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The benefits of anthropological approaches for health promotion research and practice

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Abstract

In recent years health education practitioners have been looking for ways to extend the social psychological analysis of human behavior with approaches that focus on the cultural and social context of human behavior. In this article the value of the 'thick description' approach, borrowed from anthropology, is explored by examples from the Caribbean and South Africa. It demonstrates that an anthropological approach has much to offer as a basis for sound interventions for understanding human behavior. However, although an anthropological approach offers valuable starting points for interventions, its broad scope exceeds the traditional goals of health education (changing health beliefs, health counseling). Interventions will not aim at informing individuals, but at improving cultures. They may concern the change of basic cultural and social structures such as gender roles. To limit the risk of ethnocentrism, adequate ways need to be developed to make optimal use of the information thick description offers, while avoiding ethnocentrism. The article ends with a discussion concerning the assets of a dialogical approach towards health promotion. A dialogue between health promoters and their target population may help solve the problem of ethnocentrism in broadly scoped interventions.

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Introduction

Changing people's health behavior is a major challenge for public health workers, particularly when interventions focus on people whose social, cultural, ethnic or economic circumstances differ from health professionals' own backgrounds.

Health education emphasizes the importance of a systematic analysis of determinants of health behaviors, and the consequent development and evaluation of interventions. Predominant models in this field, such as the Health Belief Model and the Theory of Reasoned Action (Rosenstock, 1974; Fishbein and Ajzen, 1975; Ajzen, 1988, 1991), are based on understanding behavior of individuals within the paradigms of social psychology and health psychology. The dominant concern is how to effectively improve health behavior. An important assumption of these cognitive models is that a compilation of an individual's perceptions about the susceptibility and severity of a health threat, perceived advantages and disadvantages of preventive actions, and perceived barriers, determines her or his willingness to change. Barriers range from material factors (lack of transport or money), to social norms (one's expectations about how important others will judge a behavior) and self-efficacy (the estimation of one's ability to perform a behavior). Wrong risk and illness perceptions and other barriers to healthy behavior need to be overcome through health education programs.

In recent years health education has been criticized for its strong emphasis on individual cognit-

ive processes, and its limited attention to the embeddedness of human behavior in cultural contexts and social structures (McLeroy *et al.*, 1988, 1993; Simons-Morton *et al.*, 1988; Burdine and McLeroy, 1992; Gottlieb and McLeroy, 1993; Freudenberg *et al.*, 1995; Landrine, 1995). According to these critics, the current theoretical models assume that health behavior results from separate, isolated behavioral determinants, each of which explains different aspects of individual behavior. While the models recognize the importance of 'social norms' in shaping behavior, choices and attitudes, the main focus remains on the individual who can, if properly educated, overcome social and cultural pressure and act rationally. Assuming that people have autonomous choices in deciding what they do and why, health education renders individuals responsible for their illnesses while attracting attention away from structural, political and economic causes, such as unsafe working conditions and environmental hazards. It blames the victims (Crawford, 1977; Minkler, 1989; Pitts, 1996).

Inspired by this critique, Green *et al.* (Green *et al.*, 1994) and McLeroy *et al.* (McLeroy *et al.*, 1993) pleaded for a combination of theories from multiple disciplines, to better comprehend of health behavior. In response to this debate the 'new' public health paradigm of health promotion has developed. It aims to involve different levels of analysis, i.e. intrapersonal, interpersonal, organizational, community and public policy factors, in understanding and affecting health behaviors (Green and Kreuter, 1991).

Health education has also been criticized for its ethnocentrism and its self-evident acceptance of the superiority of western (scientific) culture.

> Developed specifically to help public health specialists convince people to act more rationally—to use preventive services, obey doctor' orders, or use medical services 'appropriately'—such theories evaluate health beliefs for their proximity to empirically correct knowledge concerning the seriousness of particular disorders or the efficacy of particular behaviors or therapies. The wealth of meanings associated with illness in local cultures is thus reduced to a set of propositions held by individual actors, which are in turn evaluated in relation to biomedical knowledge. (Good, 1995)

In this article, we will use examples from our fieldwork in Dominica and South Africa to explore whether an anthropological approach can contribute to a health promotion that takes into account the dynamic role of culture and social structure, and avoids victim blaming. Although this article uses examples from the developing world, its message extends to post-industrial settings.

Anthropology's potential: linking society and culture

Contemporary approaches in medical anthropology study relationships between cultural and social structures, people's beliefs about cause, course, cure and prevention, and their health behavior. 'Culture' extends to issues of power, control, resistance and defiance as well, and anthropology seeks to understand the links between social stratification (gender, ethnicity, social class), access to material and immaterial goods (food, water, health services, education), illness representations, cultural constructions of femininity and masculinity, attitudes to health promotion, and health behavior. These elements form a specific cultural system in which tasks, responsibilities and proper conduct have become self-evident (Lock and Scheper-Hughes, 1990; Morsy, 1990; Singer, 1990). Describing the relations between these elements is called a 'thick description' (Geertz, 1973). Thick descriptions are based on meticulous fieldwork which may include participant observation, open-ended, unstructured or semi-structured interviews and many other techniques.

Throughout the years anthropological studies into religion and cultural symbols depicted the body as the central organizing concept in cultures across the world (Evans-Pritchard, 1937; Douglas, 1966; Lock and Scheper-Hughes, 1990). By examining ways in which a culture envisions the human

body, one got a profound insight in that particular culture. In the past two decades this focus on the body was accompanied by a heightened interest in the role of 'discourse' in constituting and maintaining social order. Many anthropologists turned to the analysis of cultural discourses concerning the human body (Atkinson, 1990; Jensen, 1991). They were inspired by authors such as Foucault (Foucault, 1975, 1979) and Armstrong (Armstrong, 1983) who viewed the human body as a social construction shaped through discourses and other cultural practices. Notions regarding the human body that arise from such discursive practices include implicit perceptions of the relationship between humans and nature. They reflect societal norms and determine individuals' experience of their bodily self (Lock and Scheper-Hughes, 1990; Armstrong, 1993). By defining bodily difference between the sexes, cultural discourses produce implicit standards for 'male' and 'female' behavior. Socially constructed gender differences become 'natural', and therefore universal and unchangeable. They form the 'natural' basis for social and economic organization of society, and justify power relations between the sexes (Martin, 1987; Jacobus *et al*., 1990; Lupton, 1994, 1995).

In her analysis of gynecological textbooks, Martin reveals that representations of menstruation and menopause reflect notions on femininity which are linked with asymmetrical power relationships between the sexes (Martin, 1987). Menstruation is referred to in terms of 'disintegration' and 'degeneration'. This reveals the implicit notion that the male body is normal (the golden standard), whereas the female body is deviant and, consequently, socially inferior. Menstruation, according to this perspective, has become a disorder, which needs treatment. This cultural image influences women's individual experience of and coping with menstruation. Martin's example shows that cultural and social constructions of the body, and consequently of masculinity and femininity, not only shed light on differences in social power between women and men, but also relates them to illness representations and consequent health behaviors (Richters, 1991b; Schoepf, 1991; Krumeich, 1994).

Unraveling the way in which a specific culture links notions on the human body with gender constructions and perceptions of health and illness provides a fruitful basis for the understanding of that culture. In the next paragraph, we will explore the potential of this type of analysis for health promotion. We will present 'thick descriptions' that highlight the role of cultural constructions of the body, gender and illness in breastfeeding practices in Dominica, and in the prevention of sexually transmitted diseases (STDs) in South Africa. These thick descriptions are based on extensive periods of fieldwork in two rural villages in Dominica, and among Xhosa and Zulu women in South Africa.

The fieldwork in Dominica was carried out by one of the authors in collaboration with a Dominican counterpart from one of the villages. The counterpart was involved in all stages of the research. Different techniques for data gathering were used, including participant observation for a period of 9 months, ethnographic interviews, the keeping of diaries by mothers and grandmothers, and the recording of the life histories of mothers and grandmothers. An average of 60% of all women with children under the age of 5 and 48% of all women aged 45–64 participated in the project. These women were engaged in self-subsistence farming, informal trade or unskilled labour and could be classified as low-income. Participant observation entailed living in the household of one of the participating women. The interviews with the younger women were conducted in English (Dominica's official language). Interviews with older women were conducted in the local Patois. Towards the end of the fieldwork all women who had participated were invited to comment on the findings of the study and to brainstorm on its implications during a seminar, organized for this purpose by the Dominican Ministry of Health.

The fieldwork in South Africa consisted of extensive ethnographic interviews with 60 Xhosa and Zulu women who visited STD clinics in Cape Town and the rural community of Mapumalanga.

These women belonged to the low-income group. South African research assistants, trained by three of the authors, conducted the interviews in the Xhosa and Zulu language. The interviews were audiotaped, transcribed, translated in English and analyzed. The results were discussed extensively with key informants.

Gender and health in Dominica: 'breast is best'

In Dominica one of the aims of primary health care is to encourage mothers to breastfeed their babies. This 'breast is best' program forms an important part of the health education sessions at ante- and post-natal clinics. Krumeich has shown that Dominican gender relationships determine the chance of success of these health education interventions in different ways (Krumeich, 1994).

In Dominica, women generally head their own household or live in their mother's household. They have to make a living for themselves and their children. Female status in Dominican society is closely linked to the number of children women have and to their ability to permanently hold on to a partner. Men's status strongly depends on their virility, the number of sexual partners they can conquer and the number of children they are able to procreate. On the other hand, being able to resist marriage is also a proof of masculinity, for it reveals that a man does not let himself be captured by tenderness towards a woman. Thus, for men, there is a need to have many female partners who cannot claim him to be theirs. At the same time, he must show to the community that he is the father of the children born out of these relationships. He does so by providing infant formula (milk powder, adapted to the needs of young infants) to the mothers of his children. Giving formula symbolizes his fatherhood. It publicly shows which children are his and offers the opportunity to evade marriage. Women, unable to persuade their partner to marry, opt for second best: because the male's gift of formula publicly proves their having a relationship—an important aspect of female status—they generously accept. Since the formula can be used for other children as well, it is a welcome contribution to the household. This explains why Dominican women and men did not always share primary health care's preference for breastfeeding.

Thus, this example shows the link between women's social position (economic autonomy), cultural constructions of gender (importance of motherhood and ability to attract men for women; importance of men's ability to conquer women while remaining free) and health behavior (using formula instead of breastfeeding).

Another way in which gender relations interfere with compliance with 'breast is best' advice is through cultural notions about human anatomy and illness representations. Dominicans think of the human body as a plumbing system that consists of connected cavities. A body is healthy when all cavities have the same temperature. It is the blood's function to maintain the temperature balance throughout the body. This balance can be disturbed when the body has to deal with sudden changes in temperature, e.g. by consuming hot or cold (literally or symbolically) foods or drinks, by experiencing (negative) emotions, or by contact with cold air, water or wind. Conflicts in the relationship with a male partner lead to such negative emotions and the resulting disbalance in body temperature spoils women's milk. Additionally, since it is also believed that intercourse has a negative effect on the quality of breast milk, the woman risks losing her partner to another woman. Refraining from intercourse creates a situation of conflict in which strong emotions such as jealousy are likely to occur. If such emotions arise women often decide to switch to formula. Giving in to the partner's sexual desires, however, also leads to the use of formula because the quality of the milk has become dubious.

This example shows how the above-mentioned links between social position, cultural gender constructions and health behavior are further shaped by illness representations.

Finally, there is a third way in which cultural notions on femininity interfere with 'breast is best' objectives. Dominican women's skills and experience as mothers and caretakers determine

their social status and their self-esteem. As the nurses who provide health education are mostly young and without children, the mothers consider them inexperienced and naive. Accepting these nurses' advise would undermine the mothers' self-esteem and status.

Thus, notions on femininity in Dominica influence women's attitude towards health care providers (nurses are not taken seriously because of their inexperience with motherhood) which also contributes to non-compliance with breastfeeding advises.

Gender and health in South Africa: promoting condom use

Due to the threat of AIDS there has been an increasing attention for the prevention of STDs and HIV in South Africa. STD clinics in Cape Town townships and in the rural areas of Mapumalanga encourage safe sex and advise the use of condoms. The study of Meyer-Weitz *et al.* shows that in Xhosa and Zulu communities gender relationships interfere with compliance regarding condom use (Meyer-Weitz *et al.*, 1998).

Xhosa and Zulu constructions of femininity and masculinity mirror norms regarding sexuality. Men are supposed to be always ready to have sex, to know all about it and to take the initiative. Their status depends on the number of sexual partners they conquer. However, Xhosa and Zulu people distinguish between the 'close' woman (primary partner) and the 'distant' ones (secondary partners). A man owes love and caring to his primary partner, but not to secondary partners. Male sexual performance is linked to actual penetration, which symbolizes dominance and initiative. These images of masculinity are also related to Xhosa and Zulu men's responsibility to secure the continuation of their own clan. This explains the respect for male semen, which symbolizes procreation of the clan.

Xhosa and Zulu women, married or not, are in general economically dependent on men. Usually, unmarried women receive gifts from male partners in exchange for sexual favors. Married women can claim financial support for themselves and their children from their husband. Xhosa women's status is strongly dependent on mothering children and on being able to keep a permanent partner. A real woman is able to fulfil her partner's sexual needs by submitting to him whenever and however he wants. As a consequence, women are socialized not to express their sexual needs and preferences, not to disclose being knowledgeable about sexual issues, and to be submissive. Thus, they are responsible for keeping their partners' inclination to have sexual contact with other women under control. Therefore she is forced to either find excuses for his behavior, e.g. by blaming 'women on the street' for misusing her partner's sexual nature, or keep it secret. Bringing up the subject of his infidelity would violate norms of reservedness and submissiveness. This will provoke violence or, worse, her partner may decide to leave her.

As a consequence of gender constructions, neither men nor women find the use of condoms very attractive. For men, initiating condom use may provoke his primary partner's suspicion, because it implies that he has 'outside' contacts. To avoid trouble at home, men do not talk about condom use. Another consequence of the use of condoms is that sperm is wasted. This is considered a form of disdain towards the man's clan; it disregards the clan's continuation. Men's inclination to have multiple partners, their preference for penetration during sex and their reluctance to use condoms puts themselves and many others at risk.

For women, using condoms is even more unattractive. As women are largely dependent on men's gifts, they run the risk of missing these gifts as soon as they bring up the topic of condom use. This may suggest that they are promiscuous, in which case men may decide that they are not entitled to receive gifts. Moreover, suggesting condom use is at odds with cultural norms such as submissiveness and obedience towards men as it would force women to openly confront their partner with his behavior. It would also threaten her self-esteem as it proves that she has not been able to keep her partner 'home'. Demanding condom use by women requires a discussion about issues that do not fit with the cultural norm of

reservedness towards sex. As has been argued above, neglecting these norms increases the risk of violence or the loss of one's partner. Since condom use also prevents pregnancy, which is at odds with prestige derived from motherhood, it is clear that the disadvantages of condom use for women outweigh the advantages.

This example illustrates how social position (women's economic dependence) and constructions of gender (the importance of motherhood, women's submissiveness and reservedness towards sexuality and the men's responsibility to the primary partner and the continuity of the clan) influence people's health behavior (not using condoms).

Additionally, gender constructions seem to be related to illness representations. In Xhosa and Zulu culture STDs are referred to in terms of 'dirty blood'. A STD is perceived as an entity that has entered the human body and has polluted the blood. The source of STD infection is always ascribed to women. Both sexes accuse 'dirty women in the street' of spreading STDs. These women are 'loose', in contrast to women showing inexperience and reservedness, which is associated with cleanliness. When women bring up condom use, regardless of whether they are primary or secondary partners, this could very easily be interpreted as a confession of their own 'dirtiness'.

This case illustrates how illness representations ('dirty versus clean blood') reflect power relations between the sexes (men as dominant, women as obedient) and cultural constructions of gender (looseness versus reservedness in women). It also shows how illness representations and gender relations influence health behavior (no condom use because of fear of damage to one's reputation).

Towards an anthropological approach?

Our 'thick descriptions' from Dominica and South Africa demonstrate how different cultural elements, centred around the concept of the human body, influence each other. They reveal that the way in which these elements are connected differs from one setting to the other and they show how cultural sensitivity improves problem analysis in health promotion. The anthropological perspective facilitates the interpretation of what people say and do, and why they say and do this. It explains why and when Dominican women prefer infant formula, and why they do not trust the advice of primary care nurses. It provides an understanding of why condom use is not a very attractive option for Xhosa and Zulu men and women in South Africa. Moreover, these examples illustrate how human behavior is so deeply grounded in its specific cultural system that speaking in terms of autonomous choices and barriers for health behavior disregards its context, and is therefore problematic. This cultural awareness prohibits 'victim blaming', an inevitable consequence of the assumption of the 'rational individual' that is at the core of the current health education paradigm.

A thorough analysis based on anthropological theory and methods is also indispensable while planning and developing health promotion interventions. It provides clues to decide when, where, with whom, how and on which issues to intervene. In the first place, a problem analysis based on a thick description may result in broadly scoped interventions that at first sight appear not to have a direct relation with health because they do not directly address a change in health beliefs, health counseling or health services. As our examples highlight the role of gender constructions, one should pay attention to norms about masculinity and femininity in order to realize behavioral change. If, for example, Xhosa and Zulu men in South Africa could be convinced that masculinity does not equal sexual dominance and the production of off-spring, women would acquire a better starting point for negotiation and condom use would have less negative associations. When Dominican people could be made aware that femininity is not synonymous with being able to keep a partner and to have children, women would not have to put so much effort in keeping their partner satisfied and in showing the world that they succeed in holding a partner. They would become less socially dependent on men. As a consequence, the formula might lose its symbolic value and the notion that breast milk

can be spoiled by a negative emotion like jealousy would become superfluous. An increased popularity of breastfeeding might follow.

This broadly scoped intervention approach overcomes the earlier-mentioned criticism of a narrow conception of culture and human action. However, it aggravates ethnocentrism. Instead of just providing health education, the health promoter—cured from cultural naivety—sets out to change the whole society. He/she does not merely evaluate health beliefs but rather judges the way in which men and women relate in a particular culture. The victim may no longer be blamed, but culture is. This problem is not new in health promotion practices that focus on community development and empowerment. Nor is it new to anthropology.

For some decades doubts have been cast over the possibility to avoid ethnocentrism, to capture 'the native's' real point of view and to write it down in neutral ethnographies. Scrutinizing established universal anthropological theories uncovered the ethnocentric, often gender biased, nature of these cross-cultural theories (Said, 1978; Clifford, 1983; Ortner, 1984; Clifford and Marcus, 1986; Geertz, 1988; Fine, 1994). For that reason many anthropologists abandoned their quest for strictly defined universal theoretical models. Some proposed to study each culture in its own right, while avoiding universal claims (Johnson and Sargent, 1990; Lock and Scheper-Hughes, 1990; Morsy, 1990; Di Leonardo, 1991; Good, 1995). Others ascribed a more modest role to theory. Theory no longer offered universal truths about mankind but became a handy tool for ethnographers to make sense of an otherwise intangible local situation (Geertz, 1983). In our application of the thick description approach we incorporated both solutions. We did start from insights concerning body, gender and illness representations, but merely as a means to interpret and structure our findings. We also refrained from universal cross-cultural claims.

However, we still struggle with the problem of ethnocentrism because the problem goes deeper. Discourse analysis of ethnographic texts in the past two decades revealed that ethnographers could not describe 'the Other' as he/she really is. Taking their own cultural standards for universal truths, ethnographers create the deviant, the exotic 'Other' in their writings. This creation is grounded in the ethnographers' personal and cultural norms and values, and in their assumptions regarding gender, race and class. As this discovery gained momentum, the authority of ethnographic knowledge became an issue, and so became the ethnographer's credibility as spokesman for those he/she studied. Present day anthropologists still struggle with this crisis of legitimation (Vidich and Lyman, 1994). One way to deal with this crisis is to accept that ethnographic knowledge is different from the knowledge people have about their own lives. Ethnographic knowledge is based on systematic analysis; the people's knowledge is based on personal experience. Both look at reality from different angles, but neither is truer than the other (Said, 1978; Fine, 1994). For those engaged in health promotion the question is how to take advantage of the richness of a thick description as well as of the people's experience.

Health promotion dialogue

One way to realize this is intervening by means of an ongoing dialogue. Inspired by a number of authors (Freire, 1972, 1983; Bookman and Morgan, 1990; Wallerstein and Sanchez-Merki, 1994; Nussbaum and Glover, 1995; Young, 1997), we propose interventions in which the target population is asked to react on the anthropologist's or health promoter's cultural analysis. In this way the target population can assess whether this analysis parallels their own experiences. It enables local people to resist, correct or refine the health promoters' interpretation of their lives. Thus, the ethnographer no longer is the sole authority on the culture of the target group. His/her problem analysis, organized and interpreted in accordance with theories concerning gender, illness and cultural constructions of the body, rather serves as a starting point for a discussion in which the voices of the people whose health is at stake are included. Such a discussion may result in increased critical

consciousness among both the target group and the health promoters about cultural mechanisms that underlie personal experiences with regard to health matters.

On the other hand, the dialogue will open up discussion about the health promoters' assumptions and norms. For example, a health promoter might have linked gender constructions with health behavior in a specific community, and, because of his/her (western) point of view, be inclined to automatically interpret these gender relationships as wrong and in need of change. The dialogue with the target population might indicate that this population does not agree with focussing on this aspect in order to realize the program objectives, but would prefer to look for other starting points for intervention. A discussion might follow in which both parties can try to convince each other. Such a dialogue is an intervention in its own right.

In addition to the dialogue about the health promoter's problem analysis as intervention strategy as such, the discussion provides ideas for further steps regarding how, when and where to tackle the health problem. For example, Dominican women suggested emphasizing cultural notions of motherhood (i.e. women as responsible mothers) for the promotion of breastfeeding among young women. In this way gender relationships could remain unchallenged while promoting breastfeeding in a culturally acceptable way. Similarly, in the South African context, community nurses suggested to point out to men that their clan would be served best by producing healthy offspring, and that this is at odds with STD and HIV infections. A healthy offspring could compensate for the sperm waste associated with condom use.

So far dialogical approaches have not been practised on a regular basis, but there are examples that underscore its relevance for health promotion. Successful examples are a project on water and sanitation in Kenya (Cavanaugh, 1999), several community-based mental health projects in Africa (Roy, 1999), an employment project for widows in India (Nussbaum, 1995), and projects for high school dropouts in the US (Fine, 1991).

Conclusion

As our examples from Dominica and South Africa illustrate, thick descriptions, especially when paying attention to cultural constructions of gender and the human body, are promising for problem analysis and intervention design in health promotion. They shed light on relevant aspects of local cultures that otherwise escape attention. However, anthropological studies should be combined with a dialogical approach. Recent debates in anthropology have denounced the cultural bias in classical (universal) anthropological theories as well as in ethnographies, the products of anthropological work. A dialogical approach helps to overcome this problem. It combines the voices of the researcher whose knowledge is based on scientific analysis with the voices of those whose knowledge is based on personal experience. Moreover, a dialogical approach is not just a good way to overcome ethnocentrism. It further deepens anthropological insight into the socio-cultural context of health and health behavior, and adds to the critical consciousness of all parties involved.

In this article we did not discuss examples from post-industrial countries. Michelle Fine's work among high school dropouts shows, however, that anthropological thick descriptions can play a valuable role in understanding culture all over the world, post-industrial culture included.

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