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Toward a multidimensional understanding of culture for health interventions

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ABSTRACT

Although a substantial literature examines the relationship between culture and health in myriad individual contexts, a lack of comparative data across settings has resulted in disparate and imprecise conceptualizations of the concept for scholars and practitioners alike. This article examines scholars and practitioners' understandings of culture in relation to health interventions. Drawing on 169 interviews with officials from three different nongovernmental organizations working on health issues in multiple countries—Partners in Health, Oxfam America, and Sesame Workshop—we examine how these respondents' interpretations of culture converge or diverge with recent developments in the study of the concept, as well as how these understandings influence health interventions at three different stages—design, implementation, and evaluation—of a project. Based on these analyses, a tripartite definition of culture is built—as knowledge, practice, and change—and these distinct conceptualizations are linked to the success or failure of a project at each stage of an intervention. In so doing, the study provides a descriptive and analytical starting point for scholars interested in understanding the theoretical and empirical relevance of culture for health interventions, and sets forth concrete recommendations for practitioners working to achieve robust improvements in health outcomes.

1. Introduction

That culture matters for health interventions is not a novel contention. Scholars and practitioners increasingly argue that an intervention's success depends on the extent to which it is tailored to the local cultural and political context (Anderson and Olson, 2013; Castro et al., 2004; Kagawa-Singer and Kassim-Lakha, 2003). This is particularly crucial for specialists working in developing regions, where adjusting an intervention to suit a specific cultural and political setting often determines whether the local government will allow its implementation and provide resources to institutionalize it (Asad and Kay, 2014). Such an approach can impact long-term health outcomes (Banerjee et al., 2011; Farmer et al., 2006).

Despite consensus that culture can influence the design and delivery of health care interventions, what it means and how it matters for researchers and practitioners remains underexplored (Beckfield et al., 2013). Building upon insights from cultural anthropology, public health researchers, medical anthropologists, and sociologists have traditionally relied on a one-dimensional definition of culture as meaning (Geertz, 1973) that refers to the shared codes, signs, and symbols to which collectivities of individuals attribute significance (Kleinman, 1978, 1987; Kleinman et al., 1978). Other work has expanded this definition to include "a set of guidelines … which individuals inherit as members of a particular society" (see also Furedi, 2006; Helman, 2001). For example, in the case of American Indian communities, scholars often construct culture as including social environments, education, and responses to colonialism (Anderson and Olson, 2013; Goodkind et al., 2010). This conception has led some to conflate "culture" and "race" or "ethnicity" when examining population-level health trends, describing the emergence of essentialist racial or ethnic subcultures with their own concepts, rules, and social organization (Becker et al., 2004; Betancourt et al., 2003; Fullwiley, 2007; Lamont and Small, 2008).

As criticism mounted that these one-dimensional understandings of culture are vague and inaccurately applied in

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medical training and practice (Kagawa-Singer and Kassim-Lakha, 2003), scholars began to define the concept in new ways. Most researchers recognized culture as dynamic and heterogeneous within and across settings and understood it as providing individuals with the "tools" or "rules" required to take action but not necessarily driving it (Shim, 2010; see Swidler, 1986). They also began to focus on individual cultural contexts. This approach is perhaps best exemplified by community-based participatory research (CBPR), which emphasizes that partnerships between academics, practitioners, and local communities—with interventions adjusted to individual values, attitudes, beliefs, languages, and corresponding behaviors that are often idiosyncratic across groups (Trickett et al., 2011: 1413)—can spur community members' participation in public health advocacy and effect structural changes aimed at eliminating health disparities (Israel et al., 2010: 2094). An abundance of case studies from myriad interventions worldwide has demonstrated CBPR's potential (see Viswanathan et al., 2004 for a review).

Although generalizations about how culture operates within and across settings to shape individuals' health behaviors should be avoided (Helman, 2001; Kleinman, 1978), the proliferation of single-sited, culturally-tailored interventions worldwide has prevented a meaningful dialogue between researchers and practitioners interested in understanding the relationship between culture and health (Cockerham, 1981; Salant and Lauderdale, 2003). Instead, several "ontological myopias" have emerged whereby scholars and practitioners make assumptions about what culture means and how it operates in the resource-poor contexts they study (Rodríguez-Muñiz, 2015); pinpointing how cultural predispositions relate to health outcomes is thus viewed as almost impossible (Pescosolido and Olafsdottir, 2010; Weiss, 2001). In short, there is a need to define culture in a way that not only accounts for local variation, but that also provides a concrete framework for those interested in implementing health interventions across diverse geographic, ethno-racial, and political settings.

This article interrogates scholars and practitioners' understandings of culture. Specifically, we examine along what dimensions they conceive of culture, as well as how their interpretations of culture influence three different stages—inception, implementation, and evaluation—of a health project. We do so by drawing on 142 interviews with representatives from three nongovernmental organizations (NGOs) working on health issues in a variety of countries. Understanding how these actors think about culture's role in health interventions will serve to develop a shared definition of culture that can be applied in both research and practice.

2. Methodology

2.1. Study settings

We rely on in-depth, semi-structured interviews conducted with representatives from three NGOs working on health issues worldwide in order to understand the role of culture at different stages of a health intervention. Our approach maximizes variation in both the type of health project and the cultural context under scrutiny; this enables us to identify how culture is defined and how it matters across settings (Beckfield et al., 2013; see also Lamont et al., 2014), which is important to generate robust and generalizable qualitative findings (Yin, 2009).

The first organization is Oxfam America (OA), which is based in Boston, Massachusetts and works in ninety-four countries on projects relating to public health, community finance, gender equality, and access to potable water. One project, Saving for Change (SfC), provides "a locally appropriate tool" for villagers in thirteen countries to manage their finances in order to guard against shocks to income such as food or health expenses; malaria education is also part of some of the programs. In a recent evaluation of the organization's largest SfC site in Mali, significant improvements in food security and malaria knowledge were detected in treatment villages when compared to the control villages (Bureau of Applied Research in Anthropology, 2013). Similar results were found in El Salvador (Devietti and Matuszeski, 2008).

Partners in Health (PIH), also based in Boston, is the second case. PIH pioneered the community-based care model, which complements conventional clinical services with home-based care. For example, treatment for tuberculosis and HIV/AIDS has led to substantial improvements in patient well-being in Cange, Haiti (Farmer et al., 2001) where, in many cases, services to rural communities would otherwise not be available (Jerome and Ivers, 2010). A similar program used to control the spread of malaria in the Democratic Republic of the Congo led to a 50% decrease in morbidity in treatment villages when compared to the control (Delacollette et al., 1996).

The third case is the educational nonprofit Sesame Workshop (SW), based in New York, which produces the children's television program, *Sesame Street*, and local versions around the world, called "coproductions." In addition, SW engages in health education projects with partners in developing countries. Research shows robust improvements in knowledge and behavior along various dimensions of public health, including malaria prevention in Tanzania (Borzekowski and Macha, 2010), hand-washing in India (Policy Innovations, 2010), and road safety in Japan (Borzekowski and Henry, 2010).

2.2. Data collection

From 2007 through 2014, the senior author conducted 140 semi-structured, in-depth interviews with representatives from SW in New York, as well as their local partners in Mexico, Brazil, Colombia, Israel, Palestine, Jordan, India, Nigeria, and with members of the Gulf Cooperation Council (Bahrain, Kuwait, Omar, Qatar, Saudi Arabia, and the United Arab Emirates). The senior author, with a team of research assistants, also conducted 29 semi-structured, in-depth interviews with key officials from OA and PIH at their respective Boston offices and by phone between September 2010 and February 2014.

With permission and assistance from the leadership of each organization, we recruited respondents from all three NGOs who had international work experience using a purposeful sampling approach (Seidman, 2012). We interviewed officials from as many levels as possible until we reached saturation in how respondents conceptualized, accommodated, and transformed culture at all stages of an intervention. Although confidentiality concerns preclude us from disclosing respondents' exact job descriptions, participants included high-ranking officials, project managers, and lower-level staff from all three organizations. The interview guide—part of a larger study on globalization, culture, and the politics of transnational NGO collaborations—included questions for all respondents regarding their professional background; how local partners are chosen; how a project evolves from inception to termination; and how each organization engages with state institutions at the local, regional, and national levels. Our interviews ($N = 169$)—a majority of which come from SW given the focus of the larger project—lasted between one and seven hours and had a median length of 3 hours (interviews with respondents who were relatively new to an organization and/or who had little international work experience were generally shorter). Interviews were recorded and transcribed, totaling over 200 hours of audio and generating over 3500 single-spaced pages of transcripts. The