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Influence of Cultural Health Beliefs on Healthcare Providers/Patients' Communication

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Abstract

The study examined the influence of cultural health beliefs on healthcare providers/patients' communication in primary healthcare centers in Delta state, Nigeria. The objectives of the study were to ascertain whether the cultural health beliefs of the respondents influenced communication between healthcare providers and patients in the area of study as well as the medication adherence and healthcare seeking behaviours of the patients. The triangulation approach was adopted for the study, using a combination of Survey and Focus Group Discussion (FGD) methods. Under survey method, a sample of 316 respondents was purposively selected and studied using the instrumentation of the questionnaire for data collection. Also, Sixty eight (68) FGD participants and sixteen (16) in-depth interviewees featured in the respective FGD and in-depth interview sessions that were conducted in the study. The theoretical framework for the study was provided by the Health Belief Model (HBM), and Theory of Planned Behaviour (TPB). The result of the study showed that, whereas respondents' cultural health beliefs did not influence communication between providers and patients, they influenced patients' medication adherence and healthcare seeking behaviours.

Keywords: Cultural health beliefs; Healthcare providers; Patient communication; Theory of planned behaviour; Health belief model

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Introduction

African societies and their cultural practices have over the years commanded global attention as it concerns the health conditions of the people [1]. Sule et al. observe that, in much of Africa, cultural beliefs, religion and traditional medicines have historically gone hand in hand, increasingly causing conflict with modern healthcare [2]. They state that, it is actually estimated that about 70-80% of the population in developing countries depend on traditional medicine for their health care needs. Despite the evidence of studies indicating that positive results have been recorded in the use of traditional medicine, there are also issues of complications, standardization, claims of 'all purpose-efficacy' treatment of illnesses that have resulted in more deaths among rural dwellers who are noted to be higher percentage users of traditional medicine [1].

In a bid to address these concerns about health management in Africa, several groups and individuals have collaborated with African governments, signed Memoranda of Understanding (MoU) as well as sponsored health programmes at different times to help in the improvement of the health conditions of the people. Unfortunately, these efforts have failed to yield results that are commensurate to the investments and targeted goals [1].

One of the major purposes of health communication is to inculcate health literacy in patients that will enable them make informed health choices as communication between patients and healthcare providers is important for the effective functioning of the healthcare system [3]. Therefore, it has been proposed that strong, clear and positive relationships with physicians can radically improve and increase the condition of a patient [4]. This is why Edgar and Hyde (2004) recommend interpersonal communication between healthcare providers and patients as one of the most effective strategies for achieving positive health outcomes in patients. Studies have shown that the goal of achieving effective communication between healthcare providers and their patients has always been beset by a number of barriers one of which is patients' cultural health beliefs [5,6]. Zhumadilova calls it miscommunication arising from discrepancies in expectation of both healthcare professionals and patients due to cultural and historical differences [7].

This is the situation that gave rise to the concept of cultural competence. According to Korez-vilde, cultural competence is defined as when a person from one culture is able to interact effectively with people from a different culture [8]. In the words of Betancourt and Langer, when healthcare providers fail to

understand the socio-cultural differences between themselves and their patients, the communication and trust between them may suffer [9]. This in turn may lead to patient dissatisfaction, poorer adherence to medications and health promotion strategies, and poorer health outcomes. In other words, the field of cultural competence in healthcare has emerged to achieve the ultimate goal of engendering a healthcare system and workforce that can deliver the highest quality of care to every patient, regardless of race, ethnicity, cultural background or English proficiency [9].

While agreeing with the above argument on the import of cultural competence in intercultural provider-patient medical encounter; it is the opinion of the researchers that the best practices of cultural competence are also required in intra-ethnic and intra-cultural encounter between providers and patients, especially in Africa where, through the process of enculturation into the western biomedical culture, healthcare providers are placed in disparate locations of the cultural map from those of patients in their indigenous communities, the demographies of their common linguistic and ethnic backgrounds, notwithstanding [10].

Interestingly, contrary to the preceding arguments and concerns expressed on the cultural import of patient/provider communication to the quality of healthcare delivery, Ojua, and Katung, enthuse that development, civilization and education, among other factors, have helped to introduce tremendous positive change in the beliefs and behaviour of Africans towards orthodox medicine patronage [1,11]. How true is this assertion? To be certain, it became imperative to empirically verify the influence of cultural health beliefs on the communication between healthcare providers and patients at the primary Healthcare centres in Delta State as well as how these beliefs influence the patients' medication adherence behaviour and the healthcare seeking behaviour they exhibit.

Statement of problem

There are mind boggling and frightening statistics about the clinical and economic consequences of medication non-adherence and poor healthcare seeking behaviours of patients in the world today. The World Health Organization (WHO), reports that adherence' values in various medical conditions in the world is about 50%, being much lower in the developing countries than in the western countries [12]. Medication non-adherence in health conditions is thus a critical clinical and economic problem. Unfortunately, studies have also shown that the goal of achieving effective communication between healthcare providers and patients has always been beset by a number of barriers prominent among which is patients' cultural health beliefs. This is particularly so in Africa which, in the opinion of Andrews and Boyle, belongs to the magico-religious and deterministic cultural beliefs groups, who believe that health problems are caused by factors such as supernatural forces evil forces, enchantment, preordainment etc., and that cure can only come from the intervention of powerful medicine men making use of their charms, herbs, and other paraphernalia of their calling [13]. This cultural belief system is usually expressed in defaults in allopathic medical care such as resort to alternative medicine, non-adherence to medical advice and prescriptions, self-medication, procrastinated resort to medical advice and their attendant consequences for health outcomes such as deterioration of patient health condition, worsening disease, treatment failures, increased hospitalization, increased health care costs and even deaths [14].

To solve this problem, the notion of cultural competent communication is now recognized by health policy makers, managed care administrators, academicians, healthcare providers and consumers as a strategy to eliminate the barrier of patients' cultural health beliefs to effective provider/patient communication in healthcare [15]. The problem of the study is that whereas the evidence of relevant literature reviewed shows that there is an avalanche of cultural competence literature on inter-cultural clinical encounters between healthcare providers and patients, this is not the case with intra-cultural settings. This study fills the gap in knowledge by providing empirical evidence of how cultural health beliefs in clinical encounters between healthcare providers and patients within homogenous cultures influence communication, medication adherence and healthcare seeking behaviours of patients in Primary Healthcare Centers (PHCs) in Delta state.

Objectives of the study

• To ascertain the cultural health beliefs of the people of Delta State.

• To ascertain the nature of communication between healthcare providers and patients of PHCs in Delta state

• To ascertain whether cultural health beliefs of healthcare providers and patients at the PHCs in Delta State influence their communication with each other.

• To determine the influence of cultural health beliefs on the medication adherence behaviour of patients of PHCs in Delta State.

• To determine the influence of cultural health beliefs on the healthcare seeking behaviour of patients of PHCs in Delta State.

Theoretical framework

The theoretical foundation of this study was based Health Belief Model (HBM) and Theory of Planned Behaviour (TPB).

Health Belief Model (HBM): The health belief model is a theoretical framework frequently used in the analysis of health-related behaviours. It is a psychological model used to explain and predict health behaviour by focusing on the attitudes and beliefs of individuals. It was first developed in the 1950s by social psychologists Hochbaum, Rosenstock and Kegels. The basic assumptions of HBM are that, in order for a person to take a preventive or curative action over a given disease or ailment, the person has to first, see the sickness as serious and a potential threat to his wellbeing; second, believe in the prospects of a cure from taking required action; and third, provided there are no major financial, emotional or social barriers confronting him in the course of taking that action [3].

Much more than Hochbaum's original concern of using the model to test tuberculosis screening in the 1950s, subsequent extensions of the model have been associated with its application in other

contexts, including other forms of screening, immunization and compliance with medical treatment for conditions such as diabetes, renal failure and hypertension [3]. As it is, the model has been overwhelmingly tested on the above-stated health conditions in Europe, America and presumably, other developed nations of the world. To the best of the researcher's knowledge, this is not the case in cultural settings such as ours in Africa.

Invariably, the constructs of the model are applicable to the health concerns of patients in the area and population of this study. As such, the study will provide further insight on the applicability of cultural variables in preventive or curative health behaviours, especially as it relates to the Ukwuani people of Ndokwa West LGA; and how this can be factored into the perception of the people's health conditions and motivation for cure.

Theory of Planned Behaviour (TPB): According to Barber the Theory of Planned Behaviour (TPB) was born as the Theory of Reasoned Action (TRA) before it was reformulated by Ajzen in 1988 to specifically account for some of the reasons why individuals may not behave as intended [16]. However, the core of the theory remains the same as those of other related models of behavior to the effect that, general attributes, beliefs and preferences related to behaviour predict behaviour [16]. Regardless, there are nuances in the emphasis of each of the models. For instance, even though the TRA and TPB are both value-expectancy theory based models like the Health Belief Model (HBM), they lack the threat concept normally seen as central to the HBM. Similarly, although the TRA and TPB have the shared components of behavioural beliefs, behavioural attitudes, normative beliefs, subjective norms and behavioural intentions, TPB is differentiated from TRA by the additional dimension of Perceived Behavioural Control (PBC) [17]. In other words, TPB built further on the framework of TRA such that, in the case of TPB, behavioural intentions and behaviours are taken to be functions of perceived power and perceived behavioural control. While perceived power refers to the perceived presence of factors that may facilitate or impede performance of behaviour; Perceived Behavioural Control (PBC) refers to performing the behaviour of interest. It is this inclusion of the PBC construct that created the shift from the theory of reasoned action to the theory of planned behaviour. In the words of Taylor et al. the PBC construct introduces into the TPB model self-efficacy, which may in part be determined by social positioning as well as further facilitate the inclusion of perceptions of external influences such as economic barriers to service access or discriminatory racial attitudes among service providers or other users or, as in the case of this study, cultural health beliefs constituting a barrier in the communication between healthcare providers and patients [17]. The view has been expressed that the Theory of Planned Behaviour (TPB) has been used successfully to predict and explain a wide range of health behaviours and intentions including smoking, drinking, health services utilization, breast feeding, and substance use among others. As Armitage and Christian, put it, there is a large volume of research indicating that the theory of planned behaviour has utility in predicting health behaviours, and that observed statistical relationships between its internal constructs based on behavioural, normative and control beliefs has significance across a wide range of contexts [18].

Just like the health belief model, the theory of planned behaviour is relevant to this study. This is so because of its value added benefit of explaining health behaviours outside the control of the 'threat' element of HBM. Put differently, the relevance of TPB to this study derives from its emphasis on the individuals or executioner's confidence level and ability to undertake a planned behaviour irrespective of the external factors inhibiting or facilitating an action (1853). In this case, the relevance of TPB in this study is expressed in the patent's self-control and confidence level in making health choices in the face of pressing health needs and the contending influences of his personal idiosyncrasy, the western biomedical culture and the cultural health beliefs of the Ukwuani people of Ndokwa West Local Government Area.

Literature Review

Provider-patient communication: Implications for patients' health outcomes

According to Glanzer (2008), communication is a process through which people connect, give, receive information, understand each other and share feelings. It is all behaviours, whether verbal or non-verbal such as gestures, body language or facial expression [19]. On the other hand, health communication is defined as the study and practice of communicating promotional health information such as public health campaigns, health education and between doctor and patients communication [20]. The whole point of health communication is to equip the patient with enough information that will enable him make informed personal health choices.

Developments in health communication research have incorporated training programmes for healthcare providers. This focus on healthcare providers is based on recent research findings which suggest that non-verbal and verbal communication between healthcare providers and patients can lead to improved patient outcomes [21]. Healthcare givers are exhorted to appreciate the importance of communication in relation to health because, as Giger and Davidhizar observe, it can affect the quality of care because effective communication gives motivation to both healthcare seekers and givers [22]. This viewpoint is corroborated in the submission of Edgar and Hyde that health communication relies on strong interpersonal communication in order to influence health decisions and behaviours [4]. This manner of relationship is exemplified in the connection and interaction between individual patients and their healthcare providers (e.g physician, therapist, pharmacist, nurse e.t.c.). Whatever the category of healthcare provider, studies have shown that these interactions at the personal level of doctor-patient relationship positively influence the individual's decision to make healthy health choices.

Hence, Communication in healthcare is not just a social interaction activity. Rather, it is a serious transaction with implications for patient's health and even survival. According to Spath, good care-giver/patient communication can increase

patient satisfaction, enhance patient adherence to medication and treatment regimens, reduce medical errors and improve clinical outcomes [23]. This requires healthcare providers to be attuned to their patients' body language, listen earnestly, and of course, speak clearly to ensure effective communication and positive health outcomes. Whereas much of the communication in these interactions necessarily involve information sharing about diagnosis and treatment options, most physicians will recognize that these encounters also involve the patients search for a psychosocial healing "connexion" or therapeutic relationship [3]. John and Travaline cited in Odishika enthuse that patient/physician communication is an integral part of clinical practice which when done well produces a therapeutic effect for the patient. In other words, it is called the partnership model, which increases patient involvement in their health through negotiation and consensus building between the patient and physician. Therefore, it is given that, the physician who encourages this kind of communication may obtain more complete information, enhance the prospect of a more accurate diagnosis, and facilitate appropriate counseling, thus potentially improving adherence to treatment plans that benefits long term health of the patient.

Fong et al. observe that effective doctor-patient communication is a central clinical function in building a therapeutic doctor-patient relationship with the potential benefits of addressing patient's dissatisfaction and delivering high-quality healthcare [24].

Besides, there have been results from empirical studies validating the above scholarly positions. In one of such studies, it was reported that effective patient-physician communication can improve a patient's health as quantifiably as many drugs, perhaps providing a partial explanation for the powerful placebo effect seen in clinical trials [17]. Also, one review of randomized, controlled trials on patient-physician communication reported that the quality of communication in the history-taking and management-discussing portions of the interactions influenced patient outcomes in 16 of 21 studies. Outcomes influenced by such communication include emotional health; symptoms resolution; function; pain control and physiologic measures such as blood pressure level or blood sugar level [17]. In individual studies, effective communication skills have been correlated to such positive outcomes as adherence to therapy and understanding of treatment skills [17,25].

To underscore the importance of communication to healthcare, 65% medical schools in the USA now teach communication skills, just as training in patient-physician communication is also now objectively evaluated as a core competency in various accreditation settings in the country [26,27].

Understanding culture and its influence on health beliefs

According to Leininger, culture refers to the learned, shared and transmitted knowledge of values, beliefs and lifeways of a particular group that are generally transmitted inter generationally and influence thinking, decisions and actions in patterned or in certain ways [28]. Simply put, culture can be thought of as a source of identity that situates individuals on the vast landscape of beliefs and perspectives that influence the way we interpret events, interact with others and live our lives [29]. Mays, Sciantz and Vieweg, describe culture as the interplay of many elements which include behaviours, customs, beliefs, values and institutions [30].

Recent consensus in public health and health communication reflects increasing recognition of the important role of culture as a factor associated with health and health behaviours, as well as a potential means of enhancing the effectiveness of health communication programmes and interventions [31]. It is generally believed that by understanding the cultural characteristics of a given group, public health and health communication programmes and services can be customized to better meet the needs of its members. That is, the culturally bound beliefs, values and preferences a person holds influence how he interprets healthcare messages [3]. In the view of Resniecow et al. concordance between the cultural characteristics of a given group and the public health approaches used to reach its members may enhance receptivity, acceptance and salience of health information and programmes.

In an attempt to capture this variability in the cultural outlook of different peoples, Andrews and Boyle, present health belief models that different cultural groups use to explain health and illness into magico-religious, biomedical and deterministic beliefs [13]. They explain that magico-religious refers to belief in supernatural forces which inflict illness on humans, sometimes as punishment for sins, in the form of evil spirits or disease-bearing foreign objects as may be found among Latin American, African American and Middle Eastern cultures; biomedical refers to the belief system generally held in the United States of America in which life is controlled by series of physical and biochemical processes that can be studied and manipulated by humans, hence disease is seen as the result of the breakdown of physical parts from stress, trauma, pathogens or structural changes; and determinism, the belief that outcomes are eternally preordained and cannot be changed. Other sub-context cultures that have been advanced by scholars to explain the relationship between culture and health beliefs are 'familism' and 'individualism' [32,33]; 'high context' and 'low context' cultures [22]; 'time orientation, present orientation and future orientation' cultures etc. [3]. Each of these cultural models is believed to influence health beliefs.

Indeed, all cultures have systems to explain what causes illness, how it can be cured or treated and who should be involved in the process [34]. The extent to which patients perceive health information as having cultural relevance for them can have a profound effect on their reception of information provided and their willingness to use it. The fact that cross-cultural variations also exist within particular culture groups makes the culture-healthcare-relationship much more interesting.

Cultural barriers that affect healthcare provider and patient communication

Beliefs and values affect the doctor-patient relationship and interactions [35]. Divergent beliefs can affect healthcare through

competing therapies, fear of the healthcare system, or distrust of prescribed therapies [5]. The doctor-patient relationship is one of the most unique and privileged relations a person can have with another human being, just as having access to a well-developed and effective association is important for the experience and objective quality of healthcare. Yet, over the past few decades, a number of cultural barriers have converged to reduce the ability of patients to have this archetypal relationship with physicians [36]. These cultural barriers are categorized into racial concordance of the doctor and patient, language barriers and medical beliefs. The author cautiously observes that another barrier to patient-physician communication, even if they speak the same language, is low health literacy of the patient which impairs ability to understand instructions on prescription drug bottles, appointment slips, medical education brochures, doctor's directions and consent forms, and the ability to negotiate complex healthcare systems.

Of all these cultural barriers, the barrier of differences in medical beliefs is considered very fundamental to creating disharmony in the healthcare provider and patient communication relationship. The expectation that the patients will conform to mainstream values frequently creates communication and care barriers that are further compounded by differences in language and education between patients and providers from different backgrounds. Fowler maintains that when the two parties, comprising the doctor and the patient, have different views on medicine, the balance of cooperation and understanding can be difficult to achieve [37].

This perception gap may negatively affect treatment decisions, and therefore may influence patient outcomes despite appropriate therapy [14]. Patients construct their own versions of adherence according to their personal worldviews and social contexts which result in a divergent expectation of adherence practice [33,37,38]. Therefore, it is important to identify and address perceived barriers and benefits of treatment to increase patient adherence to medical plans by ensuring that the benefits and importance of treatment are understood [14].

According to reports, Bolivia's healthcare system is particularly invaded by this cultural barrier. As Bruun and Elverdam put it, medical pluralism is a common feature in the Bolivian healthcare system, consisting of three overlapping sectors: the folk sector, the traditional sector and the professional sector [39]. Whether in Bolivia, India, China or Africa, differences in medical health beliefs constitute a significant barrier to effective patient and provider communication which is absolutely necessary to giving and receiving adequate healthcare [40].

Cultural health beliefs and healthcare seeking behaviour

There is an unmistakable nexus between a peoples cultural health beliefs and the healthcare seeking behaviour they exhibit. Different cultural groups have diverse belief systems with regard to health and healing in comparison to the western biomedical model of medicine. These belief systems may include different disease models, wellness/illness paradigms, various culturally-specific diseases and disorders, feelings about healthcare providers and seeking westernized healthcare, and the use of traditional and indigenous healthcare practices and approaches [41]. This connectedness between cultural health beliefs and health behaviours is accorded recognition in the World Health Organization's attestation that all people, no matter the race, have their beliefs and practices concerning health and disease [17]. This predisposition influences the way each society or community perceives and behaves in the management of diseases and health related problems that befall them.

In line with the foregoing, Kottak argues that all cultures have disease theory systems which include attributional concepts to explain illness causality, among which are three commonly held paradigms of disease across cultures namely, nationalistic, personalistic and emotionalistic. While nationalistic disease theories explain disease in objective, scientific terms founded on the core concept that illness occurs when the body is out of balance as exemplified in the Western biomedical culture; the personalistic disease theory attributes illness to intervention by an agent such as another human, witch, sorcerer, non-human, or supernatural force [42]. As for the emotionalistic disease theories, illness is explained as caused by strong emotional states like intense anger, jealousy, shame, grief or fright. Foster and Anderson, in Vaughn et al. report that the personalistic and emotionalistic models are easily applied to patients in non-western cultural backgrounds who are familiar with and have faith in practices from their own cultures.

Expectedly, the same differences in the cultural explanation of illness are evident in the manner of cure sought by patients of the disparate world cultures. This search for treatment to attain a state of complete physical, mental and social wellbeing is known as health seeking behaviour; a fundamental feature of health management in patients. According to Tipping and Segall, in Ojua et al. healthcare seeking behaviour is any action undertaken by individuals who perceive they have a health problem for the purpose of finding an appropriate remedy.

In Nigeria and many other parts of Africa, the factors that commonly affect the way rural people seek for health are multi-faceted but, prominent among them are the people's beliefs in Religion, spirituality and the Traditional African Medicine [1,10,41]. This assertion is without prejudice to the emergent plurality of healthcare options that have been created by development, civilization and education [1]. Whatever the case maybe, understanding the community perspective of health and healing and their health seeking behaviour is important in designing culture-sensitive and need based health interventions, especially for the poor and underserved people in the hardly accessible localities [43].

Methodology

Two methods were adopted for this study-survey and Focus Group Discussion methods. The survey research method was used was considered very appropriate for this study given its purpose of obtaining data from respondents on the influence of cultural health beliefs on healthcare providers/patients' communication

as well as patients' adherence and healthcare seeking behaviours at the Primary Healthcare Centres in Delta State. The instrument of data collection was the structured questionnaire.

The Focus Group Discussion (FGD) was adopted in conjunction with in-depth interview to supplement and support data from the survey method, also used in the study. The beauty of FGD lies in the fact that, under proper guidance by a discussion moderator, participants are encouraged to spontaneously express opinions that may have been missed in structured questionnaire interview. In all, six (6) different focus groups, one each in the six (6) local government areas randomly selected for the study were used in triangulation with the quantitative survey method. The interview guide was used for data collection.

In this study, two separate interview guides were used for the in-depth interviews conducted. While one set was designed to obtain data from the healthcare providers on the subject of study; the other was used to elicit information from six (6) elders, one each from the six (6) LGAs of Delta State used in the study. The purposive choice of the elders was based on their reputation as chief custodians of the culture and traditions of their respective communities. This choice is reflective of the subject under study, which is, the influence of cultural health beliefs on healthcare providers patients' communication in Delta State. Their contribution was meant to provide background and great insight into the cultural health beliefs of the different ethnic groups, as a basis for assessing how these beliefs influence, not only the provider/patient communication but also the medication adherence and healthcare seeking behaviours of patients in the study area.

The area of study is Delta State, Nigeria. The state is comprised of three (3) senatorial districts namely, Delta North, Delta Central and Delta South. Broken down further, Delta State has twenty-five (25) local government areas with a total of 465 PHCs between them. Geographically, Delta State has a land area of 17,698 km2. It is bounded in the North and West by Edo state, the East by Anambra, Imo and Rivers state, Southeast by Bayelsa state, and on the Southern flank is the Bright of Benin which covers about 160 kilometers of the state's coastline. Delta state is generally low lying without remarkable hills. It is still a developing state with lots of rural communities that still hold tenaciously to cultural health beliefs that constitute the concern of this study.

The population of study is 325,000 patients that patronize the primary healthcare centres in Delta State. This figure was provided by the research and statistics department of the Delta state primary healthcare development agency. Therefore, the researcher used this figure as the population of study.

Given the large number of the population of study, a sample size of 384 respondents was used: 316 for survey and 68 for focus groups. It was determined using Cozby's table of sample size determination which states that at +/-.05 error margin, a population of over 100,000 will have a sample of 384 (10). Thus, the sample size for this study is 384 respondents [44].

The multi-stage sampling procedure was used in the study. The first stage was to follow the senatorial delineation of Delta State which is three senatorial districts namely; Delta North, Delta Central and Delta South senatorial districts. The second stage involved the selection of local government areas in each of the three senatorial districts; Delta North has Nine (9) LGAs; Delta Central Eight (8) LGAs and Delta South, Eight (8) LGAs. From the list of local government areas, the researcher randomly chose two local government areas each from the three senatorial districts to get a total of six local government areas that were studied. In the third stage, the researcher listed the number of functional PHCs in each of the six selected local government areas. From the list of PHCs in the local government areas, the researcher randomly selected two PHCs from each of the local government areas to account for twelve PHCs studied across Delta State.

The study also adopted the purposive sampling technique, otherwise known as judgemental sampling for the survey and focus group discussion methods. In this case, the predetermined criteria for choosing the respondents for this study were one, that they are indigenous people of their respective communities in Delta state that are familiar with the cultural health beliefs of the people; two, they are patients that are in consultation with a healthcare providers in any of the Primary Healthcare Centres in the State; and three, that such patients are in a health condition requiring treatment at the PHC in the State in the period of study.

For the Focus Group Discussion, a 12-item question guide was used as tool for data collection. The Midwives, Nurses and Health Assistants working at the various PHCs assisted the researcher in recruiting FGD participants from their health centres. Six (6) FGD sessions were held altogether, one each for the six (6) LGAs that were randomly selected from the senatorial districts of Delta State. The FGDs lasted for an average of 75 minutes per session with a distribution of 10-12 participants. Altogether, there were 68 FGD participants. The FGD sessions took place between the hours of 12 noon and 4 pm of Tuesdays and Thursdays within the period of research. The choice of timing was so designed to after-clinic-hours so that the schedule does not conflict with clinic activities.

Findings

Five research questions and three hypotheses were designed for the study. Beginning from first, the study examined the cultural health beliefs of the people of Delta State. **Tables 1-3** below present the findings.

Table 1: Belief that some diseases are caused by spiritual forces.

Belief	Frequency	Percentage
Yes	260	82.3
No	40	12.7
Can't say	16	5.1
Total	316	100%

Table 2: Description of traditional healing methods.

Description	Frequency	Percentage
Crude and outmoded	38	12
Evil and occultic	36	11.4
Rich cultural heritage	144	45.6
Not safe for consumption	56	17.7

They are good	42	13.3
Total	316	100%

Table 3: The effectiveness of traditional healing methods.

Effectiveness	Frequency	Percentage
Very effective	180	57
Effective	12	3.8
Not so effective	70	22.2
Not effective	54	17.1
Total	316	100%
Total	316	100%

Research Question 1: What are the cultural health beliefs of the people of Delta State?

Table 1 presents the responses given by the respondents on their cultural health beliefs. The table indicates that most of them, about 8 in 10, believed that some diseases were caused by spiritual forces. This establishes the foundation of their cultural health belief.

The next table presents the responses given by the respondents when asked to describe the traditional healing methods.

Table 2 presents the description given to the traditional methods of healing by the respondents. As the table indicates, close to half of the respondents considered traditional healing methods to be rich cultural heritage (45.6%) and another 13.3% described the methods as good. The combination of these two groups shows that more than half of the respondents have positive reaction towards traditional healing methods. However, some other people among the respondents described the healing methods as crude and outmoded (12%), some said the methods were evil and occultic (11.4%), another group of 17.7% considered the healing methods as not safe for consumption.

The respondents were asked to describe the effectiveness of traditional healing methods in the next table. The table presents the responses given.

Table 3 shows the effectiveness of traditional healing methods as described by the respondents. The table shows more than half of the respondents said the healing methods were very effective (57%) and another group of 3.8% described the methods as effective.

In answering the research question, therefore, the outcomes of **Tables 1-3** indicate that the respondents have a positive perception about the cultural health beliefs of their people.

In the second research question, the study examined the nature of communication between healthcare providers and patients at the health centres. **Tables 4 and 5** contain statistical presentation of the nature of communication between both parties.

Research question 2: What is the nature of communication between healthcare providers and patients of PHCs in Delta State?

In **Table 4**, the respondents described the nature of their communication relationship with their healthcare providers. In their description, majority of the respondents said their communication relationship was easy and friendly (59.5%) and another 27.2% described it as cordial and supportive. What this means is that most of the respondents have cordial relationship with their healthcare providers.

Table 4: Description of communication relationship.

Description	Frequency	Percentage
Easy and friendly	188	59.5
Cordial and supportive	86	27.2
Distrustful and fruitless	8	2.5
Trustful and fruitful	22	7
Difficult and unfriendly	12	3.8
Total	316	100%

Table 5 shows the relationship between respondents' cultural health beliefs and the nature of their communication relationship with healthcare givers. As the table shows, cultural health beliefs did not influence communication relationship because even those who had negative health belief had good communication relationship with the healthcare givers.

Table 5: Relationship between cultural health beliefs and communication relationship.

Communication relationship	Crude and outmoded	Evil and occultic	Rich cultural heritage	Not safe	Very good
Easy and friendly	57.9	38.9	65.3	71.4	42.9
Cordial and supportive	0	44.4	25	28.6	42.9
Distrustful and fruitless	0	0	5.6	0	0
Trustful and fruitful	42.1	16.7	0	0	0
Difficult and unfriendly	0	0	4.2	0	14.3
Total	100%	100%	100%	100%	100%
N	38	36	144	56	42

The third research question examined whether the cultural health beliefs of patients at the primary healthcare centres in Delta state influenced communication with healthcare providers.

Research question 3: Do the cultural health beliefs of patients at the primary healthcare centres in Delta State influence their communication with healthcare providers?

Table 6 shows that about two thirds of the respondents said their cultural health beliefs did not create any difficulties of communication between them and their healthcare providers (65.2%). But it created for the remaining 34.8%. The next table presents the communication relationship with the healthcare providers.

Table 6: Cultural health beliefs and communication difficulties.

Response	Frequency	Percentage
Yes	110	34.8
No	206	65.2
Total	316	100%

Research Question 4: Do the cultural health beliefs of patients of PHCs in Delta State influence their medication adherence behaviour?

Table 7 above indicates that when healthcare providers give medical instructions that do not agree with people's cultural health beliefs, majority of them will not comply (71.5%). Only 28.5% of them will comply.

Table 7: Adherence to medical instruction against cultural health beliefs.

Response	Frequencies	Percentage
Yes	90	28.5
No	226	71.5
Total	316	100%

Table 8 above shows that majority of the respondents, 204, representing 64.56% switch from allopathic medicine to traditional medicine the moment they felt that allopathic medicine was not effective for their treatment, thereby affecting their adherence. Only 35.44% of them said they will stick to their treatment regimen.

Table 8: Change from allopathic medicine to traditional medicine.

Response	Frequencies	Percentage
Yes	204	64.56
No	112	35.44
Total	316	100%

Table 9 presents the relationship between cultural health beliefs and respondents adherence behaviour to healthcare providers' medical instructions. As the table shows, a lot of those who felt strongly and positively about traditional healing methods chose traditional medicine as the factor that influenced their medical adherence behaviour. In a similar vein, a good number of those who held negative disposition towards traditional healing methods, chose other factors like forgetfulness, refusal to take the drugs because they smell, non-completion of dosage because the drugs are much and discontinuation of drug use the moment they started feeling better.

Table 9: Influence of cultural health beliefs on respondents' medication adherence behavior.

Adherence	Crude and outmoded	Evil and occultic	Rich cultural heritage	Not safe	Very good
Non-completion of dosage	0	33.3	10.3	0	14.3
Refusal to take the drugs	21.1	0	14.7	42.9	14.3
Forgetfulness	42.1	22.2	0	28.6	14.3
Lack of confidence	0	0	10.3	0	0
Traditional medicine	15.8	0	42.6	0	42.9
Discontinuation of drug use	21.1	44.4	22.1	28.6	15.3
Total	100%	100%	100%	100%	100%
N	38	36	144	56	42

Research question 5: Do the cultural health beliefs of the patients at the primary healthcare centres in Delta State influence their healthcare seeking behaviour?

Table 10 above indicates clearly that majority (86.08%) of the respondents would revert to traditional healing methods when they feel that their health condition is 'not ordinary'. Only 40 of them, representing 12.66% will not go traditional even if their ailment lacked pathological explanation.

Table 10: Resort to traditional healing for treatment of health conditions that are considered 'not ordinary'.

Response	Frequencies	Percentage
Yes	273	86.08
No	40	12.66
Total	316	100%

Table 11 presents the relationship between cultural health beliefs of the respondents and their healthcare seeking behaviour. As the table shows, most of those with positive disposition towards traditional healing methods (which signifies positive cultural beliefs) took advice of their family members on issues about their health conditions. Similarly, most of those with negative disposition towards traditional healing methods (which signifies negative cultural beliefs) follow the same pattern. This shows a strong element of 'familism' in the healthcare seeking behaviour of the patients and a clear indication of the influence of the peoples cultural health beliefs in the health choices they make.

Table 11: Influence of cultural health beliefs on respondents' medication adherence behavior.

Healthcare seeking behaviour	Crude and outmoded	Evil and occultic	Rich cultural heritage	Not safe	Very good
Yes	36.8	22.2	77.8	42.9	100
No	63.2	61.1	22.2	57.1	0
Can't say	0	16.7	0	0	0
Total	100%	100%	100%	100%	100%
N	38	36	144	56	42

Besides, Table 10 above is a further indication that majority of the respondents (86.08%) have a positive disposition to embrace traditional healing methods if they felt their sickness was 'not ordinary'. This shows a strong influence of cultural health beliefs in the people's healthcare seeking behaviour.

Results and Discussion

The study set out to establish the cultural health beliefs of the people of Delta state, Nigeria. The key informant interviewees comprising custodians of the people's culture provided the background for the documentation of the people's health beliefs. The subsequent interviews with patients and healthcare providers at the primary healthcare centres further reinforced the information about the people's cultural health beliefs earlier espoused in the key informant interviews. In all, the findings show that the people of Delta State have a rich system of cultural health beliefs that covers the causative factors of sicknesses, treatment procedures and the roles of different players in the diagnostic and therapeutic processes involved. Majority of the respondents believe in the efficacy of traditional healing methods for the treatment of sicknesses. There was also this belief by majority of the patients that traditional healing methods are more effective

than allopathic medicine in the treatment of certain health conditions. They indicate that this is especially the case with health conditions that are spiritually induced. Virtually all the respondents believe in the role of supernatural spiritual forces in the cause and cure of health conditions just as they believe in the efficacy of traditional methods. This much was evidenced in the finding that majority of the patients make use of traditional medicine.

Interestingly, these findings are consistent with the findings of earlier researchers on the subject. Ojua et al. found that, just like spirituality and religion, Traditional African Medicine (TAM), has been part of Africa's cultural heritage for generations [1]. Obot, also found that the cultural health beliefs of Africans is such that misfortunes of ill health that defy scientific and orthodox treatment are explained away as caused by spiritual forces directed by witches, wizards, sorcerers, evil spirits or angry ancestors [45]. In a hospital wide survey of 228 Prince of Wales patients and visitors, Haynes at el. had found that, not only do patients acknowledge the connection between spirituality, religion and health; they also believe that religious, spiritual and traditional practices are important in providing crucial support during health crisis, treatment and cure [46]. In their own study, Dell-Arciprete et al. found that members of the studied Argentine communities tend to see disease as caused by other people or by the person's violation of taboos instead of as a biological process [47]. Again, this submission is in tandem with the findings of this study that the respondents believe that certain sicknesses are spiritually induced. This was also the case with the study of Wossilek and Patterson where it was found that spirituality is directly related to health practices in Ghana, with health choices being driven by spiritual beliefs [6]. Similarly, Archibong, Enang, Ebingha and Bassey found the predominance of traditional and spiritual healthcare practices among pregnant women in Calabar, Nigeria [48].

Objective 2 looked at the nature of communication between healthcare providers and patients at the PHCs in Delta State. The findings indicate that the communication relationship between the healthcare providers and patients at the PHCs was easy, friendly, cordial and supportive. The reports of the survey, focus group discussions and the they informant interviews with healthcare providers all point to a palpable rapport in the communication between the parties, both at the formal and informal levels. This finding conflicts with reports of earlier studies that cultural health beliefs create barriers and induce friction in the provider/patient communication and relationship [34,49,50].

On objective 3, the finding that the cultural health beliefs of patients and healthcare providers did not in any way impede communication between both parties is completely at variance with the findings of earlier researches in this area. McLaughlin and Braun had found that barriers of differences in medical beliefs are fundamental in creating disharmony in the care provider/patient communication. Fowler in his own study found that when the two parties, comprising the patient and the provider, have different views on medicine, the balance of cooperation and understanding can be difficult to achieve. Much more, Maarsid had found that the culture of the Roma patients in Finland, created friction in the Roma-Finnish healthcare provider/patient relationship [51].

Curiously, the finding of this study is in complete disagreement with the position of these earlier researchers on this issue of communication between healthcare providers and patients. As opposed to the negative, the study shows evidence of effective communication and positive relationship between healthcare providers and patients, regardless of their divergent views on a number of cultural and medical health beliefs.

On objective 4, the finding that the patients' cultural health beliefs negatively influenced their adherence to healthcare providers' prescriptions conforms to the findings of earlier works on the subject, although the result of the hypothesis indicated that the negative influence is not significant. McLaughlin and Braun had found that cultural issues such as religiosity and spirituality play a major role in patient adherence. Related studies by Tongue et al. Sawyer and Aroni and Middleton et al. also indicate that patients construct their own personal world views and social contexts which result in divergent expectations of adherence practice. Schouten and Meeuwsen found that there is more misunderstanding, less compliance and less satisfaction in medical visits of patients with differing health beliefs from those of their healthcare providers [52]. Schouten and Meeuwsen's finding resonates with those of Thorsen and Miller and Ejikeme who found that spiritual and religious activities strengthen the faith of people and assist them with decision-making in health related practices such as adherence [3,53].

On objective 5, which is how the patients' cultural health beliefs influence their healthcare seeking behaviour, the findings show that the healthcare seeking behaviours of majority of the patients were influenced by their cultural health beliefs. The results evidenced that the patient's beliefs in the diagnostic and therapeutic power of medicine propelled them to seek for help from allopathic or traditional medicine, depending on the cultural perspectives of individual patients. The findings of this study correspond with those of Ojua et al., Katung and Ejikeme, that the typical Nigerian rural dweller resorts to traditional medicine on the one hand; and to chemist shops, healthcare centres and bigger hospitals on the other hand for the treatment of sicknesses and diseases. In a related study on the Bolivian Healthcare system, Bruun and Elverdam had found a similar feature of medical pluralism in healthcare seeking behaviour. In another study by Uddin, Hossin, Mahbub and Hossain, it was found that among the Chakma people of Bangladesh, the resort to the deft combination of multiple therapeutic traditions was an important feature. Besides, there is a clear evidence of the role of the family in the healthcare seeking behaviour of the patients. Majority of them sought and received advice and support, sometimes unsolicited, from family members. This finding is in conformity with findings from earlier researches. Thaker found that there is a high level of family involvement during the treatment processes and in the everyday maintenance of the health of older Asian Indian immigrants [54]. In the same vein, Chhabra and Chhabra found that, among the Indian population of Ghaziabad, elders

of the family especially grandparents, exercised overwhelming influence on the decision of the parents regarding the dental treatment of their children.

They explain that in order to avoid such occurrence, which is very likely in the health centres' midwifery function, the men keep their distance from the health centres. Other opinions blame it on lack of awareness among the male population that the healthcare centres offer healthcare services outside of the more common antenatal, midwifery and child immunization functions. This finding is in tandem with the submission of Resniecow et al. in Kreuter and McClure that concordance between cultural characteristics of a given group and the public health approaches used to reach its members may enhance receptivity, acceptance and salience of health information and programmes. Also, the finding does not lend credence to an earlier report by Metiboba that a great proportion of the rural population in many communities do not seem to know what primary healthcare centres are all about, nor are they aware of the various services under the scheme.

Furthermore, the findings of the study are consistent with the principles governing the theories that guided the study namely, Health Belief Model (HBM) and Theory of Planned Behaviour (TPB). According to Taylor et al. even though the TPB is a value-expectancy theory like HBM, it lacks the 'threat' element of HBM [55,56]. It is this element of threat in the construct of HBM that distinguishes it from TPB. Evidence from this study is a further validation of the continued relevance of the construct in the prediction of health related behaviours. Typically, the decision of majority of the patients to seek traditional healing when the sickness is 'not ordinary' derives from an underlying threat of health deterioration or imminent death on failure to take that decision [57,58].

Conclusion

The pre-eminence of health over all other concerns of man is an incontrovertible fact of life. It is for this reason that responsible and responsive governments all over the world perennially commit a huge chunk of their annual budgets towards the establishment of hospitals, the training of medical personnel and the institution of all other extensive medical programmes designed to secure effective healthcare delivery for their citizens. As part of this elaborate programmes, health communication activities are carried out to inculcate health literacy in patients that will enable them make informed personal health choices. Edgar and Hyde acknowledge the salience of effective interpersonal communication between healthcare providers and patients in accomplishing this purpose.

However, beneath the surface of the reported ebullience in the provider-patient communication and relationship are the underlying problems of medical plurality and medication non-adherence induced by patients' cultural health beliefs. On this score, the findings of the study are in agreement with the findings of earlier researchers that patients' healthcare seeking behaviours like medical plurality and medication non-adherence come with dire consequences among which are health deterioration, treatment failures, increased hospitalization, increased health costs and deaths.

From the reported accounts of the patients and the reported evidence of the healthcare providers, these cultural health beliefs remain the core drivers of patients' health choices, especially when it matters the most. The need to properly redirect patients' predilection towards these cultural health beliefs for a more effective healthcare delivery system is one of the major concerns of this study.

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