, as well as the cultural significance of gender, with specific reference to the status of women. Depending on the roles assumed by different members of the family, power relations have been largely based on gender. While a male person has the most power in some families, there are cultures, or individual families within a culture, where the female is the dominant person. In some cultures, women are subservient to their husbands or the dominant male person of the family. It is important to determine the dominant person, because this person is seen as a leader and therefore plays a significant role in decision-making about health matters. The authority of the family leader is clearly defined in cultures with a collective consciousness. In the event of the absence of the most dominant family member when urgent decisions have to be made about the health care of a family member, it is important to advise the less dominant family member who is present to negotiate decision-making powers with the dominant family member to avoid delays in decision-making that could compromise health care.

Assessment of a client’s family structure and assigned role will enable health-care professionals to use their clients’ families as a support system in health care. Certain strengths and weaknesses occur in each family. Identified strengths of a particular family can be utilised for social support. Often family problems are the underlying reasons why clients seek health care. Health-care professionals must identify problems during assessment to assist them in addressing the underlying cause of the health problem and to avoid future occurrences.

3.6 Cultural Differences Related to Perception of Time

Time as a universal of world view is discussed in Chapter 2, and the reader is advised to read that section again. During cultural assessment, it is necessary to determine clients’ unique views about the nature and importance of time, especially as activities in Western health-care settings are time-driven, whereas clients from other cultures may award less value to time constraints and punctuality than health-care professionals in such settings.

Giger and Davidhizar (1999:95-100) describe cultural differences related to time in terms of clock time versus social time. Those who maintain a social time orientation link it to social processes, such as getting-up time, break-time and time to go home (for example, tablets are taken when waking up, at lunchtime and at bedtime). Time can also be linked to natural processes, such as the position of the sun; cycles in nature; and the return of the swallows indicating a change of season (for example,
tablets are taken at sunrise, when the sun is at its highest point and at sunset). Those people may not necessarily adhere strictly to a time-structured schedule. They may arrive late for or miss appointments because events at a particular point in time are regarded as being more important than an upcoming appointment. Persons who maintain a social time orientation may also be reluctant to terminate an appointment simply because the scheduled time has expired. They may also demonstrate a limited anticipatory and preventive approach, because of their focus on the present or past. Those who maintain a clock time orientation link time to a clock or calendar and organise their lives accordingly. Time is related to money or productivity and therefore punctuality is regarded as essential. Those who have adopted a clock time orientation maintain a future orientation, which manifests itself in anticipatory and preventive behaviour (Giger & Davidhizar 1999:95-100; Malan 1989a:43).

It is important for health-care professionals to take cognisance of cultural differences with regard to perceptions of time, as it could result in cultural conflicts and misunderstandings in health-care settings. When assessing time perceptions, health-care professionals should remember that clients’ conceptualisation of time would influence aspects such as how to attach timeframes to therapeutic interventions or what to expect from clients with regard to honouring appointments.

With respect to the issue of time, various questions arise. One such question is: What possible conflicts could arise when a health-care professional sets a firm date and time for a consultation, but a client with a present-time orientation is experiencing a personal crisis just before the consultation is due? Such a scenario could lead to cultural conflicts in both the health-care professional and the client. Whereas the health-care professional might expect that all clients exercise time management and arrive on time, a client may find him-/herself in a situation of crisis management due to a crisis at home. The client may be inclined to focus on the present personal crisis at first and ignore an upcoming scheduled appointment until the immediate problem has been addressed. As a result, he/she may arrive late or simply fail to turn up for the appointment. Health-care professionals should try to understand these cultural differences, but should stress the importance of punctuality in the health-care setting, and guide clients towards accepting such an orientation for the benefit of efficient health care.

Another question is: What possible differences in orientation need to be considered by a professional when he/she has to terminate a consultation session because the designated time is up? When terminating such a consultation, the health-care professional should bear in mind that it may be quite acceptable to clients with a clock time orientation. However, those with a social time orientation may be dissatisfied that a consultation has been terminated just because of time constraints, while some outstanding issues have not been dealt with.
Have you considered the implications of cultural differences in time orientation for giving instructions on medication use? Suppose medication has to be taken three times daily. A person with a clock time orientation may prefer instructions to take the medication at 06:00, 14:00 and 22:00. A person with a social time orientation may prefer instructions such as after breakfast, lunch and supper, or at sunrise, midday and sunset.

Perhaps you should also consider the impact on health care of differences in orientation to satisfying one’s needs. Some clients will be happy to wait for postponed rewards, while others may need rewards such as positive feedback on a frequent basis to motivate them in moving towards their desired health-care goals. For instance, those who postpone needs gratification may be susceptible to adopting a healthy lifestyle now in anticipation of future health benefits, while those who seek immediate gratification may be reluctant to do so.

3.7 Environmental Control

People and their environment have a reciprocal relationship. Clients’ interactions with nature influence their beliefs about illness and its causes. Beliefs about the causes of illness will affect their behaviour in preventing and treating it. Gathering of cultural data on environmental control gives health-care professionals insights into views about the human relationship with nature. For instance, do humans control nature, do humans live in harmony with nature, or is human destiny predetermined by forces beyond human control?

Those who believe that humans are in control of nature generally have faith in medical science to prevent and cure disease. People who have great faith in medical science may take responsibility in utilising scientific preventive measures, but may fail also to be responsible for maintaining a healthy lifestyle. While the scientific basis of having control over effect by manipulating the cause is sound, it does not relieve people from taking responsibility for their own health. For instance, some diseases may be prevented by means of immunisation. However, immunisation will not protect a person from unhealthy eating habits or living in unhealthy conditions.

Those who believe that humans should live in harmony with nature may tend to live healthy lifestyles. A healthy lifestyle may be conceptualised in terms of caring for one’s body by means of nutrition, rest and hygiene. Sound interpersonal and social relationships are also elements of a healthy lifestyle. The same is true of living in harmony with nature by, for instance, maintaining a clean and healthy environment. There are instances where people exclusively rely on a healthy lifestyle to maintain optimal health. While a healthy lifestyle is important, it is not wise to rely on this to the exclusion of scientifically tested medical preventive measures.

Those who believe that external forces, such as God, the ancestors or evil spirits, are in control of their lives may not be susceptible to the message of prevention of
disease in the scientific sense. They may believe that they can only control their
destinies if they conform to prescribed norms and religious ethical codes. They may
view health problems as a punishment from God. Their health behaviour will be
determined by their responses to their beliefs about the causes of health problems.

Clients’ views on environmental control must be assessed to enable the health-care
professional to determine whether the client has a balanced approach with regard to
environmental control or whether one or a combination of these views is maintained
to the exclusion of the other. A balanced approach is the preferred approach, because
this supports the holistic approach to health care. Where clients have not adopted a
balanced approach, health-care professionals can use the assessment data to develop
a behavioural modification strategy to the benefit of the client.

3.8 Biological Variations

In general, health-care professionals conduct physical examinations during the
assessment phase of health-care delivery. There are biological differences in, for
instance, body appearance, susceptibility to disease and bodily responses to disease.
Health-care professionals must take these differences into consideration when
assessing clients from different cultures.

When doing a physical examination, health-care professionals must take into
consideration that there are differences in bodily appearance, such as the appearance
of a healthy skin or healthy hair. Another significant cultural difference is what
constitutes normal physical growth and development. Furthermore, abnormalities,
such as the appearance of skin lesions, differ from culture to culture. This is also true
with regard to bodily responses to diseases, such as HIV/AIDS.

Biological differences that exist may render specific cultural groups more susceptible
to certain health problems. For instance, race and ethnicity are regarded to be risk
factors in diseases such as hypertension, diabetes, certain cancers and anaemia.
Clients should be screened for specific health problems that they may be susceptible
to. When a person belongs to a culture that is susceptible to a certain disease, it
would be wise to include screening for that disease in the assessment, even though
it may not be standard procedure in general terms.

The implication of the above is that assessment tools that have been developed in
countries other than those in which they are used need to be modified for use in a
specific culture. For instance, when utilising criteria for physical growth, health-care
professionals must consider that what is considered to be normal growth and
development in one culture is not necessarily normal in another. Health-care
professionals must therefore be flexible in applying assessment tools in culturally
different or diverse settings.