

Original Article

What do people believe? Some clues for health culture

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Abstract

Background: To provide a shared understanding and a shared decision, health providers must be aware of people's health beliefs and take account of cultural variations. It is important especially for dealing with compliance problems and health promotion in primary care.

Objective: The aim of this study is to examine commonly held patient health beliefs that are encountered most frequently by primary care physicians.

Design of the study: A descriptive study is conducted.

Setting: Out patient clinics of a university hospital, a state hospital and three primary health care centers.

Methods: A questionnaire including demographic parameters and 56 items about health beliefs, which were collected during the patient interviews, applied to 431 patients and their companies for two days. Results were assessed in SPSS 10 for windows; Pearson chi-square and correlation tests were used for statistical analyses.

Results: The most agreed statements (>75%) by the participants were: oranges and tangerines are good for common cold (91.9%), it is important to take medicine either on an empty or full stomach (87.7%), sitting in drafts can make you ill (86.8%), garlic lowers the blood pressure (79.8%), you must not drink water if you are perspired (77.5%), an injection is more effective than a pill (76.6%). There were statistically significant differences according to professions, income levels, education levels of participants and health centers.

Conclusion: There are many beliefs that may influence the health behavior and they may change according to the different parameters such as age, education level.

Key Words: culture, health beliefs, compliance

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Background

The idea of taking into consideration cultural differences in medical practice is not new, but an often neglected area. In order to provide a shared understanding, as well as shared decision, health providers must be aware of people's health beliefs and take into account cultural diversities [1,2]. Health professionals frequently experience difficulties while providing care to people because of existing cultural differences, especially when faced with commonly held health belief systems. Although great strides have been made in medical knowledge, this does not necessarily result in

improvements to public or individual health at the same rate. For example, even though our medical knowledge is very keen on the cessation of cigarette smoking, even people with chronic bronchitis continue smoking. Again, in spite of the evidences about the harmful consequences of obesity, our patients keep on gaining weight. These facts lead us to focus on the "patients' side" of the health care equation: as to their understanding, beliefs, concerns over health and health care. Scientific evidence plays only a minor part in a drama that is controlled by feelings and beliefs derived from experience. Thus, the call for additional research is naive, at best. No study can ever hope to provide conclusive negative proof and the necessary qualifications for any future work will only add uncertainty and fuel skepticism that "something" must be dangerous [3]. Customs, traditions, taboos and superstitions have an impact on health care systems and health expenditures as well [4]. Understanding the needs of patients and caregivers in different cultural contexts, by listening to their experiences can give valuable insights and

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comparisons that can improve the planning of health services. It is not necessary and relevant to make judgments and generalize these results because generalizing leads to prejudice in some groups [5].

Since most medical knowledge is a product of developed countries, it is not surprising to recognize the hegemony of western culture in all health issues such as health services, patient doctor relationship, compliance problems etc. This situation has significant importance for developing countries which receive almost all of their medical knowledge from developed countries. There are differences between patients living in developed and developing countries as well. These differences are reflected not only in available resources for patients, but also in their life experience of illness and health [6,7]. Although in developing countries people's viewpoints of treatment have changed over time, there has been less change in their beliefs regarding the causes of illness. This may be because health beliefs continue to play a significant role in providing a meaning for events and thereby help people cope with a serious illness and death [7,8].

Objective

The aim of this study is to examine commonly held patient health beliefs that are encountered most frequently by primary care physicians.

Method

Five family physicians collected items about health beliefs during regular patient interviews for two months. With an additional three other physicians, a total of eight family physicians evaluated these items according to two parameters. These parameters were defined as: whether they ever had a patient with a particular belief, and at what rate of frequency. If they ever had a patient with a particular belief it was considered as one point, if not it was considered as zero point. If they encountered patients with a particular belief "very often" it was considered as 5, "often" 4, "sometimes" 3, "rare" 2, "very rare" 1. A parameter of at least nine points was included if at least three physicians agreed on it. At the end of the evaluation 22 items were excluded, 56 were included.

A questionnaire including demographic parameters and 56 items applied to 431 patients and their companies who applied to various out patient clinics of the University Hospital and the State Hospital and also three Primary Health Care Centers for two days. Patients were asked to fill-in a self-administered questionnaire before their appointment. 63 of the patients did not participate because of the urgency of their medical condition.

Results were assessed in SPSS 10 for windows, Pearson khi-square test and pearson correlation test was used for statistical analyses.

Results

Demographic Data

Mean age of the participants was 41.04 ± 14.37 (min 15, max 80) and 36.4% were men, 63.6% were women. 71.0% were married, 19.0% single, 6.5% widowed, 3.5% divorced. 70.3% had children, 29.7% had no children. The monthly income level in US dollars was less than \$335 for 50.2%, between \$335-1005 for 42.9%, \$1005-3335 for 6.3%, more than \$3335 for 0.7%. 3.2% of the participants were illiterate, 3.2% were barely literate, 31.3% graduated from elementary school, 30.2% graduated from high school and 32.0% had a university degree. The variance according to their profession was, 3.7% of the participants were health workers, 38.5% had no profession and the rest 57.8% had other professions. The distribution of the participants according to their birth place was: 53.8% from the Aegean region where the study was held, and the rest almost evenly from other six geographic regions of Turkey; 3.2% from South Eastern Anatolia region, 4.2% from Mediterranean region, 5.6% from Marmara region, 6.0% from Black Sea region, 6.3% from Eastern Anatolia region and 9.0% from Middle Anatolian region, 11.8% did not answer the question.

The ratio of the participants who applied to the university hospital was 45.7%; to primary care center was 35.7%; to the state hospital was 18.6%. 21.6 % of the participants had chronic disease, and 78.4 % were without chronic disease.

Health Beliefs

The agreement of participants on items varied. We present them according to the level of agreement of participants in table 1, 2 and 3. In most of the items the agreement level changed according to the education level, the health center at which they applied, age and income level. The statistically important variances are also shown in Table 1, 2 and 3 ($p < 0.05$). Also in all items health workers agreement level was less than the others ($p < 0.05$).

There was a negative correlation between education and health beliefs, as well as, to income level in most of the parameters. There was, however, a positive correlation between age and health beliefs.

Health centers where we conducted the research were another important influencing factor in the agreement rates. We found out that the participants who applied at primary care centers had lower agreement with the 21 items. There were few differences according to birth place, marital status, having children and gender and most of these were about child care and reproductive health. The agreement level increased among those who were married, women, parents and people from the Eastern part of Turkey.

Discussion

Health beliefs held for many years neither remain parallel to, nor do they change in step with medical knowledge. For example, even though there is conflicting evidence about vitamin C's efficacy for the common cold, it seems that in our country it is accepted as an important remedy. But still it is not possible to deny the impact of education. In our study the agreement level changes according to educational level in almost all of the health beliefs. The negative correlation between education and certain health beliefs is promising. Low agreement rates on some beliefs such as "If a child has a fever, you must cover him up and make him perspire" and "When one has diarrhea it is important to drink small quantities of water to stop the diarrhea" shows the achievement of effective educational programs. It is not very far off in the distance for the authors of this study to start community education programs by ministry of health especially in the PHCCs, but also through mass media. Media has a powerful effect on health issues not only by providing accurate information but also by creating ideas about what is considered the norm [9]. On the other hand some data addresses the limited effect of education. Many of the health workers who were a small percentage of the participants of the study believed that "sitting in drafts can make one ill", "the effect of vitamin C", "sitting on cold stone causes sore kidney" etc. Because of the small number of health workers involved, the results may not represent the whole population, but it is still worthwhile to recognize some common perceptions among this group. This situation may provide an opportunity for a good patient-doctor communication, unless the doctor knows that, this is a belief, not a medical fact.

The doctor patient relationship seems to be an important variable in compliance, including the process of prescribing, but it is extremely difficult to assess the nature of interaction and to [7,10] measure its components. The model of the relationship and interacting roles which they had experienced formerly, shapes the expectations of the patients. Our study tends to favor a more doctor centered relationship just as it is in Asian cultures [11].

The most salient influences on compliance are patients' beliefs about medications and about medicine in general [10] Their own knowledge, ideas and experiences, as well as those of family members and friends, have been shown to correlate with compliance [10,12]. Beliefs related to drugs were "When one begins to feel well, one does not have to continue taking the prescribed medicines to the very end of treatment", "It is only necessary to take a pill for blood pressure when blood pressure rises", "Taking medicine can be addictive." These were some beliefs that our

study examined as the reasons for not taking or discontinuing medication .

In some studies persons with chronic illnesses have long term relationships with clinicians, a factor favoring effective partnerships [13]. This does not hold true with our chronic patients who share the same beliefs with others on doctor patient relationship. In our study, people with chronic diseases did not have different beliefs on DM, HT and obesity related items than patients who are without chronic diseases. Even people with diabetes held the same beliefs as the rest of the population at the same ratios. This result leads us to think that society at large may be a better teacher than health services to meet the increased information needs of chronic disease. On the other hand, in our study 73.1% of patients with chronic diseases were older than 45 and 75.1% of patients without chronic disease were younger than 45 years. This may be another factor that effects the agreement levels besides having or not having chronic diseases.

Even though income level is an important parameter for the agreement rate in our study, ability to access health services and health education may decrease this effect.

One major obstacle to patient compliance is ignorance of the etiology and nature of disease and the nature of the treatments and how effective these can be [14,15,16,7]. Beliefs such as "cancer is a contagious disease" or "blood transfusion may cause diabetes mellitus" neglects the etiology and nature of the diseases and makes harder to understand the reason for cessation cigarette smoking or healthy nutrition.

The low rate agreement levels in some wrong beliefs among the younger participants is promising and may be taken in favor of the education.

In conclusion, health belief is a variable which is primarily effected by education, income level, age and may not be in concordant with the medical knowledge. Taking into consideration these beliefs and their impact on health care may help to provide better health services for people.

TABLE 1: Health beliefs, those have high-level agreements of participants and the parameters which have statistically important differences according to education, health centers, income levels and age

	ITEMS	%	Education	Health center	Income level	Age
1	Oranges and tangerines are good for common cold -	91.9	-	-	-	-
2	It is important to take medicine either on an empty or full stomach. -	87.7	-	-	-	-
3	Sitting in drafts can make you ill -	86.8	-	0.01	-	0.00
4	Garlich lowers the blood pressure	79.8	-	-	-	-
5	You must not drink water if you are perspired	77.5	0.00	-	-	0.01
6	An injection is more effective than a pill	76.6	-	-	-	0.01
7	A doctor advices and my duty is to follow his advice.	73.1	-	0.00	0.04	-
8	If you sit on a cold stone, your kidneys will catch cold.	71.9	0.00	0.00	0.00	-
9	If a person touches his head with oily and dirty hands, he might get lice.	69.8	0.00	-	0.03	-
10	Worrying makes one ill	69.1	0.00	-	-	-
11	It is not always possible to obey the advice of a doctor	64.5	-	0.00	-	-
12	I don't like taking medicine.	63.6	-	0.04	0.00	-
13	Taking too much medicine can poison the body	57.0	-	0.02	0.03	0.02
14	Taking medicine can be addictive	56.4	0.00	-	0.00	0.04

15	It is normal for blood pressure to increase by age	54.5	0.00	0.01	0.01	0.00
16	Icecream gives you a sore throat.	53.1	0.00	-	-	0.01
17	Drinking cold water makes you ill	50.6	0.01	0.01	-	-

TABLE 2: Health beliefs, those have medium-level agreements of participants and the parameters which have statistically important differences according to education, health centers, income levels and age

	ITEMS	%	EDUCATION	HEALTH CENTER	INCOME LEVEL	AGE
18	Antibiotics lower the fever	48.0	0.00	0.01	-	-
19	Worrying is a cause for cancer	46.9	0.00	-	0.00	0.00
20	You have to take medicines at certain intervals	45.5	0.01	0.03	0.00	0.02
21	Weight gain can be due to a nervousness	44.3	0.00	0.00	0.00	-
22	Diet crackers do not make you gain weight	40.4	0.00	0.00	-	-
23	If a person is healthy, he does not need to go to a doctor.	40.4	0.00	0.00	0.00	0.00
24	A doctor should care for me more than I care for myself	40.4	0.00	0.00	-	0.01
25	Some people gain weight, even if they only drink water	39.7	0.00	0.00	0.00	-
26	An active child is intelligent	39.7	0.00	0.00	0.00	-
27	You must not eat yoghurt with fish, otherwise you will be poisoned	37.6	0.00	-	-	0.00
28	I have a good appetite, because my stomach is enlarged	35.7	0.00	-	0.01	-
29	If a person is a blood doner, he will have a better appetite and gain weight	34.3	0.00	-	-	0.00

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