Health and Culture: A Basis for Development of Extension Health Service Programs

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Abstract

Health is a priority need where related services should be extended to people and empower them on aspects that is beneficial to their wellbeing. However, approaches toward health intervened bythe culture outgrown by the people in a society that oftentimes influence beliefs about the origins and nature of illness and how it will be managed. Therefore, understanding individual and cultural beliefs about health and illness is essential. This is vital in developing effective approaches on how to improve health of the people though, everyone's experience with illness is unique and personalized. Community's health development through empowerment of people on services that will benefit them was the ultimate goal of this project at which participatory assessment was the initial step to identify what particular health needs to be addressed. At which, sequential explanatory strategy of mixed method research design was used where survey on holistic health indices followed by key informant interviews and observations particularly on their health-related practices, traditions were the means of data collection applied. All gathered data on health and health related problems has inference to their culture. It was also noted that culture has implication to the health status of the community. Therefore, it is highly suggested to develop extension services on promotive and preventive health programs that is more intensive particularly on healthy lifestyle, prevention and control of communicable and non-communicable diseases, family planning, environmental safety and sanitation, personal hygiene and community-based health projects based on their beliefs and practices. Moreover, clear and simple dissemination of result prior to planning should be given an emphasis to avoid conflict and to gain full participation of the community.

Keywords: *Health, culture, community, illness, health service programs.*

Introduction

Cultural perspectives show limitations that control people because of beliefs and traditions transferred through generations that are sometimes advantageous for it inculcates discipline to youth. However, these often delimits how people think and react to certain scenarios especially towards health and illnesses where cultural dimensions are essential to physiological and psychological health. The Center for Advanced Research in Language Acquisition (CARLA) defined culture as the shared patterns of behaviors and interactions, cognitive constructs, and affective understanding that are learned through a process of socialization. Further, Brives & Le Marcis described culture as a set of distinctive spiritual, material, intellectual and emotional features of society or a social group … [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.[1] At this point, health should be examined from the viewpoint of culture and health point of view because a culture of health is one in which good health and wellbeing flourish across geographic, demographic, and social sectors; fostering healthy equitable communities guides public and private decision making; and everyone has the opportunity to make choices that lead to healthy lifestyles(Evidence for Action, n.d.). Hence, connection of health and culture

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appears from the professional world of healthcare and positive impact of culture on health that is considered an essential focus on culture reflected in two strategic frameworks that underpin a project on cultural contexts of health and wellbeing in the European policy framework Health 2020[2] and the 2030 Agenda for Sustainable Development.[3]Moreover, it has always been the focus of the World Health Organization (WHO) to look on awareness of cultural contexts of health program implementation and/or understanding community resilience and wellbeing in the face of poor health and economic hardship. The Cultural contexts of health which was rationalized by 2014 Lancet Commission on Culture and Health contended that the systematic neglect of culture in health and health care is the single biggest barrier to the advancement of the highest standard of health worldwide.[4]

On the other hand, health is a priority need where related services should be extended to people and empower them on aspects that is beneficial to their wellbeing. However, approaches toward health intervened by the culture outgrown by the people in a society that oftentimes influence beliefs about the origins and nature of illness and how it will be managed. Therefore, understanding individual and cultural beliefs about health and illness is essential. In fact, Napier, Ancarno, Butler, Calabrese, et al.[5] claimed that the worldwide equality can only be achieved by recognizing cultural systems of value and countering the idea that local cultures are obstacles to worldwide equality. Indeed, a failure to acknowledge culture leaves its negative effects unaddressed and its positive potential for providing new models of thinking unrealized. Thus, ignoring culture prevents each individual the sense of belonging in a local moral world.

The argument ascertained that culture and health are related at which health beliefs and practices is vital and should be included during participatory community health assessment as basis for developing health service programs.

Methodology

The sequential explanatory strategy of mixed method was utilized in this endeavor. It emerged from the paradigm wars between qualitative and quantitative research approaches that is widely used as a mode of inquiry.[6] In this study, collection and analysis of quantitative data comes firsts followed by qualitative data collection and analysis to substantiate the findings of the quantitative data. Moreover, purposive-convenience sampling was utilized because the selection of participants is criterion- based and this study relied on available household members of Betwagan, Sadanga, Mountain Province, Philippines during the survey.

In the quantitative part of this study,a self-made family health assessment tool was utilized after reliability testing making use of Kuder-Richardson 20 (KR20) coefficient which was declared valid for the coefficients of reliability is 0.99 and the descriptive equivalent is “very reliable”.Furthermore, frequency count and percentage were used to reflect findings of the survey for it can be easily recognize which among the findings should be the priority. Furthermore, a semi-structured interview guide was used for the qualitative part of the research guided by[7] framework of themes to be explored. Meanwhile, key informant interview was conducted purposely to discover informants’ feelings, perceptions and thoughts that focused on the past, present and, the essential experiences of the participants.[8] The theme of the interview was on the health beliefs and practices of households who voluntarily agreed to participate. Descriptive analysis of qualitative data was used as it can simply connect the meaning of responses during interviews supported by the observation.

Before data collection, ethical considerations were given priority until the final stage of this study. Since participation of human persons was involved, the researchers ensured that human rights are fulfilled through the process of ongoing informed consent, continual assessment of risk versus benefit for research participants, and the prevention of harm; and conduct research that is relevant to communities of interest, are guided by participation of these communities in identifying research problems, and strive to benefit patients, society, and professional practice.[9]

Results and Discussions

Data on health and culture of the people in Betwagan, Sadanga, Mountain Province, Philippines was taken through community health participatory assessment. This is a methodological process which is focused on the local health indices of community for diagnosis, planning or development of strategies that will address the identified health needs and its implementation. Due to wider coverage of gathered information, this study regrouped the collected data into three clusters. These

are:(1) Community vital statistics particularly on age and gender of the people in the community; (2) Community health statistics which include the diseases or health conditions of the community; and the (3) Community demographics particularly on (a) socioeconomic indicators such as occupation, employment status and place of work, (b) sociocultural indices such as educational attainment, religious affiliation and housing, and (c) environmental health markers particularly on water supply, human waste and garbage disposal.

Community Vital Statistics: Table 1 presented the distribution of population according to year and gender. As shown, majority of the population belongs to the age group 21-40 years old which was almost equal in number. This stage is also called early adulthood at which, individual of this age is typically vibrant, active, healthy, and are focused on intimate relationship, romance, child bearing and careers. Physical abilities are at its peak, including muscle strength, reaction time, sensory abilities and cardiac functioning. Taking into consideration the ranks, it was noticed that it projects a direction that is conducive for a sustainable healthy community.

Table 1. Distribution of population according to gender and age group

Age Group (Year)	Male			Female			Overall		
	f	%	Rank	f	%	Rank	f	%	Rank
>60	114	10.04	4	90	7.41	6	204	8.68	5
41-60	187	16.46	2	193	15.90	2	380	16.17	2
21-40	355	31.25	1	354	29.16	1	709	30.17	1
18-20	62	5.46	7	86	7.08	7	148	6.30	7
15-17	78	6.87	6	103	8.48	5	181	7.70	6
13-14	95	8.36	5	121	9.97	4	216	9.19	4
7-12	123	10.83	3	151	12.44	3	274	11.66	3
4-6	40	3.52	9	48	3.95	9	88	3.74	9
1-3	53	4.67	8	55	4.53	8	108	4.60	8
0-11 Month	29	2.55	10	13	1.07	10	42	1.79	10
Overall	1136	100.00		1214	100.00		2350	100.00	

However, it was observed that 0 – 6 years old found at the last three among the groups while the first and second populated age group are from 21 –60 who are in the reproductive age or childbearing period. Yet, they are not family planning acceptor. Follow up were done where most of them are married at their thirties and some are still single. On the other hand, more than 60 years old was found at the 5th rank. Individuals in this stage are vulnerable to non-communicable and chronic diseases which is more on lifestyle related illnesses. Lastly, the data reflected that there was near to perfect distribution of males and females. This indicated a successful and healthy community environment as it depicts equality in terms of communication, interest and motivation. One thing, having the same number of sexes working together means more sustainable, successful work environment.

Community Health Demographics: This cluster has three focuses which are socioeconomic status, sociocultural indices and environmental health markers. Table 2 revealed the socioeconomic status of the community. Its emphases are on occupation, employment status and place of work. As gleaned from the table, most of the people in the community are farmers. The community has wide-range area for farming vegetables, rice, and sugarcane. This made people considered themselves as self-employed that is an advantage to their health because the distance of their residence to the farms are minutes to an hour which served as their daily warm up exercise. The most alarming issue is the unemployed citizens. Among them should have to become productive as what was concluded by the researchers. This should be one from the prioritized focus of developing the

community to avoid these people into not good source of income. Moreover, most of the people works within the community which means that there are tendencies of economic stagnation. An alarming increasing number of unemployed individuals sometimes an advantage for some help in terms of health-related emergencies considering the distance of the community to the main road as an access to health care facilities. However, being a stand byer due to unemployment results to bad habits like smoking and drinking as it is their common practice to gather in one area or a small convenient store if they do nothing at home or elsewhere. Good thing for people has a practice on simple investment and budgeting that made them always within the level threshold which is beneficial in the sustainability of their essential needs every day. Moreover, food is their priority for they have granaries (arang or agamang) for their stocks. With the simplicity of their life, they even save money for the education of their children.

Table 2: Socioeconomic status of the community

Indices		**f**	**%**	**Rank**
Occupation	Farmer	996	62.3	1
	Laborer	193	32.38	2
	Miner	26	4.36	3
	Army	15	2.52	4
Employment status	Employed	234	9.98	3
	Unemployed	211	16.71	2
	Self-employed	996	73.32	1
Place of work	Inside the community	968	67.18	1
	Outside the community	473	32.82	2

On the other hand, Table 3 illustrated the sociocultural status of the community. Most of the residents are elementary level. However, second most numbered residence of the community was college graduate which has narrow difference that neutralizes the finding. This was validated by the result of interview that education was the second priority of the people in the community. The direction of educational attainment is good but the 7th in rank is too alarming. Still many from them have no formal education. On follow-up, it was found that residents who had no formal education are mostly the elderly. Reasons which arose for the inability to attend schooling were: (a) they cannot afford a very expensive education; (b) they work in the farm to support their parents and sibling; and (c) there were no schools back in the old times. On the other hand, Roman Catholic is the most dominant religious affiliation despite of other sectarian group existence. Though there are varieties of religious affiliations, they have still commonalities in terms of their cultural beliefs and practices.

Table 3. Sociocultural status of the community

Indices		**f**	**%**	**Rank**
Educational attainment	Elementary Level	396	18.75	1
	Elementary Graduate	253	11.98	6
	High School Level	348	16.48	3.5
	High School Graduate	348	16.48	3.5
	College Level	318	15.06	5
	College Graduate	359	17.00	2
	No Formal Education	90	4.26	7

Indices		**f**	**%**	**Rank**
Religious Affiliation	Roman Catholic	188	60.26	1
	Baptist	36	11.54	3
	Free believers	13	4.17	4
	Espiritista	74	23.72	2
	Anglican	1	0.32	5
Housing	Wood	133	24.05	1
	Concrete	28	5.06	3
	Mixed	127	22.97	2
	Owned	248	44.85	1
	Rented	17	3.07	2

Furthermore, land ownership enhances personal freedom. The freedom can maximize owners to utilize their land with no hindrances. Most families who reside in the community have their own land and house they can stay. Moreover, majority of the families live in a house made up of light material which is wood. Some are old houses that are built years ago and are just being maintained by the family who inherited these from their folks. Some are mixed which are made up of wood and cements and it is seldom to see houses made by strong materials. As to lighting facility, electricity had reached the community where most are utilizing and minimal are still using other means. There were no street lights seenin this community that people can use during night emergencies and is considered hazardous for anybody is vulnerable to accident. One thing, path ways have no siderails for the safety of people passing considering the terrain of the community.

On the other hand, environment health markers were shown in table 4. Water is a necessity resource that every family need in the farm, family survival and other environmental activities. It was noted that most of residences shared water resources. However, each has own connection from the main line for household consumption. Shared water supply is purposely for laundry and agriculture as their main source of living.

Table 4. Environmental health markers of the community

Indices		**f**	**%**	**Rank**
Water supply	Shared	226	82.78	1
	Owned	47	17.22	2
Human waste disposal	Flush	198	61.88	1
	Pit privy/latrine	12	3.75	3
	None	93	29.06	2
	Under construction	6	1.88	5
	Shared	11	3.44	4
Garbage disposal	Collected	26	5.65	5
	Waste segregation	76	16.52	2
	Feed to animals	45	9.78	4
	Burning	233	50.65	1
	Burying	15	3.26	6
	Open pit dumping	13	2.83	7
	Dispose along the river	6	1.30	8
	Others	46	10.00	3

Further, most of them have their own flush type for human waste disposal which is an advantage due to abundancy of water. However, sanitary considerations should be strictly observed for this method considering that toilets are normally the place where waterborne diseases in the gastrointestinal and urinary started. Moreover, families who don't have toilets land at the second on rank. This means that they are utilizing other means of disposing. Nice to know that pit privy or latrine is sufficient enough within the community as the shared human waste disposal for those who don't have toilets while other families have their own.

The community was observed on its stage of development for some families are still on the process of constructing their own toilets. Further, burning was their most preferred garbage disposal. It's nice to know that segregation of waste was done before burning because burning of other materials like plastic may intoxicate people as well as the environment leading to vulnerability to illnesses. Others was the third choice which either be combination to any of those because they scored the indicator without specifying if how. The last two choice is somewhat alarming because the way they dispose their garbage is not the proper way that may result to other health problems.

Community Health Statistics: This describes the health behaviors, diseases, and injuries of people in the community and its comparison to the national targets. In this community, it is their common belief that being healthy is when anybody can be able to do their functions, work well and are productive. Further, the community has health center with trained volunteers called barangay health workers (BHW) and a midwife. BHWs are the one conducting home visits to gather health related information and disseminate health programs of the government. There were times that public health nurse (PHN) does visits in the community if necessary same as with the municipal health officer. At this point, midwife assigned in their locality was the most preferred health worker for consultation followed by BHWs. The distance between the community to nearest hospital or the main health center is far enough for a regular travel related to health consultation. Alburaryo or quack doctor were the least they visit in terms of health problems that has implication to their culture.

Breastfeeding and immunization were highly recommended and always reminded by health workers to each family of its advantages at which, mothers claimed that they practice breastfeeding until their child do not like to do. The advantages as what claimed by mothers are: free, no special preparation, accessible all the time and tends they knew the difference of breast milk and formula milk because they even claimed that breast milk is more nutritious and less allergens than the formula milk. As to immunization, there's a need for further education of what benefits a child can avail from the expanded program on immunization by the government. Records at the health center reported minimal numbers of children who are fully immunized that was confirmed by mothers during interview. Same as to the importance of the tetanus toxoid immunization of mothers. It seems they need to know more about the benefits of the said preventive regimen due to minimal number of reported mothers who underwent the vaccination. The community dominantly took medications as prescribed. They sometimes used alternatives like calamansi juice for cough and boiled guava leaves for diarrhea. Moreover, there is a government pharmacy called "botika" for them to buy medicine at affordable price where the one in-charge explains how it can be taken, its duration and alike.

On the other hand, table 5 revealed top 10 diseases and injuries encountered by the people in the community. These problems were classified under health deficit, health threat and foreseeable crisis where data needed were taken through survey, interviews, observations, and records from the health center.

As revealed, hypertension was on the top list. Food preference was one of the suspected reasons of its existence. The residents are fond of preparing cured meat they called it as "etag"followed by diarrhea which is related to personal hygiene and environmental sanitation. Pneumonia is a highly contagious disease at which suppressed immune system was one of the reasons of its occurrence. Hygiene also add on it cause. Moreover, arthritis was one of those that is related to their daily activities and diet. Farmers are hard workers while dried beans and internal organs are example of foods, they usually eat that increases uric acid. Fall was one of the reported cases related to lack of street lights and siderails of pathways for the people to pass. Heart Failure is related to hypertension and tuberculosis correlates to pneumonia. Moreover, anemia and goiter are related to the foods they are eating. Lastly, UTI (Urinary Tract Infection) is more on personal hygiene. One practice which is related to hygiene and infection is that, carrying a naked cadaver from one person to

another which are also naked which they believe that more blessing if any secretion coming from the dead body drops to the carrier.

Table 5: 10 leading diseases and injuries

Indices	f	%	Rank
Anemia	5	3.97	8
Arthritis	14	11.11	4
Diarrhea	20	15.87	2
Fall	8	6.35	5
Goiter	3	2.38	9.5
Heart Failure	7	5.56	6.5
Hypertension	46	36.51	1
Pneumonia	13	10.32	3
Tuberculosis	7	5.56	6.5
UTI (Urinary Tract Infection)	3	2.38	9.5

Conclusions and Recommendations

All gathered data on health and health related problems has inference to their culture. It was also noted that culture has implication to the health status of the community. Therefore, it is highly suggested to develop extension services on promotive and preventive health programs that is more intensive particularly on healthy lifestyle, prevention and control of communicable and non-communicable diseases, family planning, environmental safety and sanitation, personal hygiene and community-based health projects based on their available resources, beliefs and practices. Moreover, clear and simple dissemination of result prior to planning should be given an emphasisto avoid conflict and to gain full participation of the community.

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