

# Stigma, Cultural Traditions and Identities: A New Geography of Health

## Case Study

### Introduction

Where one lives in the world can have a profound influence on the standard of one's health and life expectancy. Common themes in geography such as climate, natural hazards, economic status and food security link strongly to the health of a nation and geographers have commonly sought to explore the conditions that make peoples of one location healthier and live longer than those of another. Less explored is how the cultural geography of a nation, its traditions and associated social norms and stigmas may have an influence on the health of its population. These traditions can in turn have a positive or negative effect on the economy and the development opportunities created by that country.

This case study will look in more detail at how three countries in Africa (Figure 1) are affected by different health issues and explore how changing culture, traditions and stigma have had an effect on their continuance, as well as the long term and wide ranging impacts these cultural geographies may have.



Figure 1: Specific health issues in three African countries

### What role has social stigma played in the management of the 2014 Ebola outbreak in Liberia?

The first confirmed cases of Ebola in Liberia came on the 31<sup>st</sup> March 2014 (BBC, 2014) when two sisters died of the disease having returned from a trip to Guinea. What then followed was a country wide

epidemic with over 6,500 recorded cases and over 2,700 deaths in the nine subsequent months. While popular media commonly reported the spread of the disease as being ‘out of control’, in fact the disease – whilst having high levels of mortality - is not as contagious as one was led to believe, ranking far behind the world’s biggest killer, influenza (Al Jazeera, 2014). Unlike influenza, there is no evidence that Ebola is spread by airborne particles, being instead spread by direct contact with infected bodily fluids.

The justified concern over the poor survival rate of the disease, ten to fifty per cent according to the World Health Organisation (2014), however goes some way towards explaining how Liberia’s residents created a set of complex, and often conflicting, set of social stigma surrounding the disease. Fear of coming into contact with anyone connected to Ebola, be it a victim, a relative of a victim, a survivor or someone who works in the health profession escalated to the point at which it started to have a profound impact on the economic geography of the country and its ability to recover from the outbreak.

Survivors of the disease were especially stigmatised. Despite being given the all-clear from doctors, few felt able to return to their communities where neighbours and even family members rejected them, refusing to take them in and in some cases threatening violence against them (Elbagir and Brumfield, 2014). Poor communication, knowledge about public health and educational infrastructures in Liberia allowed the spread of the stigma to go unchecked and led the Liberian Minister of Health, Dr Walter Gwenigale, to become hesitant about publically naming the districts affected by the epidemic for fear of further stigmatisation and counterproductive misinformation being circulated (Lazuta, 2014). For those orphaned by the disease, of which in November 2014 there were over four thousand across West Africa (UNICEF, 2014) this stigmatisation created a number of children being forced to look after themselves as relatives suddenly become ‘untraceable’ or became genuinely difficult to contact due to the quarantine restrictions placed on whole districts (Mark, 2014). The long term impact of this could be a generation of children who are unable financially to attend school and a long term rejection of the extended family and community networks that normally support orphaned individuals (Plan, 2014).



|                         |   | Liberia | UK     |
|-------------------------|---|---------|--------|
| GDP per capita (US\$)   |  | 454     | 39,337 |
| Life Expectancy         |  | 60.2    | 81.5   |
| Doctors per 1000 people |  | 0.014   | 2.79   |
| Literacy Rate           |  | 42.9    | 99     |
| Birth Rate              |  | 36.0    | 12.8   |

Figure 2: Development Indicators comparing Liberia and the UK (Source: World Bank Data)

Since the end of the civil war in 2003, which in itself created many single parent and child headed households (Plan, 2014), Liberia has struggled to house and rehouse those affected by conflict and the burden of disease and its social stigma has magnified this problem. With almost the whole of the country separated and quarantined into geographical parcels; a measure put in place to contain the disease at the height of its spread, it was difficult to coordinate a countrywide policy to maintain Liberia operating as a coherent nation and community and acting in such a way that did not have a long term impact on Liberia's already weak economy (Figure 2).

Stigma affected Liberians' personal and national economies. Many local traders, who had lost family members to Ebola, faced an unfounded fear from customers that their food stuffs were 'tainted' or that they themselves were vectors for the disease (Action Aid, 2014). Not long after the start of the epidemic, they struggled to feed their own families on their heavily reduced income. Since the delivery of goods nationally was also affected by regional quarantine restrictions, food and essential goods were not getting through to some outlying districts, sending the cost of food and basic necessities beyond the level most Liberians could afford. Therefore at a time when people could most use cheap and locally produced goods, social stigma compounded the problem and left many families relying on erratic charitable handouts instead (Al Jazeera, 2014).

### **How have a combination of old and new traditions created a new set of health problems in South Africa?**

There has been a long history of negative health stories coming out of the African continent but until recently one might fail to recognise obesity and diabetes as one of them. It is a misnomer that the latter is only a condition of the affluent while malnutrition is reserved only for the poorest in society (Figure 3). As South Africa has risen from the apartheid era, new cultures around eating and food, as well as a changing geography of settlement, has caused obesity to become the second biggest health challenge in the country, surpassed only by HIV/AIDS, and diabetes is predicted to overtake HIV/AIDS as the biggest cause of death in South Africa by 2030 (Birrell, 2014). Diabetes, that was once a rarity in sub-Saharan Africa, in 2012 affected over twelve million people there, with numbers showing no signs of slowing down (Project Hope, 2012).

Traditions are an influence on these rising figures in South Africa and the unique way in which long held ideals are mixing with modern geographical phenomena is creating a nation that is at risk of serious shortfalls in healthcare provision. What is considered a healthy and attractive body shape varies geographically and in South Africa, larger people are traditionally seen as being more wealthy, successful and beautiful, compared to a thin body shape which is often wrongly assumed to be HIV positive (Birrell, 2014). Equally an old tradition of eating quick-to-access street food is one that has continued through to modern times, but the *braai* (street barbeque) has now been replaced with drive through fast food restaurants. The McDonalds franchise saw their fastest expansion of any country in South Africa with thirty restaurants opening between 1995 and 1997 and over 200 in place by 2014 (McDonalds, 2014). Due to rising wealth in South Africa, traditional street food is increasingly being sustained by lower grade meat, and indeed offal, while the better cuts get bought at a premium price by the increasingly numerous

middle classes. Fast food is now the poor man's alternative: street food, but a lot more sophisticated and a menu to which those at the bottom of the South African socio-economic ladder can aspire (Baleta and Mitchell, 2014).



Figure 3: South Africa and health in numbers (Source: Keats and Wiggins, 2014; Ng et al, 2014; International Diabetes Federation, 2014)

Changing aspirations have also led to a sharp increase in the rate of urban living. At current projections, seventy eight percent of sub-Saharan Africans will live in cities by 2030 and with urban residents up to four times more likely to be diabetic than rural residents (Diabetes Leadership Forum, 2010) one can see how South Africans' choice of home can affect their health. Urban lifestyles, which usually generate higher levels of disposable income, customarily result in higher levels of inside play for children and a greater dependency on the car for private transport. In South Africa this has been compounded by historical social unrest and continuing high crime rates, which have caused many parents to choose to habitually keep children indoors and drive short distances which would normally be taken on foot (Lewis, 2012): new traditions, customs and behaviours from which it has proven difficult to move away.

More people die from HIV/AIDS in South Africa than any other nation (World Bank Data, 2014) and in light of the Millennium Development Goals which targeted reversing the spread of the disease, the country's Department of Health took some bold action. A priority was given to funding the management of HIV/AIDS and other infectious diseases over support of other health areas, including diabetes (Smedley, 2013). This has now created a 'double burden' where HIV/AIDS prevention combines with the previously unchecked high levels of non-contagious diseases (NCDs) such as diabetes and puts an enormous strain on the South African healthcare system (Diabetes Leadership Forum, 2010). The impact of this has been that many South Africans themselves may not consider diabetes to be a 'genuine' health problems when compared to HIV/AIDS and some have argued that the way healthcare funding has been

allocated in post-apartheid South Africa has in itself created a culture and tradition of ambivalence about the condition (Thornton, 2013).

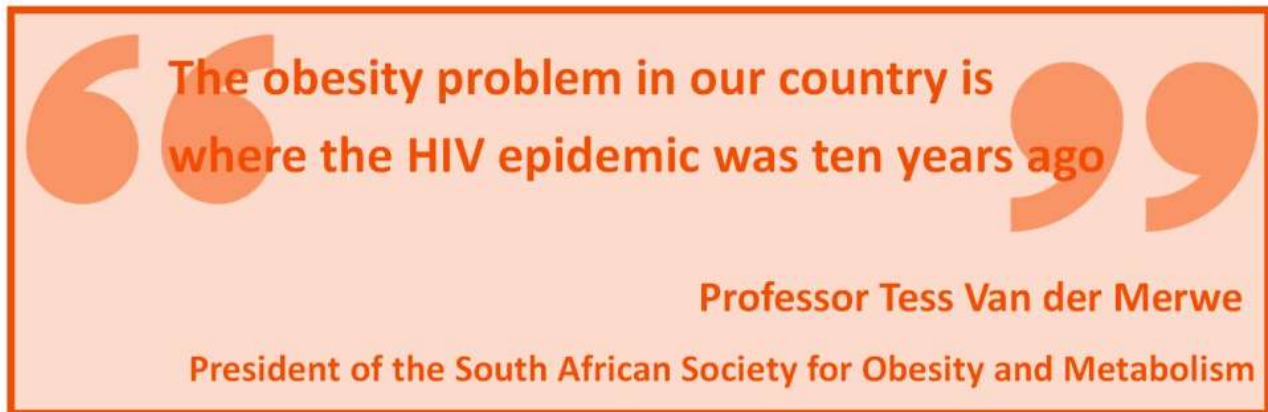


Figure 4: Comparing obesity with HIV/AIDS (Source: Birrell, 2014)

### **How have long held beliefs and adherence to cultural identities provided a backdrop for Female Genital Mutilation (FGM)?**

A practice which is thought to have been occurring for over two thousand years (Slack, 1988), Female Genital Mutilation (FGM) takes place in twenty eight African countries and in others where traditional practices have been, some would say, falsely woven into religious rhetoric. In Ethiopia this form of 'circumcision' affects nearly twenty four million women and girls – second only to Egypt in the numbers affected (28 Too Many, 2013). The practice can be harmful to many who undergo the procedure and serious health problems can ensue from it. Lifelong pain, erratic bleeding, incontinence, problems in childbirth and fistula formations are just some of the complications that Ethiopian women suffer (Plan, 2014<sup>2</sup>).

The primary reason quoted for having the procedure done is respect for tradition and to uphold one's cultural identity (EGLDAM, 2008). The patriarchal social structure found in Ethiopia means that women hold little say in the matter and this has in turn created a culture of early marriage and low female literacy rates of just 28.9% (World Bank Data, 2014) – two factors that mutually feed each other and challenge the country's level of development.

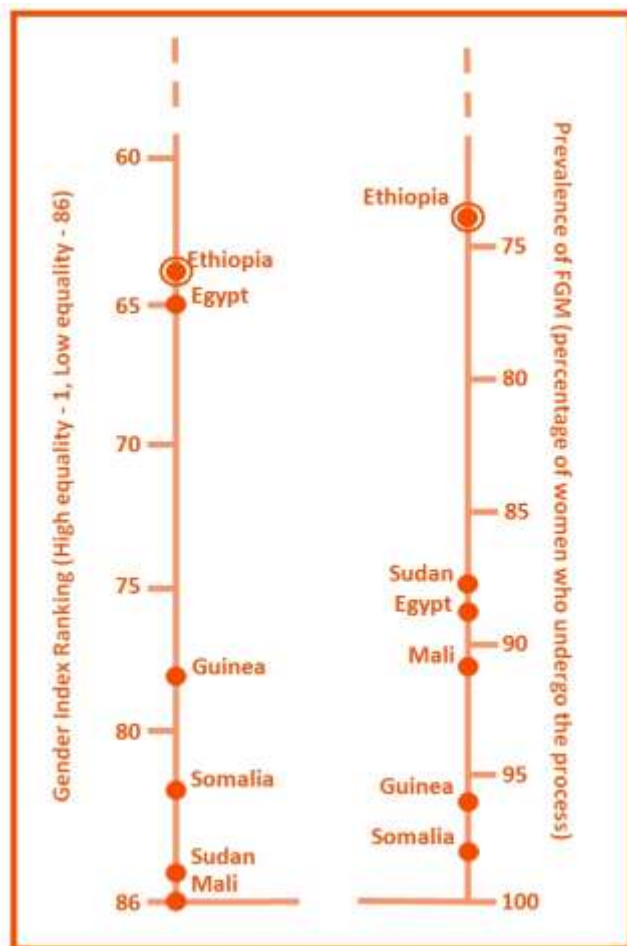


Figure 5: Comparing FGM prevalence with gender equality

(Source: UNICEF Data, 2014; OECD, 2012)

Though the practice is illegal in Ethiopia and breaks several UN conventions, the long held set of traditions and cultural norms have proved stronger than the law and in practice few cases are brought before police and the courts (Getachew, 2006). So strong is the belief in the virtues of FGM, that in areas of Ethiopia where ‘cutters’ have been targeted, the procedure is instead found in the black market economy, increasing the dangers for the young women involved (Pells and Robinson, 2014). Mothers and fathers of girls are also frequently against the procedure but pressure from community members can prove too strong, especially since the process is often a prerequisite to a marriage that can provide financial security for the girls (and her parents) in their future. FGM is thought to keep a girl ‘clean’ and ‘proves’ her virginity to potential suitors – without which she is seen to be a dishonour to her family and is likely to be ostracised from her community (Kumar, 2013). As the pressure mounted on the Ethiopian government to act more strictly against the practice, girls have been found to be marrying at a younger age than previously (World Vision, 2014).



Figure 6: Percentages of Ethiopian women who believe FGM should continue (Source: Central Statistical Agency, 2006)

Despite the UK (in 1985) and other G8 nations making the practice illegal, the response from more developed countries. Since the practice is so clearly linked to long held cultures and traditions, a fear of seeming culturally insensitive and at worst xenophobic has provided a reason not to exert pressure internationally and has allowed the rights of the culture to override the needs of individuals (Dyer, 2014). Instead, non-government organisations and women's groups within Ethiopia see the future as being one where the cultural textbooks are rewritten. They advocate a movement towards a paradigm of old traditions being adapted to suit modern lives and advise that 'cutters' be included in this process to allow them to sustain an income legally (Pells and Robinson, 2014).

## Conclusion

When studying the causes of health, geographers have traditionally focussed on easy to measure factors such as the number of calories gleaned from a staple crop, the availability of vaccinations or the extent to which people's lives are hazardous. These allow comparisons to be made easily between nations and more direct links between causes and consequences can be seen. However in a globalised society it is also interesting to look towards the cultural geography of a place and how stigma, traditions and cultural identities can shape one's ability to prevent ill health or indeed recover from it.

In the cases of Ebola, diabetes and FGM, social taboos and changing fashions have moulded the fitness of the populations of Liberia, South Africa and Ethiopia respectively and in turn have influenced those countries economically and environmentally. The challenge that lies ahead for national and international political players is that of retaining cultural vibrancy while addressing the health concerns this culture can produce, as well as ensuring that these economic and environmental issues do not come to define nations.

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