Is Health Promotion Relevant Across Cultures and the Socioeconomic Spectrum?

Alexandra García, PhD, RN

Is health promotion a White middle-class phenomenon that people from other cultures and classes do not regard as important? When implementing health-promotion initiatives, are healthcare providers making assumptions that are not valid for other cultural or socioeconomic groups? How do people of various cultures and classes perceive health and health promotion? To explore these questions, this article reviews some of the relevant literature on culture and class in relation to health promotion, exploring issues foundational to the effectiveness of health-promotion programs and pertinent to delivering health-promotion interventions to ethnic, racial, and cultural minorities and poor populations. Health promoters are encouraged to consider the social determinants of their patients’ health and tailor programs on the basis of their patients’ motivations and resources. **Key words:** class, culture, health promotion

The relevance of health promotion to heterogeneous populations is an important issue for healthcare practitioners, researchers, and policy makers who are interested in developing and delivering inclusive, culturally appropriate interventions and evaluating their outcomes. Researchers and providers have implemented health-promoting interventions for diverse groups of people for many years and have reported mixed degrees of success. They have also been aware that unequal distributions of disease and disability disproportionately affect racial and ethnic minorities and impoverished peoples. These disproportionate impacts are called health disparities. To address these disparities, healthcare providers have been directed by the Healthy People 2010 guidelines to increase the quality and years of healthy life by promoting health and preventing disease, disability, and premature death, thereby attempting to eliminate health disparities.

In the purest sense, health promotion is associated with wanting to improve one’s health via “behavior motivated by the desire to increase well-being and actualize human health potential.” Such behavior changes might include engaging in more physical activity or getting more sleep. Health promotion, consistent with the Healthy People 2010 mandate, also includes health protection, or “behavior motivated by a desire to actively avoid illness, detect it early, or maintain functioning within the constraints of illness.” Health protection might include incorporating more hygienic or safer practices into daily routines, participating in disease screenings, or obtaining immunizations and vaccinations.

Sociocultural factors, such as ethnic or racial identity, culturally based practices, and socioeconomic standing, are acknowledged in several health-promotion models but are viewed as relatively fixed and not amenable to healthcare providers’ interventions. These factors deserve closer attention because they may be the key to improving health-promotion efforts and resolving health disparities.

From the School of Nursing, The University of Texas at Austin.

Corresponding author: Alexandra García, PhD, RN, School of Nursing, The University of Texas at Austin, 1700 Red River, Austin, TX 78701 (e-mail: alexgarcia@mail.utexas.edu).
Culture and Class

We should not build on the assumption that health is a universal value that can be uniformly promoted to all populations because much of what healthcare deliverers assume about health promotion may not hold for many patients. The ineffectiveness of some health-promotion interventions may be the result of unarticulated incongruence of social and cultural assumptions between the health-promotion intervention deliverers and the targeted group. To explore questions related to issues of relevance that seem to be crucial to developing the next stage of health-promotion interventions, this article reviews literature on health promotion with respect to culture and social class.

CULTURE

Culture is a term that refers to the inherited set of implicit and explicit rules guiding how a group’s members view, feel about, and interact with the world. Cultural expressions and, to a lesser extent, cultural values change over time and are influenced by others. Individual and group beliefs about personal control, individualism, collectivism, spirituality, familial roles, and communication patterns contribute to cultural expression. Even so, cultures are heterogeneous so that there are few, if any, constants among all members.

Most people belong to more than one culture based on their ethnicity or where they live and work. Healthcare professionals themselves comprise a particular culture. The notion that healthcare providers and people outside the healthcare culture (including those who are ill or have a disability, live in rural or underserved areas, are of low education levels, or who are impoverished) may have differing beliefs, values, or perspectives on health, illness, and how to manage health has been well documented by medical anthropologists. Ethnomedicine and emic approaches have been used to understand how people conceptualize their health, diseases, illnesses, treatments, and symptoms in the context of their culture and experience. For instance, Hunt and Arar reported that though patients and physicians were usually compatible in their beliefs about the cause and course of diabetes, they differed strongly in their goals, strategies, and evaluations of care.

In fact, although researchers have focused on how people of various cultures define illness, they focus less often on how people define their health and maintain it according to their definition. Several studies have quantified behaviors believed by healthcare providers to promote health (eating a diet high in fiber and low in cholesterol, eg) but few have explored which behaviors people of other cultures (ie, minority, disabled, rural, underserved, chronically ill) consider important or the meanings ascribed to those behaviors. Arcury et al explored these questions with rural-dwelling elderly Anglo-Americans, Blacks, and Native Americans and found agreement in several domains and themes of health-promoting behaviors across the groups. For instance, balance and moderation were themes common among members of all 3 ethnic groups.

On the basis of an awareness of the importance of culture, program developers have made considerable efforts to make interventions that are culturally relevant. The following 5 questions arise from a concern for cultural relevance and health promotion.

First, is health promotion not relevant because of differences in cultural norms? For instance, is health promotion too individualistic for a member of a collectivist culture? Strong group or family-oriented values can create a predisposition not to engage in activities when they are for the exclusive benefit of an individual, especially when they interfere with that person’s obligations. Health-promotion efforts would be more successful if based on the understanding that for many participants personal fulfillment comes from satisfying group rather than individual needs.

Second, does the Anglo-American emphasis on efficiency create a barrier to people who are used to more personal healthcare systems? In Hispanic cultures, personalismo,
characterized by a trusting close relationship, is an important element for Hispanics’ interactions with their healthcare providers. Does \textit{personalismo} have a counterpart in non-Hispanic cultures? Perhaps so, for even Anglo-Americans reminisce about the “good old days” when physicians made house calls and were intimate members of their patients’ societies. Health-promotion programs might incorporate more \textit{personalismo} in order to attract and retain Hispanic clients and others preferring friendly and intimate interactions.\textsuperscript{12,13}

Third, if the culture is oriented more in the present than in the future, is a focus on disease prevention relevant? Is promoting health a goal for people who hold a fixed belief on their future health status? Some people seem governed by fatalism, which inhibits the seeking of medical help and possibly deters them from making lifestyle modifications.\textsuperscript{12} For them, it can be extremely difficult to change from a sedentary lifestyle or a long accustomed harmful diet. As cited in Hunt and Arar,\textsuperscript{9(p356)} one Mexican American said, “Well I have diabetes, what the hell, I’m gonna die anyways.”

Fourth, could a group’s pervasive low self-esteem and depression be to blame for some participants’ reluctance to engage in health-promotion activities? Hunt and Arar\textsuperscript{9(p356)} quoted an Anglo-American physician’s assistant working in South Texas who said, “\textit{Mi cuerpo es jonque} [my body is junk] is a typical comment [from Mexican American patients]. Their houses and cars are junk, too, so they accept the same for their bodies. . . . They don’t see much to live for, so they want to die happy, eating.”

Finally, some cultural beliefs may be inconsistent with the requirement to be proactive. Holland and Courtney\textsuperscript{14} suggested that Hispanic immigrants tend to expect the healthcare provider to cure their ailments and are not accustomed to an emphasis on health promotion, disease prevention, and self-responsibility. So, are differences in expectations about responsibility for health based on differences in culture? These questions and others like them should be explored for people of various cultural groups.

\textbf{SOCIAL CLASS}

Certainly, not all behaviors and beliefs can be explained by culture; many other factors may determine behaviors and beliefs. For instance, individual factors (such as age, gender, intelligence, education, and experience), socioeconomic factors (such as social class, occupation, and sources of social support systems), and environmental factors (including the natural and built environments and exposures) may influence behavior at various times.

Social classes, or “hierarchically arranged, socially meaningful groupings linked to the structure of society,”\textsuperscript{4(p377)} make up complex societies and have their own mores.\textsuperscript{4} In the sociological literature, class relates to the economic and political power described by Marx. More commonly, social class is used interchangeably with socioeconomic status (SES),\textsuperscript{16} referring to stratifications based on education, income, occupation, and property ownership.\textsuperscript{15} As cited in 2 extensive reviews of patterns of SES and health,\textsuperscript{15,17} many studies have demonstrated a clear relationship between SES and health during the latter half of the 20th century, reflecting rapid gains in health for those with high SES and worsening conditions for those with lower SES.

In general, health disparities are often attributed to low SES.\textsuperscript{1,15} Higher levels of income and education are related to lower mortality rates.\textsuperscript{18–22} Lower SES respondents were more likely to smoke cigarettes, not exercise or exercise less, and eat fewer fruits and vegetables. Furthermore, lower SES respondents were less likely to be future oriented, had lower expectations of longevity, and had stronger beliefs than higher SES respondents toward the importance of chance to health status.\textsuperscript{23} These behaviors and beliefs begin in childhood. Children who have grown up in socially disadvantaged homes are less likely to have consistent daily mealtimes and bedtimes.
or eat lunch or dinner with their family. Overall, people with lower SES die earlier than people with higher SES, partly because people with higher SES have healthier lifestyles. Moreover, social inequalities lead to unequal exposures to environmental hazards.

Although health-status differences between income groups are greater than differences between races, minority status is often used as a synonym for low SES in part because health indicators are rarely reported by income levels in the United States. Poverty affects proportionately more women of color than White women and affects more women than men. Women are vulnerable because of their responsibilities as caretakers to children and elders. Minority women are affected more than White women because race is more likely than gender to influence quality of education, leaving a larger percentage of minority women ill prepared to earn a living wage. Long-term adherence to a healthy diet and exercise regimen is always challenging for patients in terms of motivation and self-control, but it is particularly challenging for the impoverished because of the necessary extra expenditures of money and the time needed. Health-promotion strategies, therefore, may not be effective for people with lower SES because of their bigger challenges to meet their basic needs, that is, to earn a living and provide a home for their family members. It is likely that some of what healthcare providers ask people to do for health promotion is not compatible with the essential demands upon their time and income, much less with their preferences for food or “leisure” activity. Furthermore, patients who are depressed (because of the effects of disease, poverty, or racism) may not feel they can make a significant difference or even begin to learn and practice new behaviors.

Access to, and quality of, medical care, though an important determinant of health status, is not always readily available to low-SES persons. People who cannot get an appointment for illness care certainly will not try to make preventive or wellness visits. This is unfortunate because when they do receive medical care that care seems to exert a greater impact on their health than on their more advantaged counterparts. There is a definite need for creative health-promotion strategies to reach low-SES families.

For example, a low-SES Latina with diabetes could not justify time for medical visits, preparing healthy meals, or exercising because she worked 12 hours a day, 7 days a week, to care for her children. Only after her bilateral amputations when she could no longer work did she have the time (but not the income) to focus on her and her family’s health. Low-income Latinas declared that lack of time and money was a major barrier to attending preventive mental health programs and health-promotion programs for new mothers and their families.

Individuals identified as members of the middle-class described health as having “energy, positive attitudes, and the ability to cope well and be in control of one’s life.” Crawford argued that middle-class samples were more likely than working-class samples to relate health to a sense of personal control. Freund et al posited that because working-class people have less control over their circumstances than do middle-class people, the concept of personal control may be remote or even inconceivable to them. Accordingly, the amount of control people have may be the key determinant of their ability to be interested in wellness, its components, and aspects as well as their ability to follow healthcare recommendations. It stands to reason that those with some time to spare and interest in current affairs are likely to be the first to hear about the latest developments in healthcare. High-SES people also have the resources to put this information to work for them, whether in buying necessary products, changing routines or behaviors, or in accessing professional help.

People with chronic illnesses may be viewed by the medical, government, and middle-class establishments as being in opposition to the model of a good citizen, that is, the citizen “who actively participates...
in social and economic life, makes rational choices and is independent, self-reliant and responsible. Those lower SES persons who are also burdened with chronic illness usually lack the resources to be so responsible. They are not likely to engage in an active approach to healthy living, which necessitates engaging in time-consuming or costly health-promoting activities, or even to abstaining from risky health behaviors, which may provide a feeling of pleasure. The ability to benefit from health promotion seems to be related to one’s autonomy and self-determination; therefore, people who lack either or both are likely not to respond as well to health-promotion interventions.

Control over one’s circumstances allows one to consider following health-promotion advice, like choosing a health-promoting diet and engaging in regular physical activity. This “choice” seems far more real for those who actually have the ability and control necessary to opt for healthier living. Those who do not follow health promoters’ advice appear to be choosing a lifestyle that jeopardizes their well-being and are labeled as noncompliant. No one wants to die of AIDS, lung cancer, cirrhosis of the liver, or injuries sustained in an automobile accident. The public policy debate is not over the desirability of avoiding illness, injury, or premature death, but over the individual and collective sacrifices we are willing to make to maximize our chances of living long and healthy lives. If those sacrifices were simply of a material nature, the personal and social dilemmas that lifestyle modification issues raise would be less intractable. The choice, however, is rarely limited to spending more or less money; it invariably involves allowing more or less personal freedom.

Crossley (building on Crawford) explored the notion that health has become a moral phenomenon in that there is an expectation in Western society that people will do what is necessary to live long and well. She described a tension between the values of individual responsibility toward health and individual freedom for decision making. She suggested that the more extreme practices of actively resisting health messages by smoking, drinking more than modest quantities of alcohol, eating excessive amounts of fattening foods, and engaging in other risky health behaviors are a way for people to assert their rights, freedom, and independence from society at large and from what they perceive to be the government’s interference in their personal lives.

Her focus group participants expressed skepticism toward health-promotion messages and a distrust of the credibility of health-promotion authorities (scientists, government agencies, and healthcare providers) because of the frequent changing messages about particular health behaviors. Rather, the participants embraced the popular philosophy that all things can be healthy in moderation and the notion that too strict a lifestyle is unhealthy, an echo of Williams’s explanation that lay beliefs embrace pleasure as part of being healthy. In a similar vein, Blaxter noted that some working-class people “express[ed] scorn for those who need to engage in health-promoting activity [as] the mark of a self-indulgent life.” For people of these opinions, Crossley’s solution was to engage them in a dialogue about the benefits of the suggested behaviors instead of giving them authoritative directives.

According to Blaxter, members of the working class and middle class agreed that health depends on personal behaviors and that individuals are responsible for their own health. In fact, it seems that both classes have internalized the dominant Western cultural value of health as an individual’s responsibility to the extent of blaming individuals for ill health. On the other hand, those in the middle class were more likely than those in the working class to attribute ill health to environmental and social causes.

Most health-promotion messages seem to presume that lifestyles are controllable and disregard the possible effects of luck or chance and environmental circumstances. Considering that most improvements in health and life expectancy have been the result of public health achievements, such
as vaccinations, safer workplaces, motor vehicle safety, increased safety and improved nutritional content of food, family planning, safe-sex recommendations, and anti-smoking campaigns, perhaps more health-promotion efforts should be aimed at the community level. By recognizing the multiple social determinants to health and safety, health-promotion strategies can be tailored according to the unique resources, circumstances, and concerns of the community. Community-wide strategies that make health maintenance a normal way of living are of benefit to people of all cultures and classes and can make individual health messages more palatable to those who would benefit from behavioral changes.

CONCLUSION

Healthcare providers seem to be caught in the tension between the population's health perceptions and needs. In our Western society, health interventions are often targeted to individuals without taking into account important social determinants of their health status. Our current health-promotion model therefore is not necessarily relevant for people whose social determinants are so weighted against their health that they do not exercise control over their own behavior. Identification of these people and their particular frames of reference can more effectively market health-promotion efforts.

There is however a risk of paying too much attention to “culture.” We must be careful that identifying members of particular cultures does not label them with a finite set of determinants that leaves out individual beliefs, feelings, and experiences that may turn out to be important for the success of health-promotion interventions. Effective healthcare provision addresses both individually focused strategies and broad policies to improve the economic and social environment and can be tailored to address the problem at hand.

Practitioners realize that placing blame upon patients and labeling them as noncompliant is not helpful. Instead, health promoters must intervene at the individual level on health behavior because they can recognize the barriers to compliance, such as overwhelming poverty, and also try to find reasonable and viable alternatives. Individual providers cannot remedy either SES or the environment and must, therefore, work harder to adapt the plan to the circumstances.

The lifestyle choices people make depend on their individual characteristics, their personal health circumstances, as well as the biases assimilated from their culture. The challenge for health promoters is to deliver healthcare messages in a way that all kinds of people find relevant and to enable all patients to practice the advice they are given. To that end, health-promotion interventions need to be based on knowledge of cultural effects and be personalized and adapted to patients' situations and SES.

REFERENCES


