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Conceptual

Reengineering Health Promotion with a Cultural Lens among Africans in Diaspora: An Integrative Approach

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Abstract

One of the social determinants of health is culture. Studies have identified that ethnic minorities in comparison to non-minorities receive lower quality health care. One of the reasons advanced for this variation is the knowledge gap by many health care providers as it relates to a better appreciation of the culture of their clienteles. Thus, it becomes imperative that any health promotion program focusing on ethnic minorities must take into consideration that cultural differences play a role in the health status and health care of individuals.

I analyzed corpus of studies to help me have a better appreciation of the integration of culture in the planning and implementation of health promotion programs among Africans in diaspora. The facts that emerged from the available literatures on this subject matter raises concern as to how culture is prioritized when caring for a racially diverse population as in contrast to the dominant population.

Keywords: Health Promotion; Cultural; Health Care

Introduction

Over the years, we have witnessed a decline in disparity gap in some health issues and the overall improvement in the health profile of many Americans most especially in communicable diseases. One contributing factor to the positive changes in the public health landscape is health promotion programs. Despite these accomplishments, non-communicable diseases constitute a significant public health issue [1]. In the U.S., from 2001 to 2012, they have been a significant increase of 22% of chronic disease among adults, who have 2 or more of these conditions [2]. In comparison to the dominant population, chronic disease is more prevalent among multicultural populations in the U.S. [1,3,4].

The on-going influx of immigrants continues to change the demographics of the U.S. and has produced the most diverse country in the world because of her ethnic and racial milieu [5]. To this effect each immigrant groups have their generally agreed norms and values, which reinforce their conceptions of disease and how health care decisions are made in the different communities [6]. The Immigration Policy Center made a projection that the current population of African immigrants will quadruple by 2050 [7]. It is congruent, to focus on how best to meet the health care needs of this growing population.

Discussion

Over the years, studies have identified knowledge gaps as it relates to culture among physicians and health care professionals in the U.S. Some primary physicians are frustrated because of their lack of knowledge and skills in effectively navigating the needs of patients/families from a different cultural background. Differences in cultural affiliation can hinder effective health intervention. This scenario becomes very conspicuous when health practioners in the course of assessment and intervention, undermine, stereotype, or misinterpret their interactions with individuals who came from a different cultural backgrounds [8]. The poignant question is how we deal with this knowledge gap.

An activity geared toward the promotion of health of either individuals or communities is a formidable task. Endeavors of such nature demand an organized effort in understanding that cultural beliefs and practices are strong determinants of behaviors associated with health [8,9]. There exists a commonality among many health professionals of the necessity to address cultural and socio economic factors on health behaviors in at risk populations [1,10,11].

In recent years, the term "culturally sensitive" was coined to describe initiatives that were designed to include ethnic minority communities in promoting healthier lifestyle and disease prevention [12]. Sometimes, I am tempted to think that this is more of political correctness than concretely addressing the issue at hand. Interventions that are utilized as it relates to ethnic minorities are adopted at surface structure. Some scholars made a distinction between programs adopted at surface structure as against those adopted at deep structure. According to these scholars, the surface structure philosophy revolves around observable characteristics such as people and language and the latter intervention focuses on cultural, social, environmental and psychological forces that determine health behaviors [12].

A study utilized a meta ethnographic approach through data analysis to ascertain the effectiveness of health promotion interventions in ethnic minority communities. In sifting through the corpus of studies, they developed five principles to use in program developments-(1) utilization of community resources to enhance access to interventions; (2) identify factors that preclude accessibility and participation in health promotion; (3) overcoming language barriers through the use of appropriate communication strategies; (4) identification and integration of cultural and religious norms that either promote or inhibit changes in behaviors; and, (5) recognizing in the course of program planning and implementation varying levels of cultural affiliation and assimilation of the focus population [12].

In looking at the five principles, the interventions that had more impact were associated with the fourth principle, which has to do with identifying and aligning interventions with cultural and religious views of the focus population. Campaign for smoking cessation program was implemented during Ramadan, when Muslims are more receptive to religious messages [13]. This is a clear example of deep-rooted intervention that not just recognized religious values of a focus group but integrating their religious values into the planning and implementation of the intervention.

In a study conducted among male immigrants of African descent residing in San Diego, California, the participants stated that anytime that they are symptomatic, there first line of action is to consult their wives [3]. Despite the fact that African societies are masculine society, wives are held in high regards on health issues. Generally speaking with respect to health related issues, women are considered as very resourceful [3]. This statement validates an earlier study with a finding that women pay more attention to their health and are more aware of health risks than men [14]. Based on these findings, it would be very appropriate that, in any intervention focusing on African male, there is a high probability of a positive outcome, if women are involved in the planning, implementation and evaluation of the said intervention. This is a classic case of using a cultural lens to promote an intervention that resonates with an ethnic community.

Conclusion

In conclusion, I believe that for any intervention to have a positive outcome, we must go beyond stereotyping and prejudices towards others. Further, it is imperative that such an intervention should address deep rooted influences such as cultural health beliefs and practices on health related behaviors and not simply being culturally sensitive in relation to the use of language. It suffices to point out that mere modification of a program on the ground of culture may not necessarily make it very effective. Rather, taking extra steps to discover cultural norms that resonate with the focus group and to what extent those norms influence health related behaviors would produce meaningful results [15].

Bibliography

1. National Institutes of Health. Health promotion among racial and ethnic minority males. (2016).

2. Shirai T. "Toward through integration in medicine-the growth of integrative medicine and the new precision medicine and lifestyle medicine movements in the U.S". *Japanese Journal of Biofeedback research.* 45.11 (2018): 19-23.

3. Agi LA., *et al*. "Perceptions of stroke risks among West African immigrants in San Diego: A qualitative investigation". *Diversity and Equality in Health and Care*. 13.5 (2016): 372-378.

4. Gutierrez J and Williams OA. "A decade of racial and ethnic stroke disparities in the United States". *Neurology* 82.12 (2014): 1080-1082.

5. Kimbrough JB. "Health literacy as a contributor to immigrant health disparities". *Journal of Health Disparities Research and Practice* 1.12 (2007). 93-106.

6. Schneider MJ. "Introduction to public health". (3rd Ed.). Jones and Bartlett Publishers, Inc. (2010).

7. Immigration Policy Center. African immigrants in America. A demographic overview. (2012).

8. Huff RM and Kline MV. "Health promotion in the context of culture". Sage Publications (2008).

9. Simmelink J., *et al*. "Understanding the health beliefs and practices of East African refugees". *American Journal of health Behaviors.* 37.2 (2013): 155-161.

10. Resnicow K., *et al*. "Cultural sensitivity in public health: defined and demystified". *Ethnicity and Disease* 9 (1999): 10-21.

11. Howard VJ., *et al*. "Disparities in stroke incidence contributing to disparities in stroke mortality". *Annals of Neurology* 69 (2011): 89-99.

12. Netto G., *et al*. "How can health promotion interventions be adopted for minority ethnic communities? Five principles for guiding the development of behavioral interventions". *Health Promotion International* 25.1 (2010): 248-257.

13. Taket A., *et al*. "Evaluation of London-wide Ramadan Campaign". South Bank University. (2003).

14. Blocker DF., et al. "Knowledge, beliefs, and barriers associated with prostate cancer prevention and screening behaviors among African American men". *Journal of the National Medical Association.* 98 (2006): 1286-1293.

15. Chiang C. "The effects of a walking program on older Chinese American immigrants with hypertension". University of Massachusetts, Amherst, USA. (2005).

16. Shaw SJ., *et al*. "The role of culture in health literacy and chronic disease screening and management". *Journal of Immigrant Minority Health* 5 (2008): 1-9.

17. Waller J., *et al*. "Beliefs about the risk factors for cervical cancer in a British population sample". *Journal of Preventive Medicine* 38 (2004). 745-753.

18. Ward BW., *et al*. "Multiple chronic conditions among US adults: a 2012 update". *Preventing Chronic Disease* 11 (2014): E62.

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