

Evaluation of the Effect of Cultural Characteristics on Use of Health Care Services Using the “Giger and Davidhizar’s Transcultural Assessment Model: A Sample from a Village in Eastern Turkey*"

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Abstract

Background: Knowing the cultural factors existing behind health behaviors is important for improving the acceptance of services and for elevating the quality of service. **Objectives:** This study was conducted for the purpose of evaluating the effect of cultural characteristics on use of health care services using the “Giger and Davidhizar’s Transcultural Assessment Model”. **Methods:** The research is qualitative. The study group was 31 individuals who volunteered to participate in the study and living in a rural area. The snowball method was used. Data were collected in 2005. **Results:** Limitations/obstacles to the use of health care services were the widespread gender, use of traditional treatment methods, a high level of environmental control, and a fatalistic attitude about health. **Conclusion:** According to the results the most important limitation/obstacle to using health care services was being a woman.

Key Words: Cultural Characteristics, Utilization of Health Care Services, Giger and Davidhizar’s Transcultural Assessment Model.

Sağlık Hizmetlerinden Yararlanma Üzerinde Kültürel Özelliklerin Etkisinin “Giger and Davidhizar’ın Kültürlerarası Tanılama Modeli” İle Değerlendirilmesi: Türkiye’nin doğusundan bir köy örneği

Giriş: Sağlık davranışlarının arkasında yatan kültürel etmenlerin bilinmesi, hizmetin kabul edilebilirliğini artırmada ve hizmetin kalitesini yükseltmede önemlidir. **Amaç:** Bu araştırma, sağlık hizmetlerinden yararlanma üzerinde kültürel özelliklerin etkisini “Giger ve Davidhizar’ın Transkültürel Değerlendirme Modeli” ile değerlendirmek amacıyla yapıldı. **Metod:** Araştırma kalitatifdir. Çalışma grubunu kırsal alanda yaşayan ve gönüllü olan 31 birey oluşturdu. Kartopu yöntemi kullanıldı. Veriler odak grup görüşme yöntemi ile 2005 yılında toplandı. Araştırmaya başlamadan önce gerekli izinler alındı. Veriler betimsel analiz yöntemi kullanılarak değerlendirildi. **Bulgular:** Cinsiyet, geleneksel tedavi kullanımına meyil, çevresel kontrolün yüksek olması ve kaderci yaklaşım sağlık hizmeti alımındaki yaygın sınırlılık/engellerdir. **Sonuçlar:** Araştırma sonuçlarına göre sağlık hizmeti alımındaki sınırlılık/engellerin en önemli nedeni kadın olmaktır.

Anahtar Sözcükler: Kültürel Karakteristikler, Sağlık Bakım Hizmetlerinin Kullanımı, Giger ve Davidhizar’ın Transkültürel Değerlendirme Modeli.

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Even when all types of health care services are provided in a community, if community health services are not accepted or are not utilized, the reason for this needs to be researched and the results used in planning services. The literature shows that health care services need to be appropriate for cultures to be able to improve the community’s health behaviors (Tortumluoglu, Okanlı & Ozer 2004). Knowing the cultural factors existing behind health behaviors is important for improving the acceptance of services and for elevating the quality of service (Amandah, 1994; Henkle & Kennerly, 1990; Rassool, 2000; Spector, 2000; Tortumluoglu et al., 2004). Nurses need to assume professional responsibility for teaching and explaining services in a cultural and gender context.

It is impossible to achieve nursing care objectives when the individual’s cultural make-up is unknown and when all individuals are considered to be all be alike (Tortumluoglu et al., 2004). There is a need for nurses today who understand the importance of the cultural aspects of care (Duffy, 2001; Henkle, 1990; Leininger, 2002; Poss, 1999). Beginning with Leininger many nurses have developed cultural models as a guide to defining individuals’ cultural characteristics (Tortumluoglu, 2005). These models are important guides for nurses in the evaluation of the cultural make-up of the community in which they provide care (Leininger, 2002). One of these guides is Giger and Davidhizar’s Transcultural Assessment Model (GD-TAM).

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The primary purpose of this model is to interfere with one type of medical behaviors in the care of individuals. In the model every individual is considered to be unique and assessed according to six cultural phenomena. This six cultural phenomena: communication, time, space, social organization, environmental control, and biological variations. These dimensions which affect health care, are evaluated. (Giger & Davidhizar, 2000) Studies conducted on this subject have shown that cultural characteristics can be obstacles or create limitations in the use of health were available in Turkey other than professional and individual observations about cultural characteristics and the use of health care services.

The purpose of this study was to assess the effect of cultural characteristics on the use of health care services using Giger and Davidhizar’s Transcultural Assessment Model and to draw conclusions for improving the quality of community health nursing services. In addition, the association between cultural characteristics and use of health care in a rural area would be assessed and used to determine results that could be generalized for rural areas.

Methods

Design

This qualitative study (ethnography design) was conducted in 2005 in Tuzcu village in eastern Turkey. Tuzcu village is 4.35 miles from the city center and has a population of 1185 (598 men, 587 women). There are 186 families living in the village. Large and small animal husbandry is the major industry in the village. Public transportation from the village to the city center is provided by buses that leave every 30 minutes. In the village there are two small markets, one coffeehouse, one mosque, and a primary school that provides education to approximately 80 students in two classrooms. Heating is provided in all homes in the

village and in the school by heating stoves, with dried cow dung used as fuel. In general, the villagers have health insurance. Other than two shepherding families who come seasonally to the village, everyone lives in their own homes. There are no health care facilities or health care personnel in the village. The villagers receive their health care from the province center. One midwife in the province center is responsible for this village. This midwife comes to the village an average of 10-15 times a year to monitor pregnant and postpartum women, infants and children.

Sample

The research population was comprised of all 784 individuals who lived in Tuzcu village who were 15 years and older. The snowball method was used for sample selection from the population. First, the researchers went to the village mukhtar (elected head of a village) and explained the purpose of the study. He was asked to help them determine the individuals who would participate in the study. With the help of the village mukhtar it was determined that the elderly men and women had the best information about the village. These individuals were approached, and the purpose of the study was explained to them. With the participation, guidance, and help of the elderly individuals, the study groups were formed. Groups consisted of 6-7 person (According to gender, age and social role). The reason for this was to create an environment in which they would feel comfortable talking.

Research permission was received from the Provincial Health Ministry and the governor. The purpose of the study was explained to the individuals. Those who wanted to participate voluntarily in the study were included. The names of the participants were kept confidential, and consideration was given to female participants who did not want their voices recorded.

Data Collection

Data were collected using a semi-structured interview form prepared by the researchers, using GDTAM as the foundation. Because of the basis of the study and limitations in resources, data about the GDTAM biologic variables were not collected.

The individuals in the study group were told the time and location of the meetings. The researchers went to the village three times to meet with the selected individuals on the specified dates. On one of the visits one group meeting was conducted; on the other visits morning and afternoon group meetings were conducted. Data were collected by taking notes and using a tape recorder (The women stated that according to their beliefs the voice was sinful so they did not give permission for their voices to be recorded; and their voices were not recorded)

Analysis

A descriptive analysis method was used to evaluate the research data. The data analysis was conducted according to the following steps:

1. Immediately following group meetings, notes taken during the meeting were reviewed and other related details were added.
2. Voice recordings were listened to and brief notes were taken.
3. During the interviews the individuals were observed and notes were taken on their body language.
4. After all of the meetings were completed, the data collected separately from the five groups were com-

piled under headings for the same dimension. Striking statements made that brought clarity to the subject were included without change.

Results

The individuals' cultural characteristics were analyzed taking GDTAM as the foundation. The findings, according to the model's five phenomena, were considered and applied to the five study groups individually.

Communication

The villagers spoke in Turkish (two families speak Kurdish in the home). The villagers have an accent and phraseology unique to Erzurum province. Communication characteristics create limitations for the individuals in the use of health care services. Communication characteristics were a significant obstacle, since it is not considered appropriate for women to make eye contact with men, to be touched by them, or even for their voices to be heard, even if they are health care workers. In particular, women considered the situation of the male health care worker who would do procedures on their breasts and reproductive organs to be a significant obstacle to the use of health care service. Flexibility is shown to elderly women on this subject. Some elderly women thought that they could go to a male doctor if it was necessary. However, the women leave decision making to men so their opinions were not considered important.

An elderly woman said, "If the person doing the physical examination or giving the shot is a man I'd be uncomfortable, because men are forbidden. It's even very sinful to show our husbands our private parts." Another elderly woman explained, "When I go to the doctor, if the doctor at the clinic is a man, I go back home without being examined. By the time I've gotten to my age I'm not going to uncover myself to an unrelated man." One of two elderly women who did not agree with these conversations stated, "If it is necessary for my health, the worker being a man doesn't matter. Our religion allows for this." And another woman expressed her opinion in this way, "If the condition is for our health, of course, we go to male health care workers. This isn't wrong; our religion permits this." Young girls and married young women are the groups who have the least authority to make decisions about the use of health care services. Decisions are made by the men in their family on their behalf. One of the young married women stated, "Decisions are made for us by our husbands or fathers-in-law. Even if I were dying my husband would not let a male doctor examine me, wouldn't let a man change a bandage, wouldn't let a man pull my tooth." These thoughts were supported by the other young married women in the group. A young girl explained the situation in this way: "We are villagers, we aren't free like the city girls. Whatever our father and older brothers say is what will happen. If they take us to a health care facility we go. If they don't take us, we wait to get well on our own." A young girl from another group said, "I'm embarrassed by a male doctor or health officer. Even when I go to the doctor, my father tells him my problem." The other young girls in the group supported these statements.

The situation was different for the men because men make their own decisions about health care. They would prefer to go to a male health care worker, but the dominant opinion was that this would never interfere with their getting health care. One of the elderly men from the group said, "If we need to for our health we go to the doctor; the

sex doesn't matter. In fact, the nurses give us our shots." All of the members of the group agreed with this statement.

In general, the men who did not consider communication characteristics to be an obstacle for their own health did not have the same opinion for women. The men thought that the women in their families were limited in their utilization of health care services. One of the elderly men said, "I would not take my wife, my daughter, or my son's wife to a male doctor. I would not show them to a man outside the family." Another man said, "I would never take my daughter or daughter-in-law to a male doctor, but I would take my wife." An elderly man from the same group stated, "If I had no other alternative I would take my wife or my daughter to male health care personnel. I wouldn't wait around for them to die, you know." Another elderly man said, "Some people wouldn't take their wife or daughter or daughter-in-law to a male doctor. They wouldn't let them explain their problems. He would even tell the doctor about their problems. In fact, some would go get a medicine without taking their wife or daughter. But if my wife was helpless from a sickness, I would take her to a doctor even if he was a man. But first I would look around and be sure there were no female doctors." One of the young men said, "Even if my older sister was dying, I wouldn't take her to a male health care worker, but if my mother had to go to a male health care worker I would take her." The other young men in the group agreed with this opinion.

Space

The need for space when receiving health care is an obstacle to receiving health care. As was true in communication, this obstacle is particularly true for women. The general opinion of the young girls was that when they did not need to, they would avoid close contact with male health care personnel; in fact, male relatives would not give permission for this. The situation for young married women in receiving health care was no different than that for the young girls. One of the young married women stated, "If the health care worker is a woman, there is no problem. But if he is a man, my husband would not even take me to be seen. If I had to, I would stand at the door; I would not go close to the doctor. I, or my husband, would explain my problem from a distance." The others agreed with this opinion. One of the elderly women explained her feelings in this way, "Sometimes I have to go to a male doctor. When I do, I stand at the door of the examining room and explain my problem. When the doctor says, 'Come get on the table and I will examine you' I have to accept it, but I am very embarrassed to be that close to him." The others in the group agreed with her opinion.

It was determined that there were no limitations on the distance between the male elderly villagers and health care workers when receiving health care. One of the elderly men said, "Normally we would not get close to women who are not lawfully ours. But for our health it doesn't matter how close, there is nothing to be shy about. If we need it for our health, we'll do it." The other men in the group agreed with his opinion. However, elderly men did not have the same opinion regarding their wives, daughters, or daughters-in-law. One of the elderly men stated, "A respectable woman would not get close to a man she is not related to," and the rest of the group agreed, in general. All of the young male villagers had the same opinion.

However, this opinion was slightly more flexible for older women.

Social Organizations

In the village women and men spend their time in completely different ways. There are so few shared tasks that practically speaking there are none. Women in general spend all of their time in the house, and men generally work and spend their time outside the home. Women are responsible for every kind of care and service to their family members, do not make their own decisions, occasionally get together with each other, and begin to prepare for marriage at a young age. However, the men are shown respect from an early age, are shown favoritism, always given priority, and are in a decision making position. A shared answer was given by all of the groups to the question, "What are women's duties?" "The most important duties of women are to marry, have children, raise children, take care of all the needs of their family, and have their honor protected," was how they answered.

In addition to this, the young girls sadly stated that they were bothered by the general attitude that women are always second, are always interfered with, and are guilty for everything. One of the young girls in the group verbalized her opinion in an irritated manner, "They practically won't let us get past the door of the house so that nothing will happen to our honor before marriage. An elderly man added, "Women are helpless; they need us" which was supported by the elderly group. The young men's answer was, "A woman's duty is to have children within her four walls and protect the honor of her husband."

To the question, "Do women participate in decisions?" one elderly widowed woman answered, "In our home my decision is asked." Another elderly woman said, "In the village the elderly are given importance; their opinions are asked. Our children do what we want." However, another elderly woman stated, "Because we are women our word is not always valid. We can't interfere with buying and selling; men make the decision." One of the elderly women was bothered by this situation and said, "Men even buy our clothes and we wear them." One of the young girls explained, "Girls and young married women don't participate in decision-making, but elderly women participate in a few decisions." The other young girls agreed. The answer by the young married women was clear: they are not able to participate in decisions in their families. One of the elderly men stated, "It's not good to get advice from women very often. Women can't make a decision; work isn't done by their word." The other elderly men in the group agreed with this statement. Although the young men were more flexible on the subject of women participating in decision-making, their opinions were not very different from the elderly men.

In particular, all decisions for young girls and young married women are made by men in the family. As they grow older women are more valued in society and they may be able to get into a position in which their voice is heard. However, decisions are still made by men, and the final word is always theirs. One of the young married women verbalized her feelings in this way, "We can't even go alone to a female health care worker. There is always someone with us." Another young married woman said, "I told my sister-in-law, let's go to the Family Planning Center. I don't want to have any more children. Since that day, they won't let me go to the midwife alone." These types of answers were common in the group. When three

widowed elderly women were asked whether or not it was difficult to live in the village as a widow, the shared opinion of the widows was that it was not difficult. The reason given was that when the husbands die, women who live in a traditional extended patriarchal family are able to continue living their same lives. However, it is difficult for young widowed women in the village. They are in a group which is excluded from everything in the society. There are no cases of divorce in the village. Being a single mother is not even spoken of. A woman cannot marry again when her husband dies; she continues to live in the home of her mother-in-law and children, but men can marry again at any age.

Time

All of the groups answered the following question similarly: "Do you live your life thinking about some events that happened in the past, in the present or the future?" All of the men and women participating in the study stated that they live in the present. The shared answer of the groups was, "What Allah says, will happen, every moment anything can happen. Nobody has a guarantee of tomorrow; there is no meaning in life thinking about tomorrow."

Environmental Control

Environmental control is defined as the capability of persons within a particular cultural heritage to plan activities that control their environment as well as their perception of one's capability to direct factors in the environment. All of the individuals participating in the study gave more importance to environmental control in receiving health care services. Even though they lived in a village that was very close to the province center, it was determined that more often they used and trusted traditional treatment and traditional healers when their health deviated from normal. An untrained religious teacher was said to breathe powerfully in the village and was the first person the villagers went to when they were ill.

To the question, "What do you do to prevent and treat illnesses?" the elderly women's group gave the same answer: "According to the condition, we go to the doctor, religious leader, bone-setter, neighbors, the graves of saints." To the question "How do you determine this?" their common answer was "according to the illness." One woman in the group explained, "A while ago my arm came out of its place. I went to the doctor. The doctor took an X-ray and gave medication. But it didn't help, my pain got worse. There's a bone-setter in Erzurum. I went to him at night. I took the X-ray the doctor had taken. The bone-setter looked at it and said my arm was out of its socket. Then he put it back in the socket. He made a salve from herbs, spread it on my arm and wrapped it. Now I'm fine. What I mean is that doctors don't know much about bone-setter's procedures. In these situations the bone-setter is better." Another said, "Madimak (*polygnum cognatum*), stinging nettle, evelik herb (*rumex crispus*), and parsley are used a lot. These are used first to try to treat all illnesses. If the person doesn't get better, if they are hopeless, and if they have health insurance then they are taken to the doctor." Another woman said, "In the village a young boy got bowel cancer. His family got more herbs, cooked them and fed them to him. They brought them in bags from other villages, but it didn't help. The young boy died, but they helped my son's body. He went to the doctor and medicines didn't help. He drank boiled stinging nettles for a while. Now his wounds are healed."

To the question, "What other types of traditional practices do you do for preventing and treating illnesses?" an elderly woman from the group said, "We have a lot of religious leaders in our village. They pray about wounds that occur in our bodies and we get well. We have them write amulets for our children," and her statements were supported by the group. Another common opinion shared by women in the group was that it was acceptable for traditional treatment methods to be used first in the village for illness, but when the results were not positive, they would go to the doctor. Also when they were ill they would get advice, first from neighbors and elderly villagers. However, another woman responded to the question in a different way. She said, "I don't have any confidence in health; for healing first I look in the village; if I don't get well, then I bow my head to my fate."

The other groups' explanations about the environmental control phenomena were similar to the elderly female group's explanations. However, it was understood from some of the statements that when men get ill there is more of a tendency to go to a doctor than with women. An elderly man stated, "Allah gives both illness and the cure. Finding it is up to us. We go to a doctor for a cure," was approved by the group. Another elderly man's statement was, "There are verses of healing in the Koran for illnesses. I would write them. That's how my illnesses that the doctor couldn't cure were cured by my amulets. However, Allah not leave anyone without a physician."

Discussion

GDTAM has been used by nurses and other health care workers to define the cultural differences of individuals for whom they were giving care and has contributed to improving the effectiveness of the treatment and care given (Davidhizar, Dowd & Giger, 1998; Dowd, Giger & Davidhizar, 1998). GDTAM has been considered to be a useful tool for community health nurses for assessment of the public's cultural characteristics (Davidhizar & Betchel, 1999). The effect of cultural characteristics of individuals living in a rural area was analyzed using this model.

According to the results of this study, cultural, religious, and gender characteristics are the most important obstacles in the use of health care services. The results of this study show that being a woman was sufficient cause on its own, whether or not health care services were utilized. Being a single girl was a more limiting characteristic than being a young married woman. If the health care worker is male, women may be completely prohibited from receiving health care services by the men in their families. The reason for this is that in this village women making eye contact with men other than their close male relatives, touching men, speaking with men, and standing close to men are considered inappropriate. All of these behaviors give a woman a bad image in society. In another study conducted on this subject, it was determined that health care workers being male was a significant obstacle to Asian women getting health care services (Degazon, 1996; Giger & Davidhizar, 2002b). In a study with Afghan and Arabic individuals, it was determined that it was forbidden for men to touch a woman if he was not their husband, son, or father, or for the woman and man to touch each other (Giger & Davidhizar, 2002b). In a study conducted in Puerto Rico, avoiding eye contact was determined to be a sign of respect. In the same study it was reported that touch was not a preferred communication style (Transcultural Assessment Model, 2004). The results of

our study are consistent with the literature and related research.

According to the results of this study, women are individuals in society who have children, have to care for all members of the family, can only leave the house when given permission by men in the family, do not have the authority to make decisions, and gain status as they grow older. In the literature it has been reported that women's authority for making decisions and status increases as they age (Degazon, 1996; Transcultural Assessment Model, 2004). In another study it was determined that in many Afghan families a woman cannot go outside, cannot work outside the home, and cannot continue her education without getting permission from her husband, father, or son. In the same study it was determined that health care decisions are made by the father, the oldest male child or the elderly. In Afghan families women are responsible for health care (Giger & Davidhizar, 2002b). The literature reports that in traditional extended families women are not able to make their own decisions about where and how to get health care services (Bolsoy & Sevil, 2006). The results of this study are consistent with the literature.

According to the results of our study. When individuals become ill, they first try traditional treatment methods and go to traditional healers. In addition, when someone becomes ill, the men and elderly in the family decide what will be done. In other words, in this study utilization of health care services was associated with external controls. In another study Afghans were determined to have higher environmental controls than internal controls (Giger & Davidhizar, 2002b). The literature reports that individuals who adopt environmental control display more fatalistic attitudes and have difficulty accepting behaviors that improve health (Giger & Davidhizar, 2002a; Giger & Davidhizar, 2002b). Having more of an environmental control as a result of the cultural structure of society in this study was not a desirable result since it is a limitation in the use of health care services. The results of this study show that individuals are more time oriented as they grow older and display a fatalistic attitude toward health. Other studies conducted on this subject have shown that western societies, such as America and Canada, are more future oriented (Degazon, 1996; Spector, 2000). Eastern societies, such as Afghanistan, Puerto Rico and Pakistan, display a lifestyle that is more focused on the present and past than on the future (Giger & Davidhizar, 2002b; Transcultural Assessment Model, 2004). In Puerto Rico and Pakistan everything, including health and illness, are under the control of religious powers and can change at any moment (Transcultural Assessment Model, 2004). The results of studies in Afghanistan, Pakistan and Puerto Rico show similarity to the results of this study. These similarities may be a result of the societies' cultural characteristics.

Conclusions

In this research GDTAM was used as the basis for the determination of individuals' cultural characteristics. Individuals were assessed according to communication, space, time, social organizations, and environmental control dimensions.

According to the research results:

- Cultural characteristics limited or interfered with the acquisition of health care services. Being a woman was seen to be the most significant obstacle in getting health care services. Speciality

sin, forbidden, shame are effective on behaviors of women.

- Men in the family make the decisions about where and how health care will be received. As women age they may be included in decision making. Older women is more effective on decision.
- When illness occurs, they try traditional treatment methods and go to traditional healers first. Environmental control has a significant influence on decisions.
- Individuals think that the time in which they are living is important and leave the future to fate.

Recommendations

Based on these results the following recommendations are made for villagers to use health care services effectively:

- When health care services are planned, the interventions should be planned so that women will take advantage of health care services more effectively, and that projects be prepared that will help women gain status in society (For example: upgrade of the level education in women, to provide economic freedom for women, facilitate access to health care, support of the clergy about religion topics, etc)

Interventions can be planned to determine traditional treatment methods, to prevent those which are harmful, to direct individuals to health care facilities, and to decrease to the minimum the environmental factors that have an effect on the utilization of health care services. Men should be included in all health care services so their cooperation can be ensured.

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