

**HEALTH EDUCATION IN CROSS CULTURAL ENCOUNTERS -
AN AGOGICAL PERSPECTIVE**

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HEALTH EDUCATION IN CROSS CULTURAL ENCOUNTERS - AN AGOLOGICAL PERSPECTIVE

SUMMARY

In contemporary multicultural societies, health is emerging as a fundamental right alongside education and welfare: a frame of reference endorsed by the Government of National Unity in South Africa. Health workers are confronting issues far beyond the more traditional modes of health education. The initial thrust of this research was to investigate the most relevant social, health and education knowledge bases and issues relative to health education in cross cultural encounters in order to formulate universal guidelines applicable to the national situation. Differences inherent in allopathic and traditional health systems are explored in historical time, in conjunction with concepts of social change, communality in diversity and the co-existence of multiple realities. An understanding of common denominators across all human and group experience emerges and, with it, insight into problems that occur when universalistic conceptions of human behaviour are linked to communicocentric hegemony.

The parameters within which cross cultural health education are viewed are extended through an analytical, empirical evaluation of the andragogic consequences of a broader conceptualisation of culture and the patterned relationships existing between elements within society. The ontic fact that similar variables may have widely different meanings and be differently construed by people whose life experiences differ is affirmed. Culture shock becomes a potential personal reality for all engaged in cross cultural encounters.

Radical reflection on human nature and the *eidos* of man constitutes the foundation upon which the aims and various theories of health education are systematically and progressively evaluated. Evidence surfaces that the original intent of the research was rooted in the Western medical tendency towards standardisation, specialisation and the creation of scientifically validated routines for professional practice and that gaps exist between the theory and practice of health education and the everyday experiences of people. On the basis of scientifically based insights, guidelines have been formulated to narrow the divide between the factual, linearly based procedural aspects of health education and the human experience of learning. The guidelines embody the notion that the health educator's role in cross cultural encounters is one of facilitating meaningful, appropriate and informed choices on the part of adult learners.

KEY TERMS

Health Education; Cross Cultural Education; Multicultural Education; Intercultural Communication; Transcultural Nursing; Philosophy of Education; Adult Education; Primary Health Care; Community Development; Andragogics.

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CHAPTER ONE

GENERAL ORIENTATION: ANALYSIS OF RESEARCH

THEME AND METHOD OF RESEARCH

1.1 INTRODUCTION

South Africa is a country with a multiethnic, multilingual, multiracial, multireligious and multicultural population which, in turn, is characterised by a multiplicity of overlapping, competing and changing value systems (Arthur, 1992:1). The intrinsic nature of such a social reality creates opportunities for multiple cross cultural encounters at every level of human interaction: whether in the fields of politics and justice, economic and social activities, education, health and the social services or within the boundaries of family and community life. South Africa is also a region experiencing dynamic social change (cf 4.4.3), accelerating technological development (cf 1.3.1.5), burgeoning urbanisation (cf 4.2.5) and high unemployment rates.

The nation is engaging in reform as it confronts the long term effects of discriminatory policies based on the traditional practice of organising intergroup relations around racial groups as units for national planning and policy formulation. As an aspect of historicity (cf 3.2.1.12) these policies have generated a number of interactive core problems which continue to play a role today. The problems include tensions stemming from officially designated group membership and inequality, segregation, isolation and insulation of one group

from another as well as cultural diversity. As a result, opportunities for members of the different groups to perceive one another as individuals and not merely as representatives of clearly identifiable classified social groupings has been limited. (In spite of the new political dispensation), South African society remains characterised by people who have become isolated from one another, while at the same time remaining interdependent upon one another (Human Science Research Council in: Marais, 1985:39).

The complexity of the South African situation is intensified by the fact that the social and economic structures of society are rooted in Western cultures and reflect a world view (cf 1.3.1.1) which may, in part, be described as contemporary (cf 1.3.1.4), technological (cf 1.3.1.5) or First World (cf 1.3.1.2). By way of contrast, the vast majority of the South African population are of non-Western origins with a world view which, from a technological point of view, falls along a continuum ranging from a broadly based Third World (cf 1.3.1.3) to a newly emerging First World perspective. The degree to which persons and groups may be regarded as technologically underdeveloped, developing or developed is dependent on the degree to which they have had to adapt to the demands of technology for their livelihood in a predominantly Western orientated technological society. The complexities of the First-Third World dichotomy are intensified by the fact that adaptations to a First World way of life do not proceed along a universal, predictable course nor at a uniform rate in any one sphere of human existence (Arthur, 1992:1-2). In addition, the field of health care is still characterised by a very marked discrepancy in the practice of Western Medicine (cf 2.2.2) and traditional African medicine (cf 2.2.1).

Industrialisation and technological advancement, in association with a changing socio-political climate, have been instrumental in bringing about a situation which is characterised by an ever-increasing demand for the extension of all kinds of services to the townships and rural areas that have been neglected in the recent past and are regarded as vital in bringing about overall social and economic advancement. Consequently, the introduction of better agricultural schemes and conservation methods, the improvement of public amenities and communication services, the upgrading of education facilities and the establishment of health centres are viewed as matters of urgency. At the same time, the cultural roots of the established systems and services in health and education are founded in the annals of the history of the Western World.

Traditionally, in South Africa, health and health education services have evolved as a result of the societal needs of the dominant group and the demands of ever-increasing technological change as defined and developed in the First World. As South Africa is a land in which services are not available to all sections of the population, the AFRICAN NATIONAL CONGRESS (1994(b):7-8) has identified meeting the basic needs of the people as first priority in its 'Reconstruction and Development Plan' (hereafter referred to as the RDP). Key areas in human need satisfaction include a clean and healthy environment, nutrition, health care and social welfare in addition to jobs, land, housing, water, electricity, telecommunications and transport. Central to the success of the health related aspects of the plan is the concept of primary health care (hereafter referred to as PHC) (cf 2.3.4.1) which, in turn, is heavily dependent on successful outcomes of health education and health education programmes.

On an international as well as national level, this is an age marked by democratic ideological systems, a heightened awareness of, and interest in cultural and sub-cultural difference and the implications of such difference for levels of educational attainment, standards of living and health in the various social groupings. These features manifest in a cry that each socio-cultural group be respected to ensure that the human dignity (cf 3.2.1.14) of each individual in society is recognised (Staples, 1987:2). These trends are especially marked in societies where cultural resources are differentially distributed throughout the population whether in terms of race (cf 4.2.1), ethnic group (cf 4.2.2), social class (cf 4.2.3), gender (cf 4.2.6) or geographic region (cf 4.2.5). Unequal access to the pool of cultural resources is accompanied by difference in life-style which may, and does, reflect differential access to resources that are both needed and/or desired by the people (Booyens, 1991:482). Democratic ideals leading to increased expectations amongst groups with unequal differential resources, together with the cry for respect for human dignity, has resulted in members of dominant groups reflecting seriously on issues of inequality (Banks and Lynch, 1986:ix).

BRUGMAN, (in: Van Gent, 1991:87) refers to the great correlation between education and medicine which, by implication, may be extended to health care systems. Health education, in this context, may be viewed as an activity bridging the systems of both health and education and having relevance to community life outside the school as well as to the future needs of its children (Theron, 1981:2). It may also be inferred that the problems of health and education are interrelated.

Traditionally, the South African health and education systems functioned to maintain and

reinforce established ethnic and racial patterns. However, according to RASH (1988:211), the present constitutes a significant time in global history in which topics relating to peace and understanding have come to the fore. Whereas thirty years ago, concepts of cross cultural and intercultural communication (cf 1.3.6.4) were relatively unknown, today increasing numbers of people and organisations realise that the current situation necessitates a system of health education which will sustain a functionally effective role in meeting the health needs of a rapidly changing and developing industrialised, multicultural post-apartheid society. In this regard, the formulation and development of health education policies and practices which relate to cultural and ethnic diversity, in the situatedness of cross cultural encounters, have become a matter of urgency.

Against the background of these introductory remarks, the question can and must be asked as to how health education, as an aspect of education, may be of relevance to South African communities, in all their diversity, thereby enabling them to improve the scope and quality of their lives. In modern, contemporary, multicultural societies, health is emerging as "... a fundamental right, along with education and welfare" (Theron, 1981:8): a frame of reference which is upheld by the WORLD HEALTH ORGANISATION (hereafter referred to as WHO), and the UNITED NATIONS (in: LOEWY, 1987: 783).

1.2 PROBLEM FORMULATION

Health educators are clearly facing the challenges of confronting and addressing issues far beyond the more traditional modes of health education (Ashton, 1991:47). In approaching

the phenomenon of health education in cross cultural encounters, attention is focused on man as human being (cf 3.2.1.1), existent (cf 3.2.1.2) in a world of meaning (cf 3.2.1.3) and on the demands of the *agein* (cf 1.3.2.1). Initially, because of its scope and dependence on multidisciplinary scientific approaches and spheres of endeavour, the field of study may appear ill-defined and confused. However, as attention is directed towards the essential features of the phenomenon, form and structure emerge.

1.2.1 NATURE OF THE PROBLEM

Coping with health problems occupies a great part of the lives of the majority of people throughout Africa. Yet for millions, access to basic biomedical or Western technological health care remains an elusive, remote prospect (Good, 1987:1). As a result, traditional medicine provides for most of the health requirements of at least 80 per cent of the African population (Koumarè, 1983:25). Consequently,

"Traditional societies have always considered their medical practitioners as influential spiritual leaders who handle both the routine and extraordinary medical problems of the society. Using magic and religion as two pivotal rites in their employ, traditional medical practitioners help to conceptualise the ultimate reality of their culture and all the activities they employ" (Ayensu, 1983:175).

In the complex society that is South Africa today, a highly sophisticated technological medical system co-exists with traditional beliefs and practices concerning health. Therefore, the problem of accommodation (cf 4.4.3.1) between both systems arises and becomes a question of major importance (Hammond Tooke, 1989:12): not only to the health care system as a

whole, but also in respect of the effective implementation of acceptable health education programmes where the principles of accessibility, affordability and equity of services are also taken into account.

According to FRAZIER ET AL. (1988:27-28), health education, as a new applied professional field, presents a complex conceptual structure on account of its interdisciplinary nature, almost limitless scope and the everchanging locus of its application. The academic foundations are likewise broad and the relevant literature base scattered throughout biomedical, physical, behavioural, social science, pedagogical and andragogical journals. While the aims (cf 2.4.2) of health education are not ambiguous, health education does not possess a well established, readily identifiable body of knowledge and textual sources that reflect standardised technology or a set of referenced operating guidelines (cf 5.3.5.4).

Because of the correlative interwovenness between a system of (health and/or) education and the milieu in which it exists, each exerts a reciprocal (and dynamic) influence on the other. Not only do problems of (health and) education stem from a particular cultural milieu and social background, but both exert a formative influence on a society and its cultural evolution (Van Vuuren, 1990:147) with regard to its health and education systems, folklore, practices and related social institutions. This statement is of relevance to all cultural groupings for man is a cultural being (cf 3.2.1.11). Hence, it also underscores the importance of identifying issues relating to cross cultural encounters within a multicultural society. In similar vein, health or ill-health is closely related to the national wealth and prosperity of a nation. LEININGER (1978:42) confirms that every aspect of the social structure of a society

has an impact on beliefs and practices concerning health, illness and caring within a particular culture. Multiple systems such as religious, kinship, education, social, economic and political systems greatly influence the health care system.

Health care professionals, as well as those towards whom health care is directed, are cultural beings, interpreting and attributing meaning to their world in accordance with their personal, social and cultural experiences. In respect of the health care system and health education, cross cultural encounters occur between co-professional health workers, between the various categories of health care workers and between health care workers and their clients. Professional health workers, regardless of cultural affiliation, as employees of the various agencies within the national health system, tend to share the dominant Western biomedical or allopathic (cf 2.2.2) perspective of health and ill-health.

A critical problem arising from this situation, and one which poses a challenge of major proportions to leaders in the fields of health, education, community work and related social services, lies in the means whereby large numbers of scientifically trained and highly knowledgeable professional and allied workers can be prepared for interdependent transcultural experiences to the mutual benefit of society, as a whole, and the individuals, families and communities which are served, in particular. The problem relates to the need to develop constructive human relationships and the establishment of a dynamic balance between the interests of the group on the one hand and those of the individual on the other (Human Science Research Council, *in*: Marais, 1985:39).

A further manifestation of cultural distinctiveness surrounds differences in the communication styles (cf 4.3.1.2(c)) and rules (Hecht, *et al.*, 1989:385) inherent in and between specific languages. These differences are influenced by region, class and gender as well the overt characteristics of the various languages. Therefore, the question of language is complex and fraught with difficulties. Even when people from the same culture communicate, the message received may not be exactly the same as the message intended because of the unique set of life experiences and personal frame of reference of each individual. Intercultural communication compounds obstacles to comprehension, thereby increasing the chances that messages conveyed will differ from those received. Furthermore, vocal inflections, gestures, body language, manners and concepts of time and space all contribute to possible misunderstanding (Gibbs, *et al.*, 1988:2).

Cross cultural encounters, in the health system, continue to take place against a background of unremitting social change (cf 4.4.3) in which transition from an official policy of separatism to multiculturalism has been sudden while the conflict inherent in a deeply segmented society remains. Integration of people from widely divergent racial and socio-cultural milieus into the dominant or mainstream health system has become a historical reality with almost immediate effect. The question arises regarding the degree to which the cultural imposition of value systems and the ethnocentric tendencies of a dominant group may or may not affect the realisation of authentic health education. Authentic in this sense of the word implies reliability, trustworthiness, authoritativeness of undisputed origin by the real doer of the deed (Van Rensburg, *et al.*, 1994:318), in this instance, the health educator. An authenticity which may only be realised when measured against educational criteria derived

from the ontological ground structures of human existence (cf 3.2.1): criteria which have equal relevance to all human beings within the context of man as cultural being when viewed against the background of culture as overarching ground structure of human existence (cf 3.2.1.11(a)).

In addition to the rapidity with which socio-political change is taking place, sub-Saharan Africa and parts of Asia are experiencing some of the highest levels ever of migration from rural to urban areas, as well as the most rapid relative rates of urbanisation. The absolute level of urbanisation is not the most important factor, but the relative speed with which it is occurring is a problem (Harpam, *et al.*, 1988:9). According to KATUS (1989:39), it is difficult for individuals and groups to establish a more or less integrated way of life in complex societies subject to rapid change. Such societies comprise communities made up of a bewildering variety of social worlds or realities which, in many ways, are communities without a territorial base. The situatedness of each individual and community becomes the culmination of distinct sets of communication channels (interactions), the boundaries of which are set neither by physical proximity, nor by formal group membership, but by the limits of effective communications and interactions with their (human) world. The individual, and the group, is dependent upon these channels of communication and interactions to construct a personal world of meaning and a group (or normative (cf 3.5.1.10)) model of reality as a basis for making decisions (Shibutani, 1986:109). Many decisions have to be made in problem situations where the alternative to realisation of potential, be it in health, education (or any other circumstance of life), is the threat or fact of stagnation (and regression) of action. Where such circumstances exist, it may be concluded that acculturation (cf 4.4.3.1) may be

taking place so rapidly that traditional ethnic, linguistic and religious links no longer provide guidelines concerning the socio-cultural realities of the people concerned.

South Africa is very much part of sub-Saharan Africa and the problems outlined by Katus clearly indicate that questions relating to cross cultural encounters may go beyond inter-cultural contact between members of clearly distinguishable groups or sub-groups. The encounter may extend to include exchanges with people who are dissociated from formal group identification and physical boundaries and are dependent purely on available channels of communication and interactions with their dynamically changing world. Such human realities could be described as shifting, fragmented and lacking in stability. The dynamics of social change in all its dimensions constitute a further problem for the implementation of meaningful health education.

Widespread disenchantment with health care exists in many developing countries for reasons common to nearly all of them. Health resources tend to be concentrated in areas catering for a mere 20 per cent of the population. Facilities and specialist services utilising costly technology are available to only a small percentage of the more affluent population while, at the same time, absorbing a major part of the health budget. Meanwhile, the conventional and orthodox health services devised for Third World populations remain economically unattainable. Disparities between high costs and low returns in health care have become apparent in both developed and developing countries. The economics of health care systems is becoming a major political issue in many lands (Bannerman, 1983:319) and a potential problem area in respect of health education programmes based on First World technology.

ELLIS (1993:16) attested to the fact that South Africa, shares with the rest of Africa and other developing countries, an ailing, under- and unequally funded, expensive, urban centred, curative orientated health service which is in urgent need of restructuring. He pointed to the need to move away from the doctor based hospital system so that health care can be taken to the people at a cost that they and the country can afford. He highlighted the fact that greater emphasis should be placed on health education to bring about a better state of health for all people.

The above statement finds an echo in the policies of the previously mentioned RDP of the African National Congress (hereafter referred to as the ANC). This policy, in turn, has close links with the Alma Ata declaration of 1978 (cf 2.3.1.3(a)) which may be viewed as the point at which "... primary health care became a focus uniting developed and developing worlds" (Ashton, 1991:41).

The World Health Assembly at Alma Ata prioritised health education as the first of eight essential activities required for successful PHC programmes in developing countries (Loevinsohn, 1990:788). Given the strategic importance apportioned to health education by the WHO in the global strategy toward the implementation of PHC, the reservations held by LOEVINSOHN (1990:791) concerning difficulties in reaching any firm conclusions about the effectiveness of health education, is disturbing. He cites the paucity of methodologically sound studies relating to health education and states that while health education sometimes leads to changes in behaviour and health status, there remains room for legitimate scepticism about the end results. Earlier studies, carried out by THOMAS and WHITE (in: Jansen,

1982:224-225) illustrate that improvements in standards of nutrition amongst children related more closely to employment opportunities and family stability than to extended health education programmes. On grounds of these and other studies, JANSEN (1982:184) questions whether health education, as practised, warrants the tremendous financial outlay and whether the returns are not too small for the amount of effort and energy expended. She feels that the whole matter of health education should be re-evaluated. More specifically, FABES (1982:42) argues that if a major goal of identified health education programmes is a reduction in the rate of unwanted pregnancies, few studies have shown a measurable impact on these fertility rates. WEBB (1994:16, 18), more recently, addresses the same questions within the context of efficiency, effectiveness and cost, in ethical terms.

The question arises as to whether health education is as ineffectual and expensive as has been suggested or whether the problems are associated with the more fundamental issues of health and education as an aspect of man as human and cultural being and of the *agein*. Considering the vested interests in health education world wide and in South Africa, in particular, further questions arise concerning the degree to which health education is an effective educational activity in realising the global strategy of 'Health for All' by the Year 2000 (WHO, 1981: Title) and the degree to which authentic education may be realised in cross cultural encounters.

A further question relates to whether culture, manifesting as difference between people as groups as opposed to culture perceived as levels of ignorance and disadvantage by Western medical practitioners, does affect the learning outcomes of health education in cross cultural

encounters (adapted from Reese-Dukes, 1981:110-111). According to GROSSE (1982:105), research has not yet revealed links between education and health in developing countries, nor identified those educational activities which produce change. In South Africa, too, it appears that little more than lip service has been paid to health education as an effective channel of communication in cultural perspective. There is little concrete evidence to suggest that cultural difference and health educator-client relationships have been addressed in practical terms in spite of the fact that an interpersonal approach is critical to the development of an intercultural perspective (Cushner, 1988:159).

On the positive side, in terms of the new political dispensation, the problems feature high on the list of national priorities. The challenge lies in redirecting the focus of a health system, in which health education *per se* continues to reflect a technological world view and First World approaches, to one in which the needs of people from social groups with differing cultural perspectives of the human world are meaningfully addressed. In this respect, a number of questions require answers. For instance, what constitutes the essence of effective intercultural activities? What factors stand in the way of, and what factors facilitate, successful health education in the cross cultural encounter? What personal qualities, characteristics, abilities, activities and perspectives make up the fundamental attributes of successful health educators? In fact, can answers to such questions be clearly identified? A further query relates to whether the mere presence of learners and educators from different cultural backgrounds constitutes multicultural health education and, if not, what are the implications for the realisation of authentic health education in cross cultural encounters?

Although the scope of research into, and interest in, multicultural education in South Africa has escalated over the last decade, it appears that little work, having reference to health education in cross cultural encounters, has been carried out in the fields of adult or health education. This study will concentrate on probing the relatedness of culture, education and health as they pertain to health education and the challenges faced by health educators in meeting the demands of the *agein*. Knowledge of the universal dictates of the phenomenon of education to ensure that authentic education becomes apparent is dependent on scientifically verified insights into the phenomenon itself regardless of the setting: whether formal or informal, in the classroom, in the home, or in the community.

In the light of the above, certain areas have been identified as problem fields in need of investigation. It is the intention of the researcher to approach these problems in the following manner.

- * A review and reflection on perspectives and trends occurring in health education in the situatedness of cross cultural encounters within a multicultural society, will be instituted.

- * An elucidation of the primordial common denominators of human existence will be attempted in order to present agocically accountable educational guidelines for health education on which the planning and implementation of health education programmes may be based, in accordance with the demands of the *again*.

- * An endeavour will be made to identify and interpret the significance of variables pertaining to culture which may affect the learning outcomes and health status of individuals, families and communities in response to health education programmes, within the situatedness of cross cultural encounters.

- * An effort will be made to reflect on and bridge gaps in conceptualisations across and between many disciplines.

1.2.2 JUSTIFICATION FOR THE RESEARCH

Although educators have recently taken an interest in understanding the needs of racial and ethnic minority groups, a review of adult education literature over the past five years reveals that adult education researchers have not displayed a similar interest in health education for adults. Publications relating to minority groups comprise less than one per cent of the more than 1500 adult education articles published between 1985 and 1990. It appears that, for the most part, non-white men and women, together with the non-middle classes and women in general, remain groups set aside for future study (Ross-Gordon, 1991:3).

Furthermore, in the context of health care, the truth is that individuals and families make most of the important decisions that affect their health and not the doctors or other health workers (cf 2.2 3.3). If decisions are to be made wisely, people need to be equipped with the knowledge and skills required to exercise individual and community responsibility (cf 3.2.1.9). It is in this context that education and communication for health are especially

important.

On grounds of the nature of the problems, current research findings and personal professional experience, this research should be seen as the author's attempt to arrive at responsible answers to questions concerning the means whereby health services may respond to the new demands and pressures stemming from the differential distribution of resources throughout the population in the contemporary world which is South Africa today. It is necessary to search for answers that are not based solely on educational and health preferences, but on the universal dictates of the phenomena of both education and health care: answers which are not absolute or final, but that systematically reflect some universal tie which underlies human nature and transcends all diversity (Oberholzer, 1979:55) and which will help educators and learners gain a firmer grasp of the social, cultural and educational realities and preferences prevailing in the cross cultural situation. An endeavour will be made to distinguish essential from non-essential answers in order to arrive at solutions which may be of value in an understanding of man and the demands of the *agein* (Staples, 1987:39).

According to COLLIER (1989:289), attention to intercultural communication competency is not only essential, but timely in an increasingly culturally diverse world. In many developing countries, education in the mode of adult education, is one of the most available and important forms of education for the total community. Health, viewed from an increasingly holistic point of view, carries the implication that health education is integrated with other sectors involved in, for example, agriculture, community development and non-formal education (Jones, 1992:37).

That close parallels exist between education and medicine has also been suggested by HIRST AND PETERS (1979:19). It is the intention of the researcher to draw on relevant findings relating to multicultural education and examine and draw conclusions about the effects of culture on both health and education in an attempt to formulate agogically accountable guidelines for effective health education programmes in instances of cross cultural encounters.

It may be stated that in the cross cultural agogical event, the central issue remains man and his culture or man as unique human being engaged in his human world and involved with becoming someone in compliance with the demands of culture. He is not only a cultural being concerned with cultural development, of which health and health related matters are important components, but is also a bearer of that cultural mandate. His very involvement in becoming that which he, as individual, is capable of becoming, whether physically, socially, emotionally or cognitively, is an expression of this cultural mandate: a mandate in which agogics has a fundamental role to play in the mode of education and training in health related matters.

The issues surrounding multicultural education and cross cultural encounters are both complex and generally oversimplified with data that are frequently imperfect and incomplete and with practices that are often the result of expediency rather than long term strategy (Craft, 1984:1). The findings of fundamental agogicians, based on the agogic phenomenon as it exists in real life situations, can be very useful in suggesting, influencing and, to some extent, prescribing educational practice (Mentz, *in*: Codrington, 1981:11). This study concentrates on questions surrounding the relatedness of culture, health and education and the responsi-

bility of health educators in meeting the demands of the *agein*.

Although philosophical analysis is ultimately concerned with a coherent and clear articulation of ideas as opposed to a definition of words, there remain very solid grounds for any philosopher to pay due regard to the analysis of, and the meaning of words and concepts in order to iron out and explore any contradictions, confusions, obscurities and absurdities which may be involved in people's grasp of the ideas in question (Barrow and Woods, 1988:xvi, 3). To know, it becomes necessary to draw a distinction between that which is relevant to the purpose of the research and that which is defined as irrelevant. Descriptions and analyses necessarily follow an act of distinction, because the questions posed imply an act of distinction. Furthermore, there is always a connection between epistemology, the questions which are asked, that which is revealed and any action which is taken. The concept of epistemology has reference to a set of immanent rules used conceptually by groups of people to define reality (Auerswald, *in*: Webster, 1989:59) and to "... the fundamental principles of our *knowledge* of reality" (Brenner, 1989:1).

It, therefore, becomes necessary to set the research in a context in which problems and possible solutions can be interpreted and evaluated and to specify those concepts which lay the foundations on which the study will be judged as being valid, relevant and important. This becomes an act in which the conceptual system relative to the entire research project is laid down (Griesemer and Wimsatt, 1989:81). To this end, analyses and definitions are required for the purpose of bringing to light or allowing that which is relevant and significant, in this thesis, to emerge (Novak, *in*: Tumin and Plotch, 1977:29). Specific terms describing

the social reality of the South African situation and those used in the title of the study are defined and concepts pertaining to the theme interpreted in the following section (Arthur, 1992:12,17-54).

1.3 ANALYSIS OF THE RESEARCH THEME AND RELATED CONCEPTS

The elimination of misunderstanding and the need to overcome the semantic confusion generated by a proliferation of scientific and pseudo-scientific terms with their accompanying range of meaning is "... an important precondition for authentic scientific practice" (Griessel, *et al.*, 1989:3).

An elucidation and identification of the fairly precise meanings, specific usage and implications of relevant and related concepts follows. As the study progresses and more meaningful insights based on cumulative reflection emerge, these concepts will be elaborated upon more extensively, for the majority of important concepts in the social sciences do not lend themselves to univocal, universally applicable and absolute definitions (Novak, *in*: Tumin and Plotch, 1977:29).

A statement has been made that the social and economic structures in South Africa are predominantly Western orientated and that the health care system is based on a technologically orientated First World biomedical system. An explanation of the concepts involved becomes necessary in order to provide a baseline for penetrating reflection on health systems and the *agein* in the contemporary social order.

1.3.1 A TECHNOLOGICAL WORLD VIEW

The contemporary modern world can be described as a technological world (Marais, 1983:111) where technology represents a mode of evolution, of commerce, of medical science and of the forging of history. It is not a purely material phenomenon (Van Pearsen, in: Marais, 1983:113). It is also a world in which the different cultural groups are economically interdependent (Marais, 1983-111). Such interdependence holds profound implications for the health care delivery system and health status of all South African citizens regardless of ethnic group, creed, colour and social background whether in terms of class or First-Third World views.

Before briefly describing the nature of a technological society, there are a number of concepts in the above paragraph which require clarification.

1.3.1.1 World View

World view according to ANDERSON (1976:358), constitutes that aspect of ideology which is directed towards a description and interpretation of the world surrounding human beings and their place within it. It is the way cultural groups perceive events and people (Bennett, 1990:47). Whatever its form, a world view substantiates different principles whether religious, ethnical, social, political or scientific (Makinde, 1989:27-28).

World view, as concept, has reference to every attempt to impose meaning on man's human

world and to make intellectual sense of life. As such, this concept involves theories of explanation which are not only intellectual statements, but reflect statements about the foundation of man's individual and social being. Hence intellectual objectivity merges with subjective value systems (cf 3.2.1.10 and 3.2.1.11) (Hammond Tooke, 1989:33). World views are accepted without questioning as "... the way things are" (Gudykunst and Kim, 1984:40).

The term 'world view' may be used interchangeably with 'frame of reference', which is described by ZADROZNY (1959:127) as the points of view, hypotheses, assumptions, evaluations and thought categories through which an individual approaches social phenomena.

1.3.1.2 First World

The term, 'First World' has reference to the economically advanced capitalist countries of Western Europe, North America, Japan, Australia and New Zealand. These countries were the first to experience sustained and long-term economic growth (Todaro, 1985:586).

1.3.1.3 Third World

The term 'Third World' was introduced after World War II in reference to the underdeveloped countries of Asia, Africa and Latin America which share certain common characteristics. Third World nations are predominantly non-white, underdeveloped, agricultural societies with high birth and illiteracy rates, substandard living conditions and low

per capita income and productivity rates. A shortage of technical and human skills frequently exists (Grolier Academic Encyclopedia, 1983:170).

1.3.1.4 Contemporary Modern World

The contemporary modern world has reference to the present, human world of today, also known as the scientific and technological era, which has emerged as a result of the social phenomenon described as modernisation (cf 4.4.3.2). Modernisation is a broad concept which HOROVITZ (1982:31) describes as a technical term pertaining to features such as the displacement of human labour with machine labour, the automation of services, rapid movement of people and goods and instant communication of information. It is a historical progression of actions that are set in motion by complex forces which take place continuously in a series of stages and lead to a modification of the pattern of civilisation (Kopf, 1982:17). These historical events have been identified by findings that emerged through the application of the scientific method which began during the eighteenth century.

1.3.1.5 Technology

Technology refers to the application of knowledge gained from the natural sciences. The word is derived from the Greek 'techne' and 'logos' meaning 'art or craft' and 'word' respectively. The concept has been described as those improvements resulting from the application of technical advances in industry, the manufacturing and commercial world and the arts. Technology represents a history of the transformation of natural products to

artificial provisions or products (Van Rensburg, *et al.*, 1994:551). From the definition of technology, it may be deduced that a First World frame of reference represents a world view that is scientifically and technologically based.

Two features within a technological representation of a human world are of importance. The first constitutes an image of the meaning of life based on answers provided by science concerning the composition and causation of things, whether of man or nature. The second concerns the rapid, even revolutionary, changes which are occurring in present day society, in both the material and non-material culture, as reflected in the ways of thinking and values of men (Toffler, 1981:25-26). It should be born in mind that modernisation (cf 4.4.3.2) may be regarded as a specific form of desired social economic change associated with technology and that the same modern elements are found throughout the Third World (McNulty and Weinstein, 1982:70).

Application of some of the rigorous methods of investigation of the natural to the human sciences resulted in all phenomena being reduced to one particular form of reality so that man was, and still is, regarded as an extension of nature to be explained interms of causal mechanical laws (Oberholzer, 1979:183). Man is, however, not an object with qualities, he is a human being (cf 3.2.1.1), an initiator of relations (cf 3.2.1.4) within a human reality in which he is continuously situated (cf 3.2.1.2, 3.2.1.3). To regard man as an extension of nature is to objectivise, degrade, dehumanise and depersonalise him so that he is stripped of his human dignity (Oberholzer, 1979:183) (cf 3.2.1.14). The world with which and by which man is engaged (cf 3.2.1.3) and in which he institutes action (cf 3.2.1.4), under the

determining influence of norms (cf 3.2.1.10) and culture (cf 3.2.1.11), is existent (cf 3.2.1.2) and should be identified as such.

The First World is the statutory world in which medical and health practitioners and the recipients of their care, as self-transcending intentional beings (cf 3.2.1.6) are, in part, required to constitute a world of meaning (cf 3.2.1.5) regardless of their socio-cultural background. It is a world in which people are faced with ever increasing challenges in the making of responsible, independent choices (cf 3.2.1.9) and decisions in every aspect of their lives: choices which may also have repercussions on their levels of physical, emotional or social health (Arthur, 1992:17-21).

While Third World, largely agrarian communities are undergoing modernisation, adaptations to technology do not occur in a void. The people do not give up traditional aspirations, but infuse the new adaptations with new combinations of indigenous and imported meanings (Le Vine and White, 1986:13).

1.3.1.6 Résumé

For the purpose of this research, a scientific technological world view and social change have been identified as two important features of the contemporary world in which the issue of health education, in the context of cross cultural encounters, needs to be addressed.

The terms 'agogical' (cf 1.3.2.1) and 'perspective' (cf 1.3.2.2) as presented in the title of this

thesis are pointers to the fact that the study lies within the scope of the discipline of Philosophy of Education. The positioning of this research, in respect of the controversy surrounding the field of study, is clarified in the next section.

1.3.2 PHILOSOPHY OF EDUCATION

"The philosophy of education is concerned with goals and means of education and the interplay between them ..." (Maddock, 1991:91).

Philosophy has an association with education that extends back in time to the sophists who were the first professional philosophers (Maddock, 1991:99). However, according to MORROW (1989:xiii), to pay attention to philosophy of education is to move into contested terrain, for a hallmark of all branches of philosophy is that philosophers are in permanent dispute about what it is.

BURBULES (1989: 230-231) illustrates how academic discourse ranges between those, such as Philips and Siegel, who emphasize the need to protect the intellectual integrity of the scholarship of philosophers of education and those, such as Broudy and Soltis, who maintain that philosophy of education requires practical problems on which to base its conceptual and analytical explications. Broudy and Soltis also claim that education is dependent on philosophy to illuminate the underlying premises and values of its theories. Philips and Siegel are concerned that, in making philosophy of education more relevant or applied, philosophers run the risk of neglecting subtle distinctions and points of argument or of blunting the critical edge required from philosophy of education as an academic discipline. Broudy and Soltis

view an approach which ignores the field of practice as both sterile and self-indulgent. WAKS (1988:172-173; and *in*: Burbules, 1989:232), in turn, accepts the dichotomy between a disciplinary- and a practice-based approach to philosophy of education, merely urging that both roles are attended to by different participants in the field.

The description of philosophy of education which follows is not intended as a contribution to the debate concerning the apparent dilemma of establishing the current position of philosophy of education and its future direction, but rather as an attempt, by the author, to place the research within a particular contextual frame of reference within the subject speciality which is philosophy of education.

It is appropriate to conceive of philosophy of education as a branch of the discipline of general philosophy which draws on the established branches of philosophy, bringing them together in ways that are relevant to educational issues (Hirst and Peters, 1979:13; Hamm, 1989:1). Philosophy of education is a theoretical discipline which has as aim, the critical investigation of those forms of understanding that are relevant to education and includes agenda that are essentially open (Morrow, 1989:xiii). It is a rather distinctive type of higher order intellectual pursuit: an analytical quest with the primary aim of understanding concepts utilised in all other forms of lower order knowledge and awareness, and in primary forms of understanding, whether in the sciences, in history, in morality or other similar spheres. The discipline, may also be regarded as the pursuit of truth, a search for the meaning of life or that which deals with the ultimate reality (Hirst, *in*: Hamm, 1989:5).

According to MORROW (1989:xiv, xix), the main objective of philosophy of education lies in the "... disciplined, analysis, assessment, criticism and construction of arguments ..." which are always embedded in frames of meaning, understanding and conceptual schemes. Furthermore, the thoughts of a particular author are inevitably influenced by particular historical forces (cf 3.2.1.12) and are located in a particular place and society (cf 3.2.1.2) in a particular time. MORROW (1989:xiii) is in agreement with RORTY (in: Burbules, 1989:230) that philosophy of education, unlike other fields of investigation, is not an autonomous science. Because philosophy of education is concerned with issues that are of profound importance to everyone, there is no way in which philosophy of education can be isolated as a distinctive subject, occupying a distinctive place in culture or proceeding in accordance with some distinctive method. To accept that philosophy of education crosses disciplinary boundaries permits of a broad interdisciplinary perspective and unique insights into public policy issues, particularly in respect of normative aspects (Waks, 1988:167). Such an approach carries no concession that philosophy is the handmaiden of the social sciences or public policy. By drawing upon its own resources, philosophy confronts these sciences with questions of sense and significance, of meaning and method (Scheffler, 1980:402). Philosophy is less about generating knowledge of new matters than about affording greater understanding of that with which man is familiar (Barrow and Woods, 1988:vii). Philosophy does not facilitate policy or practice, but enlightens them by posing traditional questions of validity, veracity, virtue and value (Scheffler, 1980:402). From such an approach, guidelines in respect of specific problem areas may emerge. Relevance is established for a particular set of persons or person, and relative to a particular concern or problem (Burbules, 1989:232).

Relevance and philosophical competency are necessary conditions of any endeavour to build a body of fundamental work in the discipline of philosophy of education, regardless of the scope of the study and however diverse and numerous the methods used. Unless the research is relevant and philosophically competent, it will fall short of the conception of philosophy of education (Maddock, 1991:94).

On the basis of the above argument, the study is to be grounded in an existing educational concern which is rooted in the phenomenon of the agogic. An elucidation of the meaning of agocial perspective is called for at this juncture.

1.3.2.1 An Agogical Perspective

Two clearly identifiable, but interrelated concepts may be distinguished under this sub-title.

The term agogic has as its source, the Greek "... *agein* meaning guidance" (Van Vuuren, 1990:7), or to lead (Van Rensburg, *et al.*, 1994:310). The concept has reference to accompaniment, is frequently used as a synonym for education, encompasses the subtle, reciprocal and meaningful interactions which take place between educator and learner as active participants in the agogic event (adapted from Van Vuuren, 1985:11-12).

The agogic, as primordial fact, is at the root of man's existence and manifests as a relationship or companionship between people of different ages. It is possible to distinguish between various modes of the agogic, amongst them the following:

- * the pedagogic derived from the Greek *pais* meaning 'child' and his accompaniment by an adult in respect of the original educative occurrence;
- * the andragogic derived from the Greek *aner* meaning 'adult' and his accompaniment by another adult; and
- * the gerontagogic also derived from the Greek *geron*, meaning 'grey-haired man', and pertaining to the support and accompaniment of elderly people.

The modes of the agogic can not be hermetically separated, one from the other, which implies that the agogic also occurs in the pedagogic-andragogic and in the andragogic-gerontagogic modes. Neither is it possible to indicate precisely the point at which transition between one agogic mode and the other occurs (Van Rensburg, *et al.*, 1994:310, 397, 470, 486, 488, 489).

The *agein* does not only manifest in the sphere of the agogic but also in the health and social services where man's dependence upon and need for support from others is clearly recognisable. The link between educating and learning and health and social service is made apparent in the role of the *agein* (cf 1.3.5).

Agogics must view man against the background of the whole reality in an attempt to reveal that which is: the being of everything. Ontology and anthropology may be said to act as two basic disciplines that are very closely associated with agogics. As all three disciplines

are founded in the social sciences, it becomes justifiable to speak of ontological-anthropologically founded agogics (adapted from Van Vuuren, 1990:9-10). Based on this elemental principle, the search for universally valid, scientifically accountable knowledge is to be undertaken from an agogical perspective.

The term perspective denotes a given angle from which a particular structure is viewed. The concept is derived from the Latin word *perspectare* meaning to regard an object discerningly until it becomes "... clear, bright and transparent" (Van Rensburg, *et al.*, (1994:482)). Similarly, the term agogical perspective implies a critical attitude or scientific approach towards the educative event in order to describe and explain those essential characteristics which are "... immutable and without which the phenomenon cannot exist" (Reeler, 1985:7).

As the statement has been made that this is a study which is grounded in an existing educational problem and rooted in the phenomenon of the agogic, it is appropriate to reflect on the significance of this claim. The concept of grounded may be used synonymously with founded which, in turn, constitutes part of the definition of fundamental as it manifests in the concept of fundamental agogics.

1.3.2.2 Fundamental Agogics as Perspective

"Only if we get our philosophy straight can we think straight about education"
(Hutchins, 1984:10).

A fundamental perspective covers a radical and systematic consideration of a phenomenon and

everything associated with it, so that the phenomenon as a whole can be investigated and interpreted. The term radical is derived from the Latin *radix* meaning root (Van Vuuren, 1990:15; Van Rensburg, *et al.*, 1994:599). The derivations of fundamental are *fundamentum* meaning basis, ground, foundation, and *fundare*, to base. In conjunction, the two words have reference to probing founded matters and bringing to light that which is perennial: those essentials which are continually occurring and universally present (Van Rensburg, *et al.*, 1994:393). According to OBERHOLZER (1979:43), universal in this regard, refers to those all-founding and over-reaching fundamental truths which are applicable to all men. A fundamental approach to agogics aims at disclosing the foundations of the phenomenon and serves the special function of grounding agogics in the essential recurring and universal reality of life (Van Rensburg, *et al.*, 1994:393).

1.3.2.3 Résumé

In the light of the arguments as presented, the author has determined that a study of health education in cross cultural encounters falls within the scope of agogic concern.

As the focus of this research is that of the *agein* in the context of health education in cross cultural encounters, it is appropriate to analyse the meaning of the concept of health education.

1.3.3 HEALTH EDUCATION

The question arises as to whether the concept of health education merely represents the sum total of the conceptualisations of 'health' and 'education' or whether it gains in dimension to represent more than the sum of its parts. Therefore, the key concepts embodied in the construct will be subject to closer scrutiny.

1.3.3.1 Education

WITTGENSTEIN (in: Barrow and Woods, 1988:4) drew attention to the connection between words and their usage, thereby revealing the connection between different kinds of meaning and different usages of language in respect of fact finding, descriptions of events or supplying of information and in evaluative and emotional usage. The connection is of significance to an understanding of the meaning of the concept of education in the light of the controversy as to whether the word 'education' derives from the Latin *educere* or *educare*. The former term, besides meaning 'to lead out' was also used in the context of 'to train' and the latter, besides meaning 'to train' was also used in the sense of 'to nourish' in reference to plants. Both words were used by the Romans in respect of the education of children (Barrow and Woods, 1988:110).

The controversy surrounding the origin's of the term 'education' is closely linked to the debate as to whether adulthood is the aim of childhood, thereby restricting the usage of the concept to childhood, or whether education, is in fact a life-long event. The latter argument

acknowledges the validity of usage of the word in respect of both child and adult education. The two opposing approaches are reflected in the following descriptions of the aim of education.

According to VAN RENSBURG ET AL. (1994:366), education is an activity occurring in respect of the child, which may be defined as the practise of

"... conscious, purposive intervention by an adult ... to bring him to independence ..., with the specific purpose of effecting changes of significant value ... with the educand co-operating in full acceptance of his mentor's guidance. The final issue cannot be scientifically determined or guaranteed, nor can education in its pedagogic form go on indefinitely. As the ... educand shows himself progressively amendable to decide for himself and to accept responsibility for autonomous choice, the educator removes himself more and more from the scene of action, leaving his charge to do things on his own".

Inclusion of the phrase education "... in its pedagogic form ..." to the latest definition by VAN RENSBURG ET AL. (1994:336) indicates a shift in position by the authors since the last publication (Van Rensburg and Landman, 1988:330). However, they do not use the term education in the context of andra- or gerontagogs (1994:310, 397) and continue to hold that the "... aim of education in its pedagogical form ... is adulthood" (Van Rensburg, et al., 1994:366). Conversely, the classical Greeks held that

"... the real man, the complete man, must be something more than a mere breadwinner, and must have something besides the knowledge to earn his living. He must have also the education which will give him the chance of developing the gifts and facilities of human nature and becoming a full human being" (Livingstone, 1984:3).

Careful reflection of the two statements reveals that any assumption concerning childhood as the main stage of a person's life during which education can take place appears to give little credence to the fact that learning, whether the result of formal, non-formal or informal training or education, "... must be seen as a life long occurrence ..." (Codrington, 1985:12) in which meaningful learning experiences continue to bring about change and growth in the learner, whether child, youth, adult or aged person. Any educational event which does not do so falls into some kind of rote training trap rather than education in the true sense of the word (Codrington, 1985:15).

The implication that adulthood is the purpose or aim of childhood, as opposed to perhaps one of the goals of childhood (Morrow, 1989:17), encourages the thought that education can at some stage be thought to be complete and represents a failure to understand what education is.

"'Being educated' is not a destination or a terminal state...; it is more like a direction or way of living" (Morrow, 1989:23).

Being educated, as a way of living, may be likened to a situation in which the individual can reflect critically on life and the conditions of existence so that he can make a committed and disciplined contribution to a particular kind of interaction which is directed toward the discovery of what is true (Morrow, 1989:23). LINDEMAN (1984:18) contends that "... *education is life* ..." not merely a preparation for an unknown kind of future living. He (1984:19) continues that the purpose of adult education "... is to put meaning into the whole of life".

The above discourse leads to the conclusion that education may be regarded as a life-long event but does not clarify the important question asked by educators as to what constitutes the 'correct' usage of the word itself. In order to do so, it appears appropriate to reappraise the nature and construct of the concept itself (Lawson, 1989:12).

When analysing the concept of education, the parallel between content and process is very exact, for PETERS (*in*: Woods and Barrow, 1975:12) maintains "... that education (as process) is a polymorphous concept ...". Therefore, it is a mistake to think of education and educating in the light of one activity only.

PETERS (*in*: Hamm, 1989:32-38) makes certain incidental observations about education and isolates three central criteria for usage of the term 'education'. According to HAMM (1989:39), this analysis has withstood multifold and severe criticism and, therefore, with minor adjustments can be considered acceptable. Peters states that education is 'achievement' not in the sense of a specific activity or activities, but rather in the sense of the outcome of a person having engaged in a series of activities which result in that person becoming educated. Similarly the education of people implies a series of processes "... whose principle of unity is the development of desirable qualities in them" (Hirst and Peters, 1979:19). For Peters, the central features of education are the critical attributes of the value or desirability condition, the knowledge condition and the condition of procedural requirements.

Education, as the acquisition of something worthwhile and desirable, lies at the core of

Peters' analysis of education. It is a logical contradiction to state that man has been educated, but has in no way changed for the better. The term education, therefore, carries normative implications. Any connection between education and what is considered valuable does not imply a particular commitment to content but to that which is thought valuable (Woods and Barrow, 1975:10). The concept of education as having achieved something that is *intrinsically* valuable is indicative of the fact that education is not merely a tool to do things, but is desirable in so far as the knowledge and understanding obtained become a feature of the individual's personality and shape his sense of that which is of ultimate value.

Education without knowledge is logically impossible. Therefore, the fact that educated people are knowledgeable is a definitional truth. The cognitive aspects of knowledge require both breadth and depth. The twin aspects of breadth and depth ultimately complement each other in that they confer a cognitive perspective: an ability to understand and see connections between various forms of knowledge and a grasp of how they play a part in a unified and coherent way of life. Knowledge has a direct influence on the educated person's attitude and direction in life, transforming his outlook and adding new dimensions to his life. Narrowness of focus and education are antithetical concepts.

The procedural condition, as an essential condition of education, relates to the appropriateness of the procedures or task aspects required for the bringing about of education. These procedures must be consistent with the ends to be achieved in so far as they bring about educationally valuable achievement and do not infringe on the fact that the learner has a choice and, therefore, can resist instruction.

In the light of the above, education may be defined as

"... the achievement of a desirable state of mind characterized by knowledge and understanding in breadth and depth with cognitive perspective and by corresponding appropriate emotions and attitudes, these brought about deliberately, in a manner not to infringe upon the voluntariness and wittingness on the part of the learner" (Hamm, 1989:39).

This definition together with Peters' analysis of the term education implies inclusion of the theory and method of educational practice. Together, they also embody the goal of change, in the form of achievement, so that the educated person is enabled to perform his life task creatively. Education should enable the individual to see the "... 'reason why' of things ..." and to approach knowledge, from the "... inside of a way of thought ..." (Peters, in: Hamm, 1989:37-38).

The question arises as to whether the insights revealed in this section are of relevance to the concept of health education. Before probing this question, it becomes necessary to clarify the concept of health as it relates to this thesis.

1.3.3.2 Health

The concept of health has been defined in widely divergent ways ranging from those in which health is seen in unidimensional, static terms to those that view health as a set of qualities involving the total person in his encounter with his human world.

WHO (in: Potter and Perry, 1993:38; Stanhope and Lancaster, 1988:29)) defines health as

"... a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".

However, health described as an absolute state has not been universally accepted, for it is viewed as unrealistic and difficult to use when trying to determine who is or is not healthy (Potter and Perry, 1993:38). According to SPRADLEY (1990:9-10), "Health is a relative, not an absolute concept" because the term "... refers to a state of being" which is affected by the many different characteristics and qualities making up the world of individuals and communities. All the dimensions of life that are embedded in physical, social, cultural psychological, intellectual and spiritual experience and that affect everyday functioning, collectively determine individual and community health. As a 'state of being' which people define in relation to their own values, health may not be regarded as a part of the body, a function or a thing, nor as an acquired piece of scientific knowledge (Potter and Perry, 1993:38).

PARSONS (in: Baumann, 1961:44) observed that somatic health refers to the optimum capacity of the individual to perform the valued tasks of society effectively and to fulfil his role obligations. This definition with its emphasis on social performance alone, highlights the social dimension of health, but ignores a holistic perspective.

SCHLENGER (in: Maykovich, 1980:63-64) identifies the two conceptually distinct dimensions of equilibrium and actualisation in respect of the concept of health. The idea of

equilibrium ranges through disequilibrium, imbalance or disease to balance. Balance being indicative of the optimal functioning of bodily systems. Disease manifests as a result of the influence of multiple outside agents, such as germs and stress, that act on the physiological and psychological systems and disrupt their equilibrium. The actualisation component refers to any change and growth that occurs in order to deal effectively with the environment thereby denoting actualisation of potential. Health as balance, integration and harmony are possibly the most prominent themes in holistic definitions of health: the word 'health' itself deriving from the English word for 'wholeness' (Lowenberg, 1989:30).

The definition of health most closely reflecting the meaning of the term as used in this study is one which evolved from concepts of health embodying notions of holism, balance, integration and harmony as outlined above and developed by others such as JAFFE, DOSSEY, BLOOMFIELD AND KORY, CHOW, BRENNER AND PELLETIER (*in*: Lowenberg, 1989:30-31). It is a definition which simultaneously brings together the internal and external forces that may affect man at a particular point in time. It is one that is based, more specifically, on definitions developed by NEUMAN and KING (*in*: Stanhope and Lancaster, 1988:143).

On the basis of the above, health or wellness may be described as a condition in which all the variables or parts and sub-parts of the internal and external forces surrounding man represent

* a state of harmony with the whole of man, in which

- * social, psychological and spiritual well-being are emphasized equally with physical well-being (Lowenberg, 1989:30), and where
- * disharmony reduces the wellness state, so that
- * continuous adjustments to stressors in both the internal and external environment are required, in order to
- * make optimum use of existing resources for the realisation of maximum potential for daily living.

Such a definition, reflecting health as a holistic and dynamic life experience, shows man to be in a state of reciprocal interaction with his internal and external environment, and, by implication, acknowledges the possibility of change in respect of health status.

A definition of health by MACDONALD (1984:234) may be viewed as an applied interpretation of the above definition and one which proceeds from philosophy. It also serves to focus more directly on the links between the concepts of health and education in respect of the concept of health education. The definition reads

"Health is determined by the ability of the individual, family, group or community to set realistic and meaningful goals and to mobilize energy and resources to attain these goals effectively. This is accomplished while caring about self and others, feeling good about one's self, and helping others feel good about themselves with the fewest negative effects on the environment".

1.3.3.3 Health Education as Concept

A reflection on the concepts of health and education has reference to both health and educational theory and practice. Health education, therefore, concerns all the life experiences of individuals, groups or communities which influence health beliefs, attitudes and behaviours as well as the processes and activities aimed at producing the changes necessary for optimum health (Richards, *in*: Loevinsohn, 1990:788).

Health education is concerned with changes in the health knowledge, behaviours and feelings of people in order to develop health practices that are believed to bring about the best possible state of well-being (WHO, *in*: Sibiya, 1986:168). As a process, health education aims at enabling individuals, groups and families to set realistic and meaningful goals in keeping with MacDonald's definition. Such goals may be realised through the mobilisation of peoples' individual and collective energies and resources with due consideration to themselves, others and their environment. Therefore, health education may be seen to include

"... any combination of learning experiences designed to facilitate voluntary adaptations of behavior conducive to health" (Green *in*: Marsick and Smedley, 1989:507).

An elucidation of the concepts of health and education within a specialised, clearly delineated field indicates that there is no radical shift in meaning of either one or other of the two concepts: each may be said to complement the other as a sub-discipline within the field of both health and education. What may be questioned is whether the field of study known as health

education resorts within the discipline of philosophy of education.

The grounding of the study in respect of an existing problem and education as a life-long event, have been explicated in sections 1.3.2 and 1.3.3 respectively. A contentious issue may, however, be raised in respect of the argument that to be educated, in the full sense of the word, requires breadth and depth of knowledge: a criterion which may be seen as lacking in respect of both adult education (cf 2.4) and health education.

An accusation of narrowness of focus may be levied against the field of health education with regard to limitations in the scope of breadth and depth of knowledge and an apparently circumscribed study of man in bodiliness alone, whether in health or illness, as an anthropological ground structure of human existence.

Such an accusation excludes the whole of the experienced reality which exists for individuals and communities in the context of a personal and communal framework of logic, a frame of reference or knowledge based on experience, an aesthetic and ethical code and a philosophy of life built on religion and/or around organised group life. It is acknowledged that this reservation, although important in the context of the discipline of philosophy, does not necessarily coincide with the goal of education in the sense of a search for the truth of the matter in respect of health.

Of greater scientific and philosophical relevance is the fact that to exclude the field of health education from the discipline of philosophy of education, is to exclude the conceptualisation

of the Ancient Greeks regarding the complete human being as revealed in the trinity of body, mind and character. Body, mind and character are each capable of *areté* meaning virtue or excellence. The virtue of the body is health, fitness and strength, the firm and sensitive hand and the clear eye; that of the mind is to know and understand, to think, to have some idea of what the world is and of what man has done and can be; the excellence of character lies in the great virtues. Man's aim is to make the most of all three. Education assists him in doing this, not merely because a sound body, mind and character contribute to success and happiness, but because they are good in themselves and, therefore, are worthwhile (Livingstone, 1984:3-4).

This approach constitutes the essence of the conceptualisation of man as human being and, in historical terms, is the source of modern day philosophy. At the same time, it permits of the focusing on a part of that which is the whole of man to achieve that which is worthwhile and desirable: in this instance, in the field of health. As with general education, health education without the knowledge condition is clearly not possible. In addition, procedural tasks lie at the core of guiding man to reflect critically on the conditions of his own life in order to make a commitment to the well-being of self, the family and the community. This approach does not negate the interrelatedness of that which is the body, mind and character of human beings, neither does it conflict with the criteria of willingness and choice as aspects of learning.

Therefore, it may be stated that health education, in which health represents the purpose of all health education behaviours (adapted from MacDonald, 1984:234), is not a narrow

specialisation, but denotes a sub-discipline where people are guided into worthwhile activities. These activities should be characterised by knowledge and understanding in breadth and depth of health related matters. Consequently, any person educated in health will not merely acquire skills and habits, but will have mastered the existing forms of knowledge available to him. Health education implies levels of understanding and a capacity to reason and justify health related beliefs and conduct. Health education carries the connotation of 'cognitive perspective' in which multiple experiences are connected to form coherence and consistency (adapted from Hamm, 1989:163-164) so that the individual responds to the demands of reason as well as the setting of such demands. He is enabled to ask and answer questions concerning health and well-being (Hamm, 1989:170-171).

1.3.3.4 Résumé

An attempt has been made to establish the essence and parameters of health and education as universal phenomena within the context of health education. The author has concluded that health education may justifiably be classified as a sub-discipline within the discipline of philosophy of education. Such a conclusion does not imply that the field of health education is normative in that it prescribes or proscribes any health educational event. However, it is normative in the sense that certain andragogical categories and criteria may be postulated whereby specific systems can be evaluated as andragogically acceptable or not.

As the life experiences of man are deeply embedded in the social reality of culture in respect of both health and education and since culture is at the root of the concept of the cross

cultural encounter, it becomes important to arrive at a clear understanding of this concept and any relationship it bears to conceptualisations of education and health.

1.3.4 CULTURE

"Culture is a normative notion" (Barrow and Woods, 1988:155). The concept of culture is in no way self-explanatory and "... is itself a cultural construct" (Palmer, 1986:1) which has been defined and understood in many ways over the years. These variations in meaning reflect the scope of human experience under different historical circumstances (Marais, 1983:3). CAMILLERI (1986:8) found that at least 160 definitions were attempted between 1871 and 1950 alone. Therefore, the concept of culture cannot be readily defined and delimited in a few words.

MARAIS (1983:5), quoting Downs and Bleibtreu, stresses the acceptability of a wide range of definitions stating that a definition of an operational concept, such as culture, is seldom so static that it cannot be reinterpreted, modified, and developed in keeping with new insights and information as revealed by science. Anthropological, sociological and dictionary definitions of the term point to the holism and pervasiveness of the concept as it influences man's relationship with his world, himself, his fellow-man and his history. In an attempt to present as comprehensive an exposé of the concept of culture as possible, the researcher has elected to quote a variety of definitions and extracts from definitions by means of which, it is believed, the essential meaning of the concept may be more completely revealed.

WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY (Babcock, 1961:552) defines culture as the all-encompassing patterns of human behaviour which include thought, speech, action and artefacts and depend on man's capacity for learning and transmitting knowledge to succeeding generations.

This definition has reference to the foundational aspects of culture as reflected in the shared, learned and transmitted social activities of the group. It encompasses that part of the man-made environment which enables man to adapt to the world in which he finds himself in order to satisfy his basic needs and survive. Each culture constitutes an interdependent system whose unity is felt rather than rationally constructed (Kneller, 1965:6).

HALLOWELL (*in*: Conco, 1972:283) characterises culture as a 'psychological reality' in reference to the shared patterns of beliefs, feelings and knowledge, in the form of basic values, axioms and assumptions, which members of a group carry in their minds as a definition of reality and as a guide for conduct. This cultural reality is shaped in such a way that individuals have no conscious thought about it.

WILLIAMS (*in*: Kats and Glastra, 1989:47), in turn, conceives of culture as that set of practices through which people actively respond to the conditions of their social experience and creatively fashion experienced social relationships into diverse, structured patterns of living, thinking and feeling. The emphasis, in this instance, is placed on the notion of human agency.

COOMBS (1985:244) highlights the distinctive identity conferred by culture to each society which is expressed by FRIEDL (*in*: Marais, 1983:8) as that aspect of existence which makes some people similar to others and yet different from the majority of people in the world. Features identified as accounting for the distinctive identity, cohesiveness and continuity of culture include the society's system of values, ideology and social codes of behaviour; its religious dogmas, myths and taboos; its social structures, political system and decision making processes; its productive technologies and modes of consumption. However, once a culture comes into contact with other cultures, selected elements are borrowed for assimilation into the respective cultures (Coombs, 1985:244) with the result that no culture can remain static (Goodey, 1989(b):3).

The cultural attributes of continuity and change are clearly expressed in BULLIVANT'S (1984:4) definition of culture which he describes as

"... an interdependent and patterned system of valued traditional and current public knowledge and conceptions, embodied in behaviours and artefacts, and transmitted to present and new members, both symbolically and non-symbolically, which a society has evolved historically and progressively modifies and augments, to give meaning to and cope with its definitions of present and future existential problems".

LYNCH (1983:13) in presenting a working definition not only endorses the previously mentioned elements of culture, but introduces the concept of cultural capital. He records that culture

"... is an active capital of non-material, socio-historical character which attracts 'compound interest' in interaction with the social and natural environment so as to secure the survival of the individual and the group. All accretions to the culture are achieved through the 'good offices' of the existing capital".

Careful reflection of these definitions reveals that culture is a purely human attribute and that the term behaviour as used in the above definitions, and which may be used in the remainder of the text, refers to a purely human activity and is, therefore, not used in the sense as used by the Behaviorists. Further reflection reveals that culture is a complex and integrated whole which is transmitted to and learned by each successive generation. It is normative and unique to a particular group at a particular point in history as that group adapts to the environment to secure its survival. Culture comprises the cultural heritage of a group encompassing both the psychological and the concrete aspects of man's definition of his human reality. It is dynamic and accumulative, embodying both the traditional and the current, demonstrating continuity and change and an established "... shared standard for ways of thinking, feeling and acting" (Erickson, 1986:117).

The key concepts embodied in the socio-anthropological and working definitions become significant when examined in the light of the ground structures of human existence at the level of the agogic (cf 3.2). The term culture, expressed as culturality (cf 3.2.1.11), is itself a ground structure of human existence.

Culture as a representation of the total way of life of groups describes a world that has been designed by man, for man and belonging to man and has reference to human groups and

purely human activities (cf 3.2.1.1). By postulating that culture is learned behaviour, one poses that human life is not determined by blind causal mechanical and instinctual means, but that man lives in a state of interhuman, co-existential involvement (cf 3.2.1.8), that man is a related being (cf 3.2.1.4), a being in and engaged in this world (cf 3.2.1.3). Man is, therefore, a being in communication with his fellow beings and with his world. Man is capable of learning and his is an existence of personal openness (cf 3.2.1.5), a ground structure that implies normativeness (cf 3.2.1.10) and a being in a state of becoming (cf 3.2.1.7), for man is a self-transcending, intentional (cf 3.2.1.6) and a religious (cf 3.2.1.17) being. Because it is subject to change, culturality as an aspect of man's existence (cf 3.2.1.2), and as an ontic fact, is creative (Marais, 1983:13). Culturality permits of changeability in unchangeability (cf 3.2.1.13) which, in itself, is an aspect of learning. Change and continuity in time are, in turn, aspects of past and future. Historicity, as futurity (cf 3.2.1.12), is an important aspect of being engaged in the world, of being capable of responsible choice (cf 3.2.1.9), of being involved in a hidden and changing future in which the present links man's past and his future. In bodiliness (cf 3.2.1.15) and culturality man interprets and experiences health and is a being in possession of human dignity (cf 2.2.1.14) (Arthur, 1992:29-30).

It is these aspects of culture, the associated structures and their interrelatedness, which will be placed under close scrutiny in the examination of health education in the situatedness of cross cultural encounters.

In describing culture as a representation of the total way of life of groups, it may be inferred

that health, as concept and human reality, constitutes an integral part of culture as a social construct. An elucidation of the relationship between culture and health follows.

1.3.4.1 The Relationship between Culture and Health

The statement that culture is a normative notion (cf 1.3.4), not only holds the key to the link between culture and health, but is also an ontological fact (cf 3.2.1.11(a)), for cultural norms and values play a role in the arena of health by the definitions and priorities they provide (Shuval, 1981:339)(cf 3.2.1.10(a)). The word 'ontological,' comes from the Greek word meaning 'being' and 'reason' and applies to any theory that purports to explain what is involved in being one thing rather than another, "... or even what is involved in just *being* at all" (Graham, 1988:29).

The definitions of what it means to be healthy or ill are never value free (Lowenberg, 1989:3) for health has reference to a state of well-being which "... is mainly known and expressed in cultural meanings and ways" (Leininger, 1984:4). There are a multiplicity of ways to structure definitions of health, ill-health and healing interactions for "... culture is largely the blueprint for predicting human motivations ..." and action patterns (Leininger, 1978:2).

The significance of the complex relationship between social factors is of great importance (Cockerham, 1986:1). The cultural norms, the particular patterns of living, the technologies and the many values and beliefs of the people are all dynamic factors influencing the health status of a cultural group (Leininger, 1978:118). Because cultures evolve in response to

environmental demands in respect of every aspect of human life including health, JANSEN (1982:62) concludes that culture is a creative process whereby reciprocal adaptation between the members of a group and their environment is sought to ensure survival and a reasonable state of well-being. With regard to these adaptations (cf 4.4.3.1; 4.4.3.2), every culture assumes a limited selection of behaviour patterns from the total of human potentialities, both individual and collective. The selections tend to be made in accordance with certain dominant values and assumptions basic to that culture. The resultant behaviour patterns are exemplified in a more or less coherent and integrated structure or system of actions. These range from economic, education and health systems to those of family, religion and politics.

Because culture influences behaviour and thinking so profoundly, it is an essential dimension of health related interactions. In the same way that physical and psychological factors determine people's attitudes and needs regarding health and illness, so does culture (Spradley, 1990:132-133). Every society organises its experience of health and illness, together with the provision of health care services, in ways which are congruent with its dominant values and institutions (Lowenberg, 1989:1). Furthermore, the health practices, values and beliefs of the group cannot be isolated nor treated apart from the context of a specific culture (cf 2.2). Man's social, religious, political and economic beliefs are generally closely intertwined with his health practices (Leininger, 1978:118). More recently, JONES (1992:37) endorsed the fact that health and illness do not exist in social isolation, but within a specific cultural, socio-political and interactive context, including that of education.

Therefore, from an anthropological point of view, it may be concluded that "... health and

illness are dynamic and functional components of a culture" (Leininger, 1978:118). As culture and education lie at the core of health education in the cross cultural encounter, it becomes pertinent to discuss the relationship between these two concepts.

1.3.4.2 The Relationship between Culture and Education

The communities of mankind, despite the great variety of their cultural forms, have possessed throughout time, a common need to transmit their cultural heritage to each oncoming generation, thereby ensuring continuity and establishing the conditions necessary for further cultural growth (Kimball, 1974:7). Culture is both the creation of man and the condition of human life. Education is an important facet in the reciprocal relationship between man and his culture for, while man creates culture, his culture, in turn, makes man (Kneller, 1965:42). Therefore, culture and education can be said to be interrelated, interwoven structures. Research has shown that education systems are influenced in their development by a variety of aspects of their environments as a result of their interrelatedness with these environments. So closely are the education systems in every country related to every aspect of their environments that they exhibit these aspects themselves (Stone, 1989:64-65).

Furthermore, GOODENOUGH (*in*: Bullivant, 1981:2-3) states that culture consists of that which a person has to know or believe to operate in a socially acceptable manner. Culture involves knowledge, must be learned, relates to the environment in which the group lives and acts as a perpetual 'template' through which stimuli from the environment can be 'mapped'. As culture evolves from the past, society progressively modifies and augments it to attribute

meaning to and cope with present and anticipated future problems (Bullivant, 1981:2-3). By introducing the concepts of cultural capital and cultural interest into a definition of culture, LYNCH (1983:13) highlights the fact that societies, as territorially defined political units, consider this cultural capital so valuable that special agencies are established to preserve and transmit it to all the new members of these societies. The means by which society provides for the transmission or advancement of its culture is education, of which the agogic is a fundamental mode. The fact that the word education carries normative implications (cf 3.2.1.10) implies that something worthwhile has been intentionally transmitted in a morally acceptable manner (Peters, *in*: Barrow and Woods, 1988:8).

According to MARIQUE (*in*: Stone, 1989:121-122) all educative agencies, of whatever kind, when combined into one whole, constitute the education system of a society. However, the education system is more complex than the school system whether at primary, secondary or tertiary level, for it includes many agencies such as the church, family, media, health and welfare organisations which exist outside the school system. A distinction is made between formal and informal educative structures. The former represent educative agencies whose *raison d' être* is education, whereas the latter are those that educate either formally or informally within the context of wider socio-cultural structures and issues. These educative agencies should be viewed as entwined or interwoven structures in so far as they are linked with each other and other social structures within society (Stone, 1989:119).

A further differentiation is made between informal and formal learning. Informal learning takes place in everyday, ordinary societal settings as part of a life-long process. Such

learning tends to be inefficient or even accidental. By way of contrast, systematic planned educational programmes reduce the element of chance, by making provision for the realisation of particular learning objectives for identified groups. Such education may take place within the formal education system or in the non-formal sector where it is organised within its own system of control. Excluding universities and community colleges, it is largely within the scope of non-formal education that adult education (cf 1.3.5) falls (Courtney, 1989:18-19).

Without a viable culture there can be no common life by which men are associated (Kneller, 1971:50). In learning how to become a functioning member of society, two similar and interrelated facets of learning take place. The first, enculturation, (cf 4.4.3.1), occurs as a person acquires the content of a given culture and becomes competent in its language. The second, socialisation (cf 4.4.3.1), occurs as the person learns to function as a member of his society by learning social roles such as father, student or son, and occupational roles such as teacher, banker, plumber, medical practitioner (Miller, *in*: Gollnick and Chinn, 1986:9). Such roles are accompanied by corresponding social expectations. Formal education and training play an important but not exclusive role in each of these facets. With respect to health education, the main aim lies in the provision of opportunities for learners to acquire knowledge and understanding of health related matters in a changing technological world environment as an aspect of realisation of potential (cf 3.2.1.5(b); 3.2.1.6(b); 3.2.1.7(b)).

It is becoming increasingly evident that knowledge, in all its forms, is a social construction which reflects the perspectives, values and experiences of the peoples and cultures that underlie it. Knowledge, as a social construct, is dynamic, changing and debated among both

knowledge creators and users (Banks, 1991-1992:34).

As the concepts of health and ill-health constitute important facets of the life experience of man, it may be postulated that the means whereby society provides for the transmission of its health related culture is entrusted to the social processes of both enculturation and socialisation: to the formal, non-formal and informal structures of society, whether inside or outside institutions of education.

1.3.4.3 Résumé

Culture has been identified as all encompassing in respect of human behaviour. As ontological fact, it normatively influences all the social structures within the specific culture through which it is expressed. Health and education, as conceived and as social systems, become manifest in and through the culture of a specific society and constitute part of the life experience of the members of that society.

The conclusion has been drawn that health education falls more appropriately within the non-formal sector of the education system while remaining an entwined and integrated structure within the education system and related social structures. As a result, it is deemed necessary to identify the area of focus of this study in respect of which mode of the agogic emphasis is to be placed.

1.3.5 HEALTH EDUCATION IN THE MODE OF THE ANDRAGOGIC

In the light of the above, it may be discerned that health education cuts across all the modes of the agogic (cf 1.3.2.1). However, health may be regarded as an aspect of everyday living and an essential quality of man's life. It is also increasingly recognised that people must be assisted to take more control of their health habits (Epp, *in*: Marsick and Smedley, 1989:502). For these, and the following reasons, the author is of the opinion that health education falls most appropriately in the sphere of the *aner-agein* or the andragogical mode (cf 1.3.5.1).

- * Health behaviour plays a pivotal role in the health status of individuals, families and communities. The responsibility for health activities and health care, at family and community level, lies largely in the hands of adults.
- * Adults have already been socialised into, and internalised, the health related behaviours of their particular culture.
- * Adults play a major role in the transmission of knowledge of the cultural and health traditions from one generation to the next.
- * Adult education, more than child and adolescent education, has a symbiotic and direct relationship with the environment in which it occurs. Adults tend to respond to societal change (on a functional level), which tends to fuel

further change (Rachal, 1989:3-4).

- * Choice and decision making, at the most influential level, lie in the hands of adults who can and do change, either intentionally and consciously or unintentionally and unconsciously, as a result of an event or activity. As a result, modifications may either add to the quality of being or result in loss (Boucouvalas and Krupp, 1989:193).

It, therefore, seems appropriate to concentrate on structured, systematic and planned activities to bring about change amongst those people who have the greatest potential to influence health related behaviour within the family and community.

Such an approach does not minimise the importance of health education programmes for children and adolescents, but it is believed that such programmes fall more appropriately within the sphere of the *pais-agein* or the more formalised structures of the education system where the principles and practice of pedagogics apply.

At the same time, in drawing a distinction between andragogy and pedagogy, there lies an inherent danger of underestimating the similarities which exist between the various levels of the agogic. KEDDIE (in: Briscoe and Ross, 1989:585-586) maintains that adult education is more similar than dissimilar to the rest of education in its forms of cultural reproduction, in so far as the concept of disadvantage in education frequently neglects to challenge differential access to power and knowledge (cf 4.2). Issues relating to disadvantage constitute the

basis of the controversy surrounding questions concerning the philosophy, aims, objectives and practice of multicultural education (cf 1.3.6.5(b)) in institutions of primary, secondary and tertiary education. KNOWLES (1980:58) adds that the differences between children and adults are not so much real differences as differences in those assumptions made about them in traditional pedagogy together with the differences inherent in people having arrived at different levels of maturity. For these reasons, many of the principles of pedagogy have direct relevance to the education of adults and will be drawn upon where pertinent.

It is important to clearly conceptualise the terminology associated with adult education in order to understand the basic premises about the phenomena being researched.

1.3.5.1 Andragogy or Adult Education

According to PETERSON (in: Courtney, 1989:15), the discipline of "... adult education has evolved a vocabulary possibly unparalleled in its confusion." The terms associated with the concept of adult education abound. All have been used at some time or another and all carry more or less the same meaning. The terminology includes continuing education, lifelong education or learning, community education or development, adult education or androgogy, independent learning projects, adult basic education, facilitation and even conscientization (Courtney, 1989:15). The terms are indicative of certain of the philosophies, target groups, areas of and/or methods of implementation which underlie the concept of androgogy. The terms to be used in this study will be restricted to 'androgogy' and its derivatives or to 'adult education.' The remaining terms, if used, will be in a specifically defined context.

In the Dutch literature, a distinction is made between the concepts of androgogy and androgogics. Andragogy has reference to any intentional, professionally guided activity which is directed toward changing the behaviour patterns of adults. Androgogics constitutes the background of ideological and methodological systems governing the actual process of androgogy. Androgology, in turn, is the scientific study of both androgogics and androgogy (Knowles, 1978:19).

According to VAN GENT (1991:9, 14, 96, 172) andragology is a multidisciplinary, theoretical empirical science which deals educationally and socially with adults and one which is grounded in critical rationalism. As such, it is the task of andragology to describe, explain and, where possible, to foretell happenings by making use of observations and logic. Andragogy pertains to educational and social work with adults or andragogical activities. Therefore, andragogy is generally accepted as having reference to social work, rehabilitation, personnel work, information or communications and adult education. In a certain respect, the fields of adult education and social work may be regarded as two poles between which other types of work may be arranged.

In the context of health as social and cultural activity, and education as process, health education may be viewed as entailing both educational and social components. Consequently, individuals and groups may be provided, not only with information, as an educative element, but also with psycho-sociological support, the aim of which is to enable or activate people to cope with problems in their personal, domestic and community environments.

The definition of adult education which emerged from the EXETER CONFERENCE OF 1969 (as quoted by Liveright and Haygood, *in*: Courtney, 1989:17) continues to be of relevance. It reads: adult education is a

"... process whereby persons who no longer attend school on a regular or full time basis ... undertake sequential and organised activities with the conscious intention of bringing about changes in information, knowledge, understanding or skill, appreciation and attitudes; or for the purpose of identifying or solving personal or community problems".

The above definition reveals the accord which exists between definitions of education, health education and adult education. While to be expected, such dovetailing endorses the validity of the co-existence of andragogy and health education within a single field of philosophical study.

1.3.5.2 Résumé

Claims have been made to justify the adult as focal point of, or target toward whom, health education is most appropriately directed. At the same time, the congruency between the concepts of education, health education and adult education have been revealed.

Although, not explicitly stated, the concept of education embodies the implicit idea of an encounter. The concept of encounter may, in turn, be said to hold the key to man's point of contact with his human world, his communication with this world and all that it represents. It, therefore, becomes pertinent to clarify the concept as used in this thesis.

1.3.6 ENCOUNTER AS CONCEPT

Man and his world constitute a unit, for the world is world for man. Man's conscious existence (cf 3.2.1.2) as human being is directed towards the world in which he plans, works, and relaxes (Du Plooy and Kilian, 1990:37). In terms of man being in the world (cf 3.2.1.3), he encounters, meets with, chances upon, realises, experiences, incurs, (Roget, 1987:155) and forms relations (cf 3.2.1.4) with the phenomena that make up this world. Relationships with the world imply being engaged in the world and experiencing it in a meaningful way (Arthur, 1992:82). Man is in dialogue with himself and his world (Oberholzer, 1968:156). As a being in constant dialogue with the world, man questions and is questioned, he encounters and is encountered and, as such, constitutes a world of relationships (Viljoen and Pienaar, 1976:60-61) of involvement (cf 3.2.1.8) and one of meaning (cf 3.2.1.5).

Dialogue implies communication and communication embodies the notion of language, both of which are social realities that play an integral and significant role in the phenomenon of health education.

1.3.6.1 Communication

The term communication is derived from the Latin *communes*, meaning 'common' which in turn, derives from *com* representing 'together' or 'with', and ..., 'gift' or 'service'. The totality of meaning gives rise to the idea of making common through offering service, or

gifting to another, or the creation of a shared domain (Westwood and Borgen, 1988:115).

Communication is the basic element of human interaction which allows individuals to establish, maintain and improve contacts with others. It is a multifaceted and complex process involving relationships and behaviours which allow people to associate with others and the world around them. It is an ongoing dynamic series of events in which meaning is generated, transmitted (Potter and Perry, 1993:310) and received. Communication involves usage of both verbal and non-verbal symbols that represent an object or idea (Korzenny, 1983:10).

Verbal communication represents language and non-verbal communication: all those non-verbal activities and behaviours involved in the transmission of information and experience from one person to another (Siegman and Feldstein, *in*: Woolfolk and Brooks, (1983:105).

As a component of all social relationships, communication consists of one person, the sender, designing a message and transmitting it to another, the receiver. The sender presents the symbols he believes will produce the intended response from the recipient. The receiver then extracts meaning from the message which may or may not correspond with the intention of the sender. If both individuals share a similar cultural background, socialisation process and education, with a common language, then the chances that the meaning derived is that which was intended are greatly increased (Budd and McCron, 1981:34) (cf 4.3.1.2(c)).

The concept of communication has been described as a dynamic process, involving intent,

between two or more people, with each person being affected by the other. The intent may include the social need to belong to another, to influence the behaviour of another or to obtain needed information (Korzenny, 1983:10). While accurate, this description is limited, for it concentrates only on the domain of interpersonal and personal relationships.

POTTER AND PERRY (1983:310) point to the fact that communication occurs at inter-, intrapersonal and public levels. Interpersonal communication, in which people are constantly aware of each other, has reference to the description in the previous paragraphs. Intrapersonal communication refers to the dialogue which occurs consciously and constantly within the individual (and represents one of the means whereby he encounters and is involved with the totality of his human world). Communication at public level represents interaction with large groups of people.

Healthy communication, in all its modes, permits of problem solving, decision making and personal growth (Potter and Perry, 1993:310). At the interpersonal and public levels of communication, enhanced communication creates a more accurate flow of information, increased shared understanding and a heightened sense of mutual well-being and fulfilment (Westwood and Borgen, 1988:115).

If communication is essentially a matter of conveying meanings from speaker(s) to listener(s) and success or failure is assessed in accordance with the degree to which the intended meanings are transmitted (Kreitler and Kreitler, 1988:726), it becomes necessary to dwell on the meaning of language as a specific instrument of communication which a community uses

to analyse its experience: language being both a part and a prerequisite of culture. (Rambaud, *in*: Camilleri, 1986:132).

1.3.6.2 Language as Socio-Cultural Construct

Language is used both as a means of communication between people as well as a specific tool for the organisation of knowledge. Language constitutes a semiotic representation of the various ways in which individuals symbolise the outside world and their own actions and experiences within it (Hamers and Blanc, 1989:60). Semiotics originates with PEIRCE'S THEORY OF SIGNS (*in*: Farrell, 1987:130) as part of a phenomenology of perception and meaning that constitutes a "... systematic interpretation of signs and their attendant functions" (Farrell, 1987:130). Such a representation is partly unique to the individual and partly shared by others. Language is, therefore, a social structure for it exists in a society and is shared by members of a linguistic community. It is a social attribute on which the community confers values and one which is shaped by the attitudes, values and norms of the social environment (Hamers and Blanc, 1989:60-61).

HALL (*in*: Westwood and Borgen, 1988:120) perceives culture as co-existent with, and indistinguishable from communication. He states that people from different cultures speak different languages but, probably more importantly, inhabit different worlds. As a result, experience perceived through one set of culturally patterned sensory screens is quite different from that perceived through another.

Language is the medium through which man expresses and explains his world (Kneller, 1965:48) in accordance with a group's conceptual profile, interests and needs and the cultural models which govern it. In addition, it transmits these models in space from group member to group member, and through time, transmits culture from one generation to the next (Camilleri, 1986:132). All languages appear to be optimally functional and thought economical in terms of the reality they describe. The language used in a particular reality is, therefore, always the most natural way of processing information about that reality (Fuglesang, 1982:36). Speech patterns develop within a group to equip them firstly, for effective interaction with their own community and then, the larger community. Ultimately, speech patterns reflecting cognitive style (cf 4.3.1.2(b)) fuse with other aspects of communication within the group to provide reciprocal reinforcement for what is most valued by the group (Anderson, 1988:6). Language, as spoken, influences what is seen and thought, and what is seen and thought, in part, influences culture. It is the interrelatedness between language and culture, plus the fact that language is an indispensable tool for the assessment of "... knowledge, skills, values and attitudes within and across cultures" (Ovando, 1989:208) that has directed attention to language and communication as a focal point in the problem relating to health education in the cross cultural encounter.

1.3.6.3 Cross Cultural Encounters

In purely linguistic terms, cross cultural encounters may be viewed as meetings between people of different cultures or interactions across cultural divides. The term 'intercultural communication' is frequently used synonymously with cross cultural communication on

grounds that, anthropologically, cross cultural "... traditionally implies a comparison of some phenomena across cultures" (Gudykunst and Kim, 1984:14). To make a fine distinction between the two concepts is considered irrelevant for the purpose of this study. For this reason, with the exception of reference to specific literature, the concept of intercultural will be incorporated within that of the cross cultural encounter.

The true significance of the concept of cross cultural encounters lies not so much in the term 'cross' but in those of 'culture' and 'encounter.' It is in an act of dialogue or communication between individuals and groups whose judgements are based on experience and whose experience is based on enculturation (Herskovits, *in*: Gudykunst and Kim, 1984:5) and socialisation, that the true complexity of the concept emerges.

1.3.6.4 Cross Cultural Communication

Problems exist in the lack of clarity, and even inappropriateness, with which culture, cultural and cross cultural communication is defined (Collier, 1989:287).

If culture is conceptualised as an expression of the many unique ways in which persons group together, understand, compose and live their daily lives and, by so doing, transmit a way of everyday living to others (Barer-Stein, 1987(b):89), then in the words of GUDYKUNST AND KIM (1984:14) cross- or

"... intercultural communication is a transactional, symbolic process involving the attribution of meaning between people from different cultures".

As neither of the above definitions imply either effective or ineffective communication, it may be stated that:

"Cross cultural communication is basically an attempt to attain agreement about subject matter among peoples of various cultures who speak different languages and who are unaware of the implications of their own respective speech habits. The notion of rationality or logical reasoning has in any culture the twist of that culture - so also in ours. When we indulge verbally in our logical faculties, we do not sense that the phenomenon of our language surrounds and controls us, the speakers, as an element outside (the implications of) our critical consciousness" (Fuglesang, 1982:18).

COLLIER AND THOMAS (1988:100), in turn, incorporate the concept of cultural identity within that of cross cultural communication in so far as they view intercultural communication as contact between individuals "*... who identify themselves as distinct from one another in cultural terms*".

It is not easy for human beings to be consciously aware of their cultural assumptions and values, their manner of thinking, speaking, decision making and goal setting. Because these characteristics are so deeply ingrained, people simply accept that they are intrinsic to the way things are in life. Few are able to explain the assumptions that go along with their cultural identity (Rash, 1988:214). Only when individuals from different cultural backgrounds meet does their own way of doing things become evident. Assumptions concerning how others will behave are always present and surface rapidly when expectations are no longer realised. People quickly become frustrated in cross cultural encounters, because unconscious habits, behaviours and assumptions become apparent when they no longer work (Cushner and Trifonovitch, 1989:319; Rash, 1988:214-215). In the context of unfulfilled expectations, it

may be stated that a cross cultural issue occurs in any encounter where a contradiction or confrontation exists between the various values, assumptions and beliefs of people (Casse, in: Rash, 1988: 215-216). These issues may occur in a variety of encounters: between people of different racial and ethnic groups, those with different language, religious and national affiliations, as well as on grounds of class, gender, age and ability.

The conception that cross cultural issues may constitute communication barriers is expressed as follows.

"Intercultural communication can be defined as communication in which the cultural differences between communicator and recipient are of such a nature that they create a barrier between the communicator and his message on one hand and the recipient and his interpretation on the other" (Rensburg, 1991:21).

This definition extends the meaning of the notion of cross cultural communication significantly, for it emphasizes the tension that exists between culture as it is lived on the one hand and culture as it is conceived on the other (McLeod, 1987:68). Although mentifacts and artefacts can be viewed as cultural, they are defined as such on grounds of their communicative purpose, as culture does not exist except in the minds of men. Culture, therefore, reflects a form of discourse (McLeod, 1987:69).

The social and cultural construction of reality is of vital importance in all aspects of the cross cultural encounter including that of education in all its modes.

1.3.6.5 Cross Cultural Educative Concepts

In the research literature on the topic of cross- and multicultural education which has been published since the mid-1960's, many divergent definitions have been suggested and no final agreement reached on the meaning of these concepts - each reflecting differing educational, social and political perspectives. In addition, a plethora of related terms such as cultural pluralism, multi- or polyethnic, multicredal, multiracial, bilingual, bicultural and intercultural education, are in current usage (Grant, *et al.*, 1986:47-48). Of these, the only concept which cannot be subsumed under those of cross- or multicultural education is that of cultural pluralism which, therefore, requires elucidation.

(a) *Cultural Pluralism as Concept*

The term cultural pluralism is a common one in current (political and) educational thought (Singh, 1987:88). Conceptually, the notion has reference to a culturally diverse society, but with emphasis on a particular national policy orientation and not the structure of that society *per se* (Appleton, 1983:23). THE NATIONAL COALITION FOR CULTURAL PLURALISM (*in*: Hazard and Stent, 1973:14) described the concept as

"... a state of equal co-existence in a mutually supportive relationship within the boundaries ... of one nation of people of diverse cultures with significantly different patterns of beliefs, behavior, color, and in many cases with different languages. To achieve cultural pluralism, there must be unity with diversity. Each person must be aware of and secure in his own identity, and be willing to extend to others the same respect and rights that he expects to enjoy himself".

Cultural pluralism, as public policy, is seen as a means of preventing hegemonic control (cf 2.3.5) of the social and political life of a society by any one ethnic group (Jakubowicz, *in*: Jupp, 1984:14). Basic assumptions associated with cultural pluralism are a belief in the freedom of association, the co-existence of many competing life-styles within a society and the fact that no one group is superior to another (Pratte, 1979:xvii).

Cultural pluralists affirm that a diversity of cultures enriches a nation, providing it with alternative ways not only of viewing the world, but also of solving complex human problems (Banks and Lynch, 1986:197-198). Ideologically, cultural pluralism has gained support not because it achieves or performs any one function perfectly, but because it is perceived as promoting more effectively than any other ideology, the goal of group participatory democracy (Pratte, 1979:xvii). Consequently, cultural pluralism may be interpreted as an aspect of meaning: meaning that is established as normative and authoritative and which is articulated in cross cultural communication and multicultural education as well as in respect of health and social systems. These meanings determine limits set on the expression and organisation of diversity, resolutions regarding diversity and unity and, most importantly, "... with the symbolic construction of the individual and the group in society" (Olneck, 1990:119). For these reasons, cultural pluralism may not be used as a synonym for cultural diversity or heterogeneity, or equated with cross- or multicultural education.

Because cultural pluralism is an ideological concept, it has been changed and continuously adapted to suit the needs of modern societies. The ensuing result is that a number of related social policies have emerged in different communities (Goodey, 1989(b):8). OLNECK

(1990:117), in his statement that issues of inter-, cross- and multicultural education are rooted in the history of attempts to reduce interracial, interethnic and religious tensions, while at the same time attempting to increase the self esteem of minority groups and incorporate them into society on terms of equality, clearly demonstrates the link between cultural pluralism, as ideology, and cross or multiculturalism as educational practice.

As literature characteristically "... represents writers' positions on aspects within the field of multicultural education" (Harper, 1989:85) and, because the meaning of the term in educational practice is more complex and carries more far reaching implications than the sum total of its parts, an examination of the concept of multicultural education becomes necessary.

(b) *Multicultural Education as Concept*

OLNECK (1990:118) argues that multicultural education as practised in the 1970's and 1980's is ideologically akin to its precursor, intercultural education, and maintains that the dominant logic and symbolism of multicultural education does not depart radically from that of intercultural education. The symbiosis between cross cultural and multicultural education hereby becomes apparent.

The elucidation of the concept of multicultural education and, by implication, health education which follows is an attempt to identify a definition that clarifies the concept and corresponds with the human reality within andragogic cross cultural encounters.

Definitions and descriptions of multicultural education range from the limited and philosophical to the wide ranging and practical. Certain conceptualisations confer official recognition to multicultural education as an acceptable educational model and clarify, to a degree, the ideological basis and broad aims of multicultural education. For example, PRATTE (1980:6-7) concludes that because multicultural education is founded on an ideology of cultural pluralism, it incorporates notions of a recognition and appreciation of the value of diversity, the realisation of a greater understanding of other cultural patterns, respect for individuals of all cultures and positive and productive interaction among peoples and between diverse cultural groups. Multicultural education is viewed by its protagonists, as a means of celebrating diversity, striving towards human rights and social justice and acknowledging the legitimacy of the various life styles and alternative life choices of all people (Pratte, 1980:6).

The preamble to the new standard for multicultural education drawn up by the NATIONAL COUNCIL FOR ACCREDITATION OF TEACHER EDUCATION (in: James, 1978:13), includes notions that multicultural education is a preparation for the political, social and economic realities experienced by people in complex and culturally diverse human encounters. Multicultural education is viewed as a strategy for educational intervention and ongoing assessment to enable institutions and individuals to become more responsive to the human condition, individual cultural integrity and cultural pluralism in society. It is the means whereby individuals develop competencies for believing, perceiving, acting and evaluating in differential cultural settings. According to BANKS (1991:26), multicultural education should help individuals develop cross cultural competency to function effectively within a

range of cultures. A further dimension of change, humanness and implied social control via the curriculum is introduced by LYNCH (1983:15-16).

The conventional narrowness of focus of multicultural education is highlighted when definitions are restricted to curriculum and attitudes (Arthur, 1992:41) and to children: a problem which is compounded by difficulties in determining which sub-cultural groups are the primary foci of concern (Banks, 1988:31). For the purpose of this study, the author sees no impediment to extend the frame of reference to include adults, hereby linking the notion more directly to that of health education. That sub-cultures do fall within the scope of multicultural education may be concluded from the very nature of the previously mentioned synonyms used in respect of both multi- and cross cultural communication. Sub-cultures, in this context, refer to clusters of patterns of human behaviour which are related to and yet distinguishable from those of the general culture. They include social class, religious, regional, age and gender sub-cultures (Horton and Hunt, 1984:65). Multicultural education, therefore, encompasses not only cultural but also sub-cultural differences.

Ideally, definitions are required which describe the total educational experience (James, 1978:14) in all its modes. To this end FRAZIER (1977:11-12) argues that any definition that suggests a clearly defined body of knowledge, a specific programme or speciality is erroneous. To impute a separate and distinct system, programme or set of principles and practice to multicultural education places it outside the unified structures of that which currently constitutes the totality of education. Education that is multicultural is descriptive of a condition constituting a fundamental recognition and acceptance of education that is of

intrinsic worth to all people as integral part of the education system in all its modes. It signifies the pervasive presence of patterns of educational thought and practice which not only instil and maintain equal respect for all but provide equal opportunity for all. The term does not imply that all individuals should have identical opportunities, but that the range of opportunities should be similar for every group. Such an approach readily incorporates the notion of health education.

As a result of the deeper insights into the concept of multicultural education revealed through a reflection on the standpoints and definitions described, a definition considered appropriate for this study is one which the researcher has adapted from GIBSON (1984:112). The adaptations are purely in the form of a terminology considered more appropriate to human activity and are indicated in bold print. The adapted definition reads: Multicultural education is the **means** whereby a person **achieves** or **acquires** competencies in multiple systems for perceiving, evaluating, believing and doing (Arthur, 1992:43).

As a conceptualisation, this definition is applicable to both multi- and cross cultural education because it derives from the two key concepts of education and culture which are drawn from educational and anthropological definitions. It acknowledges the actualisation of human potential and "... dat die wêreld per definisie 'n **kultuur wêreld** is" (Kirsten, 1984:290). The definition embodies concepts which are rooted in the anthropological-ontological ground structures of man's existence as described in Section 3.2 of this study.

Further arguments supporting this definition are based, in part, on those of GIBSON

(1984:112-113). The definition is non-exclusive, encompassing **all**, whether pupils or students; children, adults or the aged. Therefore, it carries the implication that research findings are equally applicable to formal or informal education systems where the main objective is to provide learners with opportunities to acquire knowledge which is of value and those competencies that will equip them to participate more fully in the health, social and educational structures of their society. The definition is open in so far as it does not equate culture with the so-called culturally different or disadvantaged groups in society. It is not restrictive as it does not equate multicultural education with specific curricula or school programmes and acknowledges that people from different cultural sets may participate in common activities. As a definition, it avoids ideological assumptions that it is a strategy for the attainment of socio-political equality, or that it is a vehicle for social reconstruction. Neither does it affirm that cultural diversity is a valuable resource or that cultures should be preserved and maintained. Such an approach validates the selection of appropriate material from the field of multicultural education research in the search for appropriate guidelines for health education in cross cultural encounters.

In defending the choice of the above definition of multicultural education for the purpose of a study in the field of health education, it has not been the intention of the researcher to absolutise the points presented, but to highlight certain factors around which debate has centred and which form a focus of discussion in later chapters. To absolutise, to deduce an issue unconditionally or raise it to the pivot on which everything turns, leads to alienation from reality. In multicultural education, absolutisation takes place when the concept is limited to the expression of diversity among individuals in respect of values, heritage and

styles and a failure to recognise, in some serious manner, the claims and identities of groups as groups in communication which then results in a one-sided, view of being human that is not true to life, as it is not identifiable in the life-world (Olneck, 1990:118; Van Rensburg et al., 1994:303) (Arthur, 1992:37-45).

1.3.6.6 **Résumé**

A brief examination of the above terminology reveals that the concept of multicultural education, as embodied in the notion of cross cultural education encounters, is not an ideology and is all encompassing, going beyond the exclusive confines of race, ethnicity, language and religion as well as social class, gender, role differentiation and First - Third World divergence. Inherent in all the various definitions of multicultural education is a universal acknowledgement that all cultural and sub-cultural groups, regardless of difference, merit consideration and respect for their essential human dignity.

An analysis of the concepts of cross cultural communication and multicultural education, in respect of health education in cross cultural encounters, reveals that the claim of a symbiotic relationship between the two concepts retains validity. However, the point of departure of each approach differs with regard to education in multi- or cross cultural settings. Cross cultural communication stresses dialogue, in all its facets, as human phenomenon, while multicultural education lays emphasis on educative events. Both approaches, singly and in combination, are of vital importance to any study relating to health education in the cross cultural encounter.

An anthropological truism of great significance to this research is the fact that all events are given meaning within their specific cultural and social context. Outside of a given context, these events may lose one meaning and acquire a totally new one (Hansen, *in*: Gort, 1987:25). In this regard, a need to formulate a holistic approach toward the socio-cultural, psychological and cognitive factors that impinge on education and health related matters of individuals and groups, has been identified. A thorough understanding of the nature and resilience of each traditional institution and its propensity for evolutionary change must occur before artificial and possibly deleterious social engineering, in whatever form, is attempted (Robinson and Skinner, *in*: Gort, 1987:25). In the context of this research, this statement is pivotal to the conceptualisations of health and education as in health education, and foundational to testing the validity of any proposed guidelines for health education and community development.

For these reasons, the terms 'cross cultural communication' and 'multicultural education' will continue to be used as separate concepts reflecting identifiable fields of research. In respect of multicultural education, the findings to be extrapolated are those which are universally applicable to all the modes of the agogic plus those that may be exclusively applicable to the andragogical mode.

Having defined the key concepts implicit in the title of the research, an elucidation of the point of departure and method of research follows.

1.4 POINT OF DEPARTURE AND METHOD OF RESEARCH

This research is intended to be a fundamental agogic study, in which the author seeks to describe and interpret the *aner-agein* as mutual involvement, support, and accompaniment of adults by other adults, in terms of its essential ontic nature and structure (adapted from Higgs, 1984:13) and as an aspect of culturality in man's existence.

1.4.1 POINT OF DEPARTURE

The point of departure is the education phenomenon, more specifically agogic intervention as existential reality in the andragogical mode as it relates to health education in cross cultural encounters. The approach carries the concomitant implication that agogics is a human phenomenon viewed against the background of the universal, or ontic, reality (adapted from Griessel, *in*: Reeler, 1985:42).

Although the sphere of this study is fundamental agogics and HUSSERL (1964:19) states that "... philosophy lies in a wholly new dimension" and requires "... an entirely new point of departure", CHESLER (1983:27) is of the opinion that "... it should not preclude the use of other auxiliary perspectives". In this respect "... the social sciences are particularly susceptible to the cause of human betterment" (Yeakey, 1983:291).

TEN HAVE (1968:40), in turn, records that agology cannot be limited to one form of analytical reflection on the agogical process in all its diversity; to one critique of existing

procedures; to one evaluation of new developments and recommendations concerning agogical activities. He also contends that the agogic

"... is namelijk geen fundamentele wetenschap, maar een bovenbouw-wetenschap, of ook een praktische wetenschap, in die zin dat zij voortgekomen is uit de behoeften van de praktijk, nl. de praktijk van de agogische arbeid, en derhalve ook praktische belangen dient. Daarom kan zij zich niet overgeven aan pure reflexe, maar dient zij ook aanwijzingen te geven voor de praktische verbetering van de feitelijke gang van zaken" (1968:40).

Furthermore, agogics does not consist of the sum total of its particular perspectives but exists in them. In asking questions of its border disciplines, the agogician remains responsible for anything he has to answer for (adapted from Van Vuuren, 1990:11, 13).

The fundamental agogical perspective is to be augmented by findings derived from empirical perspectives which are believed necessary to provide basic insights into the subject matter as a unified whole. Cross cultural research has a lengthy history derived from the field of education, but with contributions from education, psychology, sociology and medicine (Uhlig and Vasquez, 1982:45). In the context of cross cultural education, the emphasis is on education and, as an aspect of health education, medical sociology makes an important contribution.

Therefore, the researcher is of the opinion that an approach which incorporates the findings derived from other sciences would reveal, more clearly, that which constitutes the essence of educational theory and practice, as well as those circumstances within multi- and cross cultural encounters which denote a threat to authentic education.

This is a study which demands fundamental reflection on the nature of human existence, of human being in the world and of the educative event, with the aim of arriving at findings which will prove to be verifiable and agogically grounded. The methods used during the course of this study are described in the next section.

1.4.2 METHOD OF RESEARCH

Before embarking upon an investigation or research into any matter, a decision has to be taken concerning the method(s) which are to be employed. There are a number of valid methods, but not all are equally suited to every type of research. It may be stated that the method is often determined by the nature of the investigation. The methods to be employed in this study, together with a brief justification of their choice, will be discussed in the following paragraphs.

1.4.2.1 The Phenomenological Method

The present study is a study concerned with the human or anthropic world and the role of accompaniment or the *agein* in constituting it and more specifically the *aner-agein*.

When the phenomenon of education constitutes the point of departure of a study in which the researcher endeavours to obtain a scientific understanding of life and reality, he proceeds from the empirical life-world. However, by radical reflection, fundamental andragogics attempts to penetrate to the roots of a phenomenon in an attempt to investigate essential

structures of reality. The choice of the education phenomenon as point of departure requires that it always be viewed against a background of the universal or ontic human reality (Viljoen and Pienaar, 1976:80).

Phenomenology as a mode of investigation seeks to interpret man as human being (Reeler, 1985:42) to grasp what HUSSERL (1964:7) refers to as the "... meaning of the absolutely given, the absolute clarity of the given", in an attempt to "... grasp the absolutely 'seeing' evidence which gets hold of itself". As scientific method, phenomenology stands in direct contrast to methods used in the natural sciences (cf 1.3.1.5) in order to describe an exclusively human phenomenon such as education, understood as *agein*, in a scientifically responsible and accountable manner (Staples, 1987:39-40). According to BERGAN (1983:305), one of the sources of continuing consternation and fascination in educational research is the fact that many latent variables, that pose an ongoing challenge and are of increasing importance, cannot be directly observed.

Phenomenology denotes a specific philosophical attitude of mind and a specific philosophical method (Husserl, 1964:19): a method described as "... the descriptive analysis of experience" (Koerstenbaum, *in*: Husserl, 1967:xii). By way of contrast to the causal explanations of its empirical equivalents, the phenomenological approach deals with essences, universals or abstract entities which are not to be identified with perceptual objects (Nakhnikian, *in*: Husserl, 1964:xii). Phenomenology proceeds, according to HUSSERL (1964:46), "... by 'seeing', clarifying and determining meaning and by distinguishing meanings". It compares, distinguishes, forms connections, puts into relation, divides into parts or distinguishes abstract

aspects. Subjective truth as opposed to objective validity is revealed (Husserl, 1964:37). The very word phenomenon is indicative of "... the world at which man's intentionality is directed ..." (Van Rensburg, *et al.*, 1994:489).

Thinking phenomenologically is to force aside a natural reluctance to think about what is not expressed and has not yet been said. It is to reflect on what is known and visible or 'Surface Knowings' as well as that which is not known and visible or the 'Submerged Knowings'. It is an attempt to assemble all possible facets of 'Surface and Submerged Knowings' for concentrated reflection. It is to attempt to encompass within each act of reflecting an analytical separation and then an interpretive reunion so that new possibilities of meaning emerge (Barer-Stein, 1990:167). The phenomenological approach is not only a complex procedure involving careful observation, radical reflection and an unambiguous description of a phenomenon, but also radical accountability (Du Plooy and Kilian, 1990:37) in which personal opinions and prejudices are cast aside with a view to disclosing that which is reality. Phenomenology is a means of demonstrating ontological appearances (Heidegger, 1988:59-60).

Phenomenological writings strive to record, not only that which has entered the researchers probing reflections, but also to demonstrate how these reflections shift and what it is that has gradually transformed their meaning. It is a manner of simultaneously recording both the content and process of reflection. The particular deliberate process whereby 'Submerged Knowledge' is repeatedly exhumed, analysed and interpreted, becomes part of a hermeneutical process within a phenomenological study (Barer-Stein, 1990:168).

It is considered unnecessary in a study of this nature to describe the phenomenological method because it is an acknowledged and well documented method used by fundamental agogicians. According to GUNTER (in: Du Plooy, *et al.*, 1987:231), one of the greatest merits of this method for pedagogics (and, by implication, andragogics) is that the agogician is obliged to take the actual educative event and the problems that emerge in it as the basis for scientific practice so that contact with reality is not lost. Furthermore, phenomenology is a method that permits access to a specifically human phenomenon through the application of a systematic procedure for analysing and penetrating the primordial essences of the phenomenon under investigation. The method permits the separation of essential from non-essential aspects of health education, in the various modes in which it presents itself. Ontic categories and criteria can be named and the relationship between these categories and criteria probed in order to scientifically evaluate a particular educational occurrence.

Categories, of necessity, should bring to light the fundamental essences of a particular being or occurrence, such as being human. They should designate and verbalise in a controlled manner (Van Rensburg, *et al.*, 1994:334). Naming of a particular agogical category gives the agogician a grasp of a specific aspect of the agogic situation in its ontic structure so that a particular aspect of reality may be illuminated and brought into dialogue (adapted from Kilian, in: Chesler, 1983:25). Criteria which must be based on ontological anthropological categories (Chesler, 1983:38) are evaluative norms of investigation (Van Rensburg, *et al.*, 1994:348) to establish whether specific human activities are in accordance with authentic human existence.

Although the phenomenological approach is of particular significance to the study, it has been the stated intention of the researcher to incorporate empirical data based on the social sciences for the purpose of reflecting on other ways of knowing. Such an approach reflects efforts to bridge gaps of conceptualisation and methodology across all disciplines and many authors (Lonner and Berry, *in*: Brislin, *et al.*, 1975:viii).

1.4.2.2 Empirical Studies

The word *empeira* means knowledge, experience and, in particular, experimental knowledge (Aristotle, *in*: Van Rensburg, *et al.*, 1994:373). It is the term from which empirical is derived, meaning experience as the source or origin of knowledge (Van Rensburg, *et al.*, 1994:373). TEN HAVE (*in*: Van Rensburg, *et al.*, 1994:373) distinguishes empirical andragogy as the science of andragogy viewed as an empirical phenomenon which is open to methods employed in the experiential sciences.

Experimental and scientific texts can present solutions to problems. Problems should be framed and resulting arguments presented in order to demonstrate that the results formulated actually reveal insights and/or solutions to the identified problem whether on the basis of experimental, observational or theoretical investigation (Griesemer and Wimsatt, 1989:80). In other words, "... scientific texts must manage the openness with which an audience reads (and interprets) the text" (Griesemer and Wimsatt, 1989:81).

The inclusion of empirical data in conjunction with the use of the phenomenological approach

implies that the underlying realities which are of significance to health education in cross cultural encounters will be examined in a structured analytical way. Such an approach should contribute towards further penetration of the essences of the phenomena under investigation and facilitate ultimate fundamental evaluation of suggested educational guidelines by means of agogical criteria.

The adoption of a multidisciplinary approach does have certain limitations in respect of the criteria of breadth and depth of knowledge and understanding of any one specific discipline. As the scope of research extends across many disciplines, so the breadth and depth of knowledge and understanding of a specific discipline must, of necessity, be reduced. A charge may be levied that such an approach results in an oversimplification and oversight of significant findings in that field.

Further limitations are set by the scope of the literature study in which a method of random sampling has been utilised over as broad a field as possible. This was followed up by more in depth readings of selected study areas and of the work of specific researchers. Because of the applied and multidisciplinary nature of the field of research, many of the related disciplines are also applied and all draw from the established scientific data of the human and medical sciences. For this reason, in certain instances, the author has used well established and accepted secondary sources as opposed to primary sources when referring to empirical baselines from which the applied human sciences have evolved.

In mitigation, for an applied field such as health education, so much pertinent knowledge is

available in so many different fields that it becomes necessary for attempts to be made to bring together and evaluate that which is relevant, in order to establish the procedural conditions which are appropriate for bringing about successful health education. Individual health educators do not have the time to synthesize large and diverse bodies of literature. A basis is also laid for further research in this direction, for, by its very nature, health education is eclectic. "It is strengthened by being inclusive rather than exclusive" (Glanz, *et al.*, 1990:4).

An additional problem relates to the fact that scientists from different backgrounds are not necessarily in possession of a shared background of procedures, theories, laws, exemplars and metaphysical commitments. For this reason, the author has attempted to formulate the problem and scope of research as explicitly as possible and to bridge the gaps in ways that a heterogeneous readership can be expected to accept, in the sense that argument may be stimulated and further insights realised (adapted from Griesemer and Wimsatt, 1989:80).

1.4.3 RÉSUMÉ

The purpose of this study is an attempt to establish the essence and parameters of education, as universal phenomenon, and health education, in particular, in the situatedness of cross cultural encounters. Such an undertaking does not imply that agogics is normative in that it prescribes or proscribes any educational event. It is, however, normative in the sense that it postulates certain agogical categories and criteria whereby specific systems can be evaluated as agogically acceptable or not. These categories and criteria must be derived from a valid understanding of man as he is in his human world (Chesler, 1983:38): a world in which man

is constantly engaged and one in which culture plays a mediating role.

1.5 SUMMARY AND FURTHER PROGRAMME

In this Chapter attention has been given, in broad terms, to the need for research on health education in cross cultural encounters. The need stems from the multicultural character of South African society and the socio-political changes which have taken place since the beginning of this decade and are having such a dramatic impact on the health services in this country. The terminology and related concepts used in the title have been defined and amplified and their interconnectedness briefly examined. Key concepts, as presented, may be unfamiliar to those conversant with conventional literature or health education. However, the purpose of this study is not health education *per se*, but an attempt to identify fundamentals of that aspect of education which is termed health education in the context of cross cultural encounters and multicultural education (adapted from Theron, 1981:22). As health education focuses on people's ways of life and behaviour, the general orientation and point of departure sets the framework within which relevant issues are to be discussed.

CHAPTER TWO is directed toward an evaluation of traditional and allopathic medicine, the emergence, over time, of the current health dispensation in South Africa and the position of the adult learner, as focal point, in health education programmes. A reflection on traditional African medicine and related phenomena, as social reality, provides a particular point of reference for understanding some of the issues intrinsic to the realisation of health education in cross cultural encounters in a multicultural situation where, over a period of

three and a half centuries, a technological First World frame of reference has come to dominate health care systems.

CHAPTER THREE will give consideration to the anthropological-ontological grounding of categories of the andragogical phenomenon as they pertain to the *agein*. The anthropo-ontic structures will be analysed in relation to their role and existence in the nature of man as human and cultural being, in the mode of adulthood, with a view to identifying categories and criteria as a basis for evaluating recommendations in the final chapter.

In **CHAPTER FOUR**, an analytical empirical evaluation will be undertaken to probe the key psycho-social issues and educational realities affecting health status and educational outcomes in cross cultural encounters. The andragogical consequences of the interrelatedness between culture and the associated circumstances of the situatedness of educator and learner in cross cultural health education encounters will be examined, with the aim of revealing that which is of significance and relevance in the realisation of authentic health education in cross cultural encounters.

Finally, because educational theory is of little value if not translated into some practical recommendations, **CHAPTER FIVE** is to commence with a concise overview of the theoretical basis of the practice of health education as a potential starting point in developing guidelines for health education in cross cultural encounters. Andragogically accountable guidelines to meet the challenges posed by health education in cross cultural encounters will be proposed in order to render the empirical and phenomenological description of the reality

of health education more useful and effective.

CHAPTER TWO

REFLECTIONS ON AND TRENDS IN THE MULTICULTURAL CONFIGURATIONS OF SOUTH AFRICAN HEALTH CARE SYSTEMS

2.1 INTRODUCTION

The phenomenon being examined in this study is that of health education in cross cultural encounters. On these grounds, it may appear that an elucidation of traditional versus modern medicine and the changing forms of health care in South African history are irrelevant to the subject under review. However, it is not possible to evaluate the central issue from a fundamental pedagogical perspective and suggest guidelines for the realisation of authentic health education in cross cultural encounters without understanding that the maintenance of health and prevention and treatment of disease are part of a complex social system involving more than medical or health practitioners and medical centres or health services. Every society develops "... an entire set of strategies and traditions that are relied upon to maintain and restore well-being" (Good, *in*: Gesler, 1989:129). These features are embedded in the medical system of every human community. All medical systems constitute a pattern of cultural traditions and social institutions which evolve over time from deliberate human activities to enhance health (Foster, 1983:17). Illness or the human experience of disease comprises "... a socially constructed phenomenon located within a socially organized content" (Anderson,

1986:1277).

According to TAHZIB AND DANIEL (1986:203), a root cause of inadequacies in health care in less developed countries is that patterns of medical care and health personnel education are closely copied from Western countries with authorities displaying a widespread reluctance to deviate from these prototypes. As a result, patterns of medical care and education are frequently irrelevant to the needs of less developed countries and, in fact, may no longer be suited to the countries of origin.

Although social changes, from traditional to modern, are evident in many institutions throughout the African continent, the process of transition is uneven. An institution that appears to have changed little over the years is the healing establishment (Vontress, 1991:242). During times of ill-health, the majority of people in Third World communities turn to traditional medicine (Tahzib and Daniel, 1986:203). In general, traditional healers continue to treat their patients as their forbears did in the distant past (Vontress, 1991:242).

Increasingly, in the contemporary world, social institutions are viewed through a global prism. This is especially true in respect of health, where disease is associated with a complex web of economic, social and political processes that reflect unequal power relationships and life-styles based on class, gender and race (Good, *in*: Gesler, 1989:130). Consequently, national priorities and choice at individual, family and community levels are frequently manipulated at both supra- and transnational levels. The former repre-

sent individual elites operating as heads of intergovernmental agencies and the latter, those working for inter- and non-governmental organisations including multinational corporations. On grounds of a number of factors, some medical and psycho-cultural, others pseudo-scientific and still others social, political and economic, great stress is being placed on traditional healing (Gort, 1987:1) in conjunction with PHC with its concomitant emphasis on health education.

The situation, as described, places heavy demands on every member of South African society in respect of health care. The demand is most acutely felt at the very fulcrum of cultural transmission: the formal and informal education and training programmes where health knowledge and skills are taught and learned.

At the formal level, on account of the prevailing dominant biomedical health system (cf 2.2.2) and the multicultural composition of the South African population, health professionals representing every cultural and sub-cultural group are engaged in the provision of health and medical services in the cross cultural context. All these health professionals, regardless of culture of origin, have been trained in the Western tradition. A paradoxical situation exists in which large numbers of bearers of disparate cultures are trained in a Western biomedical system enabling them to provide cross cultural services for large numbers of disparate cultures (Jansen, 1982:105). The situation is further complicated by the fact that traditional healing systems are not static. They comprise systems of beliefs and practices that continuously reaffirm or renew themselves on the basis of changing social realities and new information (Gort, 1987:90).

Concern has been expressed that health education programmes may not have achieved the desired results (cf 1.2.1) and that negative results have been associated with educational interventions where such education is inappropriate to the needs and goals of the populations concerned (Grosse, 1982:107). It has also been demonstrated by GREEN (1985:279) and stated by WALT AND CONSTANTINIDES (1990:41) that health information, although often understood and known, is not necessarily converted into belief systems or acted upon.

Health and education systems, of which health education is an integral part, have been undermined in various countries by powerful forces such as demographic, technological, political and social change. These changes, together with a growing public awareness of the relationship between culture, ethnicity, race, gender, ability and life opportunities, have resulted in aspects of these systems being judged no longer suited to present circumstances (Arthur, 1992:135). Questions asked relate to:

- * whether it is possible to obtain mutual co-operation and understanding between people in multicultural societies whose knowledge is built on very different modes of thought (adapted from Haram, 1991:171-172).
- * the feasibility of determining guidelines for authentic health education in cross cultural encounters;
- * the degree to which health education can be implemented to bring about

a more equitable realignment of health status and health services within society "... without colonizing people's minds with vested interest priorities" (Mahler, in: Wolfers, 1990:preface);

- * whether health education is a productive precondition or a complement to the effectiveness of other interventions such as water supply, waste disposal, nutrition and medicinal supplies (Grosse, 1982:106);
- * the relationship between health education outcomes and other social variables such as ethnicity, class, gender and race in relation to attitudes, stereotypes and prejudice (cf Chapter Four).

While answers to these questions may not be forthcoming and can never be complete and final, the questions themselves act as pointers which shape the course of inquiry as man is viewed against the background of the whole of reality, more specifically the human reality of health and education, in an attempt to investigate and interpret the phenomenon as a whole.

Health education theories, approaches and methods that have evolved concerning cross cultural encounters, together with the declared outcomes of their implementation, are by no means clear-cut and are extensively debated. The very contentiousness and complexity of this phenomenon, frequently studied and argued according to the principles of the natural sciences, justifies an anthropological-ontological approach toward the

problem.

Scientific responsibility and accountability demand that educational policy decisions be guided by scientific criteria for education, as *again*, to be actualised as a normative cultural event. In a society composed of heterogeneous groups, these criteria must be based on a fundamental reflection of those variables which are inextricably interwoven with health education. In an attempt to penetrate the essence of the social and historical dimensions of the problem of health education and training posed by cultural diversity and, with a view to offering authentic guidelines for health education in cross cultural encounters, this chapter will:

- * focus briefly on the traditional African practice of medicine;
- * analyse the schism inherent in paradigms of health and disease as reflected in a world view dominated by the allopathic medical model versus that of traditional healing;
- * examine the place of health education in the emergence of primary health care as national policy in respect of the health system, and as an aspect of historicity, in the andragogical mode.

By virtue of the nature of the issues to be investigated, the author is of the opinion that certain common denominators, against which the many variables may be evaluated, will

be revealed.

2.2 TRADITIONAL AND MODERN MEDICINE IN SOUTH AFRICA

From a classificatory point of view, South Africa is difficult to pigeonhole because of its complex history and socio-economic background. As a multiethnic, multiracial and multilingual society, it incorporates features of both First and Third Worlds, although it is irreversibly set on an urban-industrial economic track (Bekker, 1989:234).

The distinction between 'traditional' and 'modern' medicine is absolutely arbitrary when the personal, interpersonal and community variables affecting interchanges between healers and patients are considered within the total healing context. However, it is a generally-accepted and useful distinction denoting the modern Western-orientated, bio-medical structural system in contrast to more local, culturally relativistic, functionally strong, humoral traditional approaches (Edwards, 1986:1273).

As it is anticipated that an increase in encounters between modern and traditional health will take place, it becomes "... important to examine the relationships between the various systems of health care" (Tahzib and Daniels, 1986:203).

2.2.1 TRADITIONAL AFRICAN MEDICINE

The aim of this section is not to attribute a particular or indigenous world view to all

Black South Africans, but to analyse in broad terms the traditional structure of African medicine. According to CONCO (1972:289), it is possible to generalise and state that African tribal society has or had an all embracing metaphysical or supernatural theory of disease reflecting a basic pattern and philosophy. This conclusion is supported by JANSEN (1982:105) who states that while the cultures of South African Blacks may differ substantially on finer points, they do display great similarity on broader issues. HAMMOND-TOOKE (1989:8) points to an essential continuity relating to past beliefs of healing as compiled by WILSON (1936) on the Mpondo; those of the KRIGES (1943) on the Lovedu and his own study of the Kgaga during the mid-seventies. Descriptions of beliefs and practices by missionaries and others in the Transkei and Ciskei, during the early nineteenth century, appear identical to beliefs found among the Cape Nguni in the 1930's and 1970's when Hammond-Tooke, himself, undertook studies in these regions. At this point it appears justifiable to note a word of caution, for the function of cultural ideals is not to describe the members of a society, but to promote and reward particular sets of behaviour (Novak, 1982:28).

In order to avoid misconceptions, it becomes relevant to define the twin concepts of traditional medicine and traditional practitioner:

* **Traditional medicine may be defined as:**

"... the sum or total of all the knowledge and practices, whether explicable or not, used in diagnosis, prevention and elimination of physical, mental or social imbalance and relying exclusively on practical experience and observation handed down from generation to generation, whether verbally

or in writing" (WHO, in: Wolffers, 1990:5).

In interpreting traditional medicine exclusively as a reliance on 'practical experience' and 'observation', this definition excludes the possibility that a traditional medical system can be based on both theory and practice as is the case in Ayurveda, Unani and Chinese medicine. While acknowledging the limitations of the definition, the author accepts WHO's usage of the term for the purpose of this study in the context of African traditional medicine.

* **A traditional healer, as an acknowledged practitioner operating within the traditional medical system, is defined as**

"... a person who is recognized by the community in which he lives as competent to provide health care by using vegetable, animal and mineral substances and certain other methods based on the social, cultural and religious background as well as on the knowledge, attitudes and beliefs that are prevalent in the community regarding physical, mental and social well-being and the causation of disease and disability" (WHO, in: Haram, 1991:167).

Many religious, economic, social, philosophical and other non-medical factors determine the nature and practice of African medicine. "Traditional healing rests upon a religious frame of reference ..." (Dovey and Mjingwana, 1985:77). Religion forms the fabric of traditional African life, being closely connected to all the thoughts and activities of the people. Ideas of health and illness are an integral part of a religious system in which beliefs in a life after death play an important role (Jansen, 1982:106; Hammond-Tooke, 1989:46, 53). According to African cosmology, the universe comprises two worlds: the

world that man experiences through his senses and in which he lives and the realms of the ancestral spirits. Ancestral spirits, as spiritual beings, are invisible members of society, care for and remain responsible for their descendants. All hopes, faith and fears are centred in them, for health, prosperity and misfortune are attributed to their continued goodwill or wrath (Mdeleleni, 1987:42).

HAMMOND-TOOKE presents a comprehensive coverage of indigenous healing in Southern Africa. He (1989:46) states that the world view of South African Blacks constitutes four broadly defined sets of belief systems that purport to explain the human condition. These include the Supreme Being, ancestors, witches and pollution beliefs. The first three are part of the religious system and have direct relevance to the notions of health and well-being as discussed under 2.2.1.1(b).

2.2.1.1 The African Conceptualisation of Disease Causation

The idea of ontological or cosmological balance, having reference to a state of harmony, is an important theme found in African cultures. Ideally, balance exists between man and his total environment: natural, supernatural and social. While balance prevails, all is well. Any misfortune, including illness, disturbs the balance creating a situation of danger for all. Therefore, every effort is directed toward restoring any loss of balance as soon as possible (Jansen, 1982:108).

Africans generally recognise both natural and supernatural conditions as causes of

disease (Conco, 1972:285).

(a) *Natural causation of Disease*

Certain diseases are referred to as common or ordinary sickness (*Mkhuhlane* = Zulu; *Mokotlane* = Sotho). Such illnesses display a degree of overlapping and may be specific or non-specific. The specific have reference to distinct disease entities with observable signs and symptoms such as measles, asthma and worm infestation. The non-specific refer to a wide range of diseases including coryza, influenza, stomatitis and gastroenteritis on grounds of similarity of symptomatology and observable signs (Conco, 1972:286-288). The Batswana, for example, state "... there are times when diseases will just come and go" (Haram, 1991:172).

(b) *Anthromorphic or Supernatural Causation of Disease*

The core belief system on which traditional African medicine rests constitutes "... a metaphysical article of faith" (Conco, 1972:288) in that claims for its truth cannot be falsified or verified empirically (Conco, 1972:288). In order to explain the basic tenets of the supernatural theory of disease causation, belief systems relating to the Supreme Being, ancestors and pollution are significant.

- * **The Supreme Being:** in traditional African Society, God is a shadowy figure who made the world, but toward whom no prayers or rituals are

directed. His involvement in human affairs functions as a residual explanatory concept much like that of 'fate', 'luck' or 'chance' (Hammond-Tooke, 1989:46-47).

- * **Ancestors:** the shadows or spirits of deceased ancestors constitute an important religious entity. Ancestor belief provides a set of explanations for misfortune and disease. Ancestors, not only protect the interests of their descendants, but may also punish them for failing to honour them appropriately, for not respecting senior members of the group or for neglect of long-standing traditions and rituals. A close relationship is forged between the integration of wider descent groups and morality (Jansen, 1982:107-108; Hammond-Tooke, 1989:47).

- * **Witchcraft/Sorcery:** a mystical ability possessed by certain individuals enabling them to use their powers and the forces of nature to bring harm to others (Hoernlé, 1962:241; Hammond-Tooke, 1989:48).

- * **Pollution Beliefs:** beliefs concerning causation of disease and misfortune that function independently of spiritual and human volition. People are inadvertently in a dangerous state of ritual impurity stemming from certain life conditions such as menstruation, the birth of twins, illness and death (Hammond-Tooke, 1989:50, 91).

Two comparatively new phenomena relate to possession cults and faith healing (Hammond-Tooke, 1989:51, 126).

- * **Possession Cults:** the possession of individuals by alien spirits or individualised ancestral spirits which are clearly distinguishable from the ancestral group descent pattern. By entering the body, these spirits cause illness presenting in a variety of symptoms. Because of their recent origin, cults only fit loosely into traditional world views. Membership is restricted mainly to females (Hammond-Tooke, 1989:51, 127-129, 134).

- * **Faith Healing:** great emphasis is placed on the healing power of the Holy Spirit. Introduced in 1908, pentecostal teaching found echoes in African thought giving rise to the Zionist movement. Sects continue to proliferate. Belief centres around the ability of the Holy Spirit to provide guidance and influence the minds of worshippers (Hammond-Tooke, 1989:51, 136).

Inextricably linked with any social and cultural construct regarding disease causation, is the content and structure of the practice of medicine. Restoration of a state of balance or harmony necessitates discovering the cause of the condition and, where relevant, the responsible agent. The nature of the illness, in turn, determines the correct treatment and the means whereby a reoccurrence may be prevented. Depending on the social context of aetiological decision making, illness episodes are channelled toward specific therapeutic options (Mills, 1987:7).

2.2.1.2 The Traditional Structure of African Medicine

As a generalisation, it is possible to state that Africans believe in the unity of nature as a vital force directing and animating everything in the universe. Although God is the source and ultimate controller, spirits also have access to this force. A few human beings may have the knowledge and skill to tap, manipulate and use these powers (Vontress, 1991:243).

It is within this construct of reality that the traditional medical and healing arts of African medicine flow. Traditional practitioners or healers, in their diagnostic and healing capacity, act as mediators between the visible and invisible world to determine the forces at work and how to restore harmony (Vontress 1991:243). Treatment and prevention of the harmful event are inevitably and logically intertwined.

In African medicine, there are clearly distinguishable categories of specialists and healers, although they are not necessarily water-tight compartmentalised groupings. Sometimes practitioners are seen as being endowed with variations of power and, in other instances, as all powerful (Vontress, 1991:243). In the South African context, the following specialists are the most clearly identifiable.

(a) *The Diviner*

Divination is the process of obtaining knowledge of future events or secret things by

means of omens, astrology, oracles or contact with divine or superhuman forces. The diviner (*igqira* = Xhosa; *isangoma* = Zulu; *ngako* = North Sotho; *selaodi* = South Sotho), usually female, is called to the profession by the ancestors. It is this affirmation that underpins the divination process and bestows the authority of the sacred on it. The neophyte, prompted to divination by a series of vague and variable symptoms, submits to the inevitable and is apprenticed to an established diviner for a period of intense training (Blackett-Sliep, 1983:43; Hammond-Tooke, 1989:104-107; Vontress, 1991:247).

The role of the diviner is specifically that of controlling the forces of evil that constantly threaten the well-being of the community (Hammond-Tooke 1989:103). They make possible the fusion of human being and spirit, the seen and the unseen, the natural and the supernatural (Stoller, *in*: Vontress, 1991:244). Whatever the source of power, the primary role of the diviner is to identify the agent causing the illness and then to determine how to overcome or placate it. Therapy is believed to have little effect until the causal agent has been identified (Foster, 1983:20). A complicated system of medical practice is integral to the healing arts of traditional practitioners (Gumede, 1990:48).

(b) *The Herbalist*

The herbalist (*inyanga* = Zulu; *ixhwele* = Xhosa; *ngaka* = Sotho), usually male, is not mystically called. Herbalists decide to specialise in the use of herbal medicines and apprentice themselves to an established herbalist (Blackett-Sliep, 1989:42-43; Hammond-Tooke, 1989:104).

The herbalist is a master of his trade in pharmacopoeia and important to the well-being of the community. He possesses knowledge of a vast array of roots, plants and other substances. Some of these medicines may also be used to harm people, should the practitioner become anti-social and operate like a witch (cf 2.2.1.2 (e) (Hammond-Tooke, 1989:104-105; Vontriss, 1991:243).

(c) *The Cult Leader*

Cult leaders appear to be women of commanding and strong personality. Characteristically, women are inducted into a cult group where they regularly undergo a possession experience. Afflictions are not treated by exorcism of a possessing agent, but by arriving at a viable accommodation with it. Sufferers, unlike the victims of ancestral displeasure, are not seen to bear moral responsibility for their condition as the possessing spirits are perceived as originating from outside the society (Lewis, in: Hammond-Tooke, 1989:134-135).

(d) *The Faith Healer*

Faith healers may belong to either mission or independent churches. Healing takes place in three main modes: healing during church services, by immersion or in consultation with a prophet. The first two derive from pentacostal practice, while the third displays significant parallels with indigenous methods of healing. Praying and the sacrament of laying on of hands are the most common rites performed by prophets

associated with the sect. Use of holy water is wide-spread. The power to heal is believed to come from God and the Holy Spirit through the agency of the prophets and the efforts of the congregation (West, *in*: Blackett-Sliep, 1989:43; and, *in*: Hammond-Tooke, 1989:136-137).

Although the administration of the independent churches is almost entirely male dominated, the general importance of women is reflected in the role of the prophet, the majority of whom are female (Hammond-Tooke, 1989:137-138).

(e) *The Sorcerer/Witch*

Sorcerers, wizards or witches (*bathakathi* = Zulu; *baloi* = Sotho *in*: Conco, 1972:291) perform their work by becoming invisible, changing shape or sending 'familiar' to do their evil deeds. They are sinister, highly ambiguous figures, both human and non-human, whose activities transcend normal human powers. Their services may be used by those not endowed with mystical powers to the detriment of others (Hammond-Tooke, 1989:73).

According to HEBGA (*in*: Vontress, 1991:245), sorcerers are able to place hexes on individuals; cast spells; inflict both physical and psychological harm on people; cause them to commit suicide; plant suggestions in their minds; kill them from a distance without leaving evidence of the deed and send messages through dreams announcing happy and unhappy events.

Finally, mention must be made of those people, not practising medicine *per se*, who have some skill in treating particular conditions.

(f) *Individuals with Special Knowledge and Skills*

Certain persons are known to have skill and knowledge in respect of treating conditions especially those of natural origin (cf 2.2.1.1(a)). Specific empirical treatments may be passed on via relatives, dead or alive, be revealed by spirits in dreams or learned from a traditional practitioner without secrecy, mysticism or supernatural conceptualisations (Conco, 1972:285, 295). Bone-setters and traditional midwives may be included in this grouping.

In African medicine, the unity of cause, practice and diagnosis is well demonstrated.

2.2.1.3 The Traditional Practice of African Medicine

Expectations of diagnosis and treatment will include "... a generally accepted interpretive view of sickness and its causes" (Conco, 1972:300).

(a) *Diagnostic Techniques*

Traditional practitioners use a variety of procedures to diagnose problems. Some arrange elaborate ceremonies to invoke ancestral spirits to obtain answers to the

problem, while others go into trance-like states and yet others, may take histories. Other procedures include the use of divine objects: bone throwing where the configuration of bones indicates what is wrong; divination methods in the form of studying the flight of birds or the reading of leaves; clairvoyance and clairaudience or the seeing and hearing of things invisible and inaudible to normal vision and hearing; the use of 'mirrors' to 'see' problems and dream interpretation. Rituals are generally conducted in group context so that the 'afflicted' person is not isolated from the community of which he is a member (Dovey and Mjingwana, 1985:79; Vontress, 1991:246).

Diagnostic and healing techniques are inextricably entwined and frequently overlap.

(b) Treatment

A number of techniques are used, either singly or interactively, to prevent, ameliorate or eliminate physical, psychological and spiritual problems (Vontress, 1991:246).

- * **Pharmacotherapy:** traditional practitioners are well versed in the prescription of pharmacological agents. Directions for use are frequently geared so that responsibility for the medicine working properly falls on the patient (Conco, 1972:294), while associated symbolic values are often as important as the healing properties of the medication. For example, emetics and purgatives may be used to eject evil spirits or poisons from the body or to effect thorough cleansing so that the medicine will have maxi-

num effect (Vontress, 1991:247). Many people, especially the elderly, have some knowledge of popularly recognised roots and herbs (Conco, 1972:285).

- * **Exorcism:** this practice is as old as religion itself and remains a feature of orthodox Western religions. The expulsion of supposed evil spirits from people or places is accomplished by means of specific incantations and ceremonies (Vontress, 1991:247).

- * **Sacrifices:** the sacrifice of domestic animals is a symbolic act to propitiate the spirits of the ancestors. Harmony between the living and the 'living dead', or recently deceased, is hereby maintained or restored (Vontress, 1991:246).

- * **Possession Dances:** magicians reveal predictions and councils of the spirits during these ceremonies. In the emotionally charged environment, the sick and the group are spiritually elevated, unconsciously reconciled and leave the event feeling physically, psychologically and spiritually recharged. In a sense, such dances may be seen as group psychotherapy (Vontress, 1991:246).

- * **Music as Therapeutic Accompaniment:** music is used as a key to the invisible world and as an instrument of the inner dimensions. Music is

necessary to induce spirits to leave their domain and travel to the social world. Mediums usually require musical accompaniment to induce the trances that allow ancestral spirits to inhabit their bodies. Music also serves as a psychological tonic for villagers (Vontress, 1991:247).

- * **Shock Therapy:** in certain types of mental disorder, African-style shock therapy is used to restore patients to wellness. Repeated dunking of patients in ice-cold streams or severe fear inducing experiences may be used to effect a cure (Vontress, 1991:247).

- * **Preventive Measures:** these include practices such as immunisation, the wearing of amulets, offerings and sacrifices, the observance of taboos, prohibitions and a number of rituals surrounding body hygiene (Koumaré, 1983:27). Preventive medicines are obtained from traditional practitioners or persons with the necessary skills. Measures cover all aspects of life ranging from pregnancy and childbirth, to success in business, love-making, crops, control of hail and lightning, as well as warfare and making the home invincible (Conco, 1972:293-294). Good health and fortune are rich rewards for good behaviour and constant sacrifice to the ancestral spirits (Gumede, 1993:41). It is not possible to consider the structure and content of traditional African medicine without paying some attention to the family, as central unit, within traditional African societies.

2.2.1.4 The Traditional African Family

The family, as pivotal group around which the social system is organised, constitutes a cohesive structure. The relationship between the family and the medical system is outlined by JANSEN (1982:114-119) and VONTRESS (1991:245).

Illness or misfortune affecting a single family member becomes a crisis for the whole family. The family, as a unit, determines whether the affected member is to receive medical care or not and whether health care should be provided by the family or the formal health system. The family is involved in decision making at every stage of illness from diagnosis, to treatment, to rehabilitation (Andersen, *in*: Gort, 1987:18). Generally family members escort the affected person to the healer and remain with him until the treatment is completed.

Due to the clearly defined structured cohesiveness found in the family, illness involves the extended family, other kinship groups and even classificatory kin. Kin in the African social system are classified into broad categories in which there are accurate linguistic descriptions for degrees of closeness and seniority. Status structures are strongly hierarchical with each person holding a specific position which is uniquely his own. Both seniority and respect for age are integral aspects of traditional African cultures. Status hierarchies are different for men and women with males holding an overall dominant position. Significantly, specific patterns of behaviour in respect of duties and responsibilities, rights and privileges are codified within the classificatory terminology.

A distinguishing characteristic of the African social system is its corporate nature. In traditional African culture a life governed by self-interest is considered self-indulgent. Whatever affects the individual involves the group and anything happening in the group carries implications for the individual. What matters is the collective well-being of the extended family, usually comprising the eldest male, as head of the group, his wife or wives, their children and other consanguinous relatives such as nephews, nieces, grandchildren and grandnephews and nieces.

In order to provide a unifying framework for the reader to understand more clearly the divide which exists between traditional and Western based biomedicine, a description of the Western scientific medical system follows.

2.2.2 MODERN ALLOPATHIC MEDICINE

Historically, the world view and value systems of Western cultures have their roots in the scientific revolution of the sixteenth and seventeenth centuries. Values associated with the modern era include beliefs that the scientific method is the only valid approach to knowledge; views of the universe as a mechanical system comprising separate objects that can be reduced to fundamental building blocks, the interactions and properties of which determine all natural phenomena; portrayals of life as a competitive struggle for survival and beliefs that unlimited material progress can be achieved through technological and economic growth (Capra, 1982:12, 23).

This mechanistic conception of the world, which embodies notions that life processes can be controlled by mechanised and engineered interventions (Boyle and Andrews, 1989:28), has been extended to all living organisms. It is a frame of reference that influences many aspects of human life, lies at the basis of most of the sciences, has led to the fragmentation of academic disciplines and government agencies and contributed to the rationale for treating the environment as if it comprises separate parts to be exploited by different interest groups (Capra, 1982:23).

Modern science has contributed to the construction of a sequence of approximate and limited theories or models, each one more accurate than those preceding it, but none representing a final, complete and definitive account of natural phenomena (Capra, 1982:33, 93). The medical system emerging from this scientific world view is known as Western, allopathic, biomedical or scientific. It is a medical system widely accepted as the most advanced and prestigious of all systems. It has been stated that European and American power have assured the dominance of this system throughout the world (Booyens, 1991:483).

The primary point of separation of allopathic from traditional medical systems is not clearcut (Canary, 1983:90), but may be said to stem from philosophies of dualism and reductionism. Dualism stems from the Cartesian view of complete separation of mind and body - of the psychological from the somatic. No framework is provided whereby mind and body can be related other than through reductionism. This concept embodies the notion that an understanding of more complex entities can best be realised through

their sub-division into smaller and smaller parts followed by analyses of these parts to reveal the characteristic properties of the whole (Boyle and Andrews, 1989:28, Engel, in: Webster, 1989:23).

An elucidation of the scientific conceptualisation of medical systems follows.

2.2.2.1 The Scientific Conceptualisation of Disease Causation.

Because the principles on which allopathic medicine rests are based on a scientific approach (Leininger, 1978:190), modern medicine regards the body in purely mechanistic terms (Hammond-Tooke, 1989:145). The biomedical model accepts the doctrine of specific aetiology, postulating that specific diseases are caused by specific organisms and conditions. Simple cause and effect relationships are proposed, in keeping with the reductionist view of nature in which interactions of discrete entities are involved in a linear causal fashion (Engel, in: Webster, 1989:23). 'Objective materialism' or the notion that what is real can be observed and measured is a further feature of the biomedical model contributing to a distinction between subjective and objective realities in all paradigms relating to health and disease (Boyle and Andrews, 1989:28).

Therefore, if disease, representing a sufficient deviation from the norm, is regarded as being caused by natural or unnatural factors, then treatment is geared toward controlling or removing the cause in a rational and specific manner (Cockerham, 1986:6; Engel in: Webster, 1989:24).

The emphasis in modern medicine is on the formulation of exact laws (Webster, 1989:21). Disease and health are viewed in terms of relationships between the sub-structures of the body. The connections are mechanistic and scientific and are governed by physical, chemical and biological laws sought within the parameters of the system itself. Laws embrace concepts such as viruses, cell-sub-division and chemical imbalances. The possibility of influences originating from non-scientific sources is vigorously denied. In the search for cause and effect, outside influences stemming from spiritual forces are considered unscientific and unthinkable. Modern medicine is, therefore, quite separate from religion (Hammond-Tooke, 1989:18, 145-146).

According to this model, all aspects of health and disease can be understood in physical and chemical terms, fostering the belief that psychological processes can be reduced to a study of bio-chemical exchanges (Sobel, *in*: Boyle and Andrews, 1989:29) with some attention being paid to scientific analyses of human relationships and the human condition.

The entities postulated by medical science can generally be measured by sophisticated instruments and the theories and results of experiments can be tested and replicated. A critical attitude and objective description, made possible by the separation of the material world from that of reason, has become the ideal of scientific practice (Hammond-Tooke, 1989:145; Webster, 1989:21). This view of pathology is inextricably linked to modes of diagnosis and treatment.

2.2.2.2 The Practice of Allopathic Medicine

Disease, viewed as an area of scientific investigation, becomes susceptible to scientific treatment. Invariable correlates are sought between events and entities within the field of study (Hammond-Tooke, 1989:18) and then applied to the field of practice. This frame of reference, in conjunction with the notion of linear causality, has led to a belief system in which the future course of disease is viewed as predetermined and predictable (Webster, 1989:21) and disease and death as an enemy to be defeated (Capra, 1982:144-145; Webster, 1989:24).

Due to the development of the scientific method, the practice of medical care in this mode has taken great strides forward. Technology has led to the evolution of a wide range of sensitive and accurate analytical chemical measurements; applications of physiological principles to life support and measurement systems; provision of extensive surgical modifications to the human body including transplantation of organs and grafting of tissue; application of radionuclides to the study and treatment of bodily functions and dysfunctions; vast and rapid increases in the knowledge of chemotherapy and immunology as well as the development of potent antibiotics (Canary, 1983:91). As a result, the process of diagnosis and treatment is complex and not readily understood by the patient who, in some instances, may confuse diagnostic procedures with treatment.

Practitioners are generally organised into professional groups representing the general outline of the overall disciplines. Such groups, in addition to serving the common

interests of their members, regulate standards of training and certification of qualifications thereby conferring status on, and recognition to, their members. Discipline is enforced in cases of malpractice and research is regarded as fundamental to the practice and progress of medicine (Canary, 1983:97-98). There is a tendency to ignore or define as illegal or inappropriate those experts who use alternative assumptions, rationales and methods and operate outside the dominant medical system (Shuval, 1981:340). Exclusivity is hereby maintained.

Western medicine with its medico-centred focus has placed the Western medical officer in a central, dominant position and provided definitions of legitimate sets of supportive roles (Shuval, 1981:340). A situation arises in which the physician treats the majority of patients impersonally, or by remote control, through a vast number of specialists at his disposal. Modern medicine has become centred around the concept of teamwork (Gumede, 1990:5).

Services are rendered to the individual in an office or specifically designated medical facility and, very infrequently, in the patient's home. The majority of physicians' offices contain simple equipment with more complex tests or examinations being carried out by specialist agencies, for example, analytical laboratories or radiological practices. The number of consultations may vary from one visit of short duration to multiple encounters depending on the condition (Canary, 1983:94-96). The patient is viewed as a passive consumer of health care, client dependency is encouraged and structured routines for providing services are followed (Booyens, 1991:485).

In keeping with the philosophy of reductionism, specialists are consulted in respect of different age groups as well as in respect of the function and/or pathology related to the sub-systems of the human body. Therefore, it is possible for an individual to be treated by a number of specialists, each dealing with a sub-division of his body - the mind being the domain of the psychologist or psychiatrist.

It is interesting to note that the newly emerging discipline of 'ethnomedicine,' originally defined as those practices and beliefs relating to diseases that are the end result of indigenous cultural development and not those derived from the conceptual framework of scientific medicine, has been extended, by many writers, to include allopathic medicine. The vast body of literature in the field of ethnomedicine reveals that regardless of the apparent infinite variety of approaches toward medical practice, structure emerges as the volume of information is classified. From the midst of detailed difference, similarities begin to emerge and relatively few general principles can be extrapolated. These common elements are founded on the principle of limited possibilities. There are only so many causes to which disease can be attributed, so many ways in which a medical practitioner can acquire knowledge and skill and so many ways in which a patient can be treated (Foster, 1983:17-18).

In the light of what has always appeared to be an unbridgeable gulf between traditional and allopathic medicine, it becomes appropriate to examine the anthropological ground structure of 'communitary in diversity' (cf 3.2.1.16) in respect of allopathic and traditional medicine.

2.2.3 ALLOPATHIC VERSUS TRADITIONAL AFRICAN MEDICINE

As starting point, it should be acknowledged that, whether traditional or modern, all healers have the same goal. Their aim is to relieve pain and suffering, to cure the disease if they can and to comfort the sufferer (Gumede, 1990:153). The role of the practitioner may also include offering some explanation for the cause of the disease. In order to promote a unifying framework and bring some order to the frequently described areas of difference, it is the intention of the author to commence with the general principle of communality and proceed to analyse aspects of diversity. The general underlying principles which follow are derived from COE (1978:130-134).

2.2.3.1 The Medical System Constitutes an Integral Part of the Culture of a Specific Society

Medical cultural patterns do not occur in isolation, but are integrated within the complex network of values and beliefs constituting part of the culture of any society (cf1.3.4.1). There can be no disputing this fact, and yet, it is within the ontic fact of communality that difference lies. What is the extent of difference and to what extent are these differences mutually exclusive?

(a) *'Open' versus 'Closed' Systems of Medical Care*

Traditional medicine has been viewed as a closed system and allopathic medicine as an

open system. According to HORTON (*in*: Haram, 1991:167), the difference lies in the fact that a highly developed awareness of alternatives to established bodies of theoretical tenets (and technological advances) exists in scientifically orientated cultures, but is not found in traditional cultures. HARAM (1991:167) demonstrates that Tswana medicine, through its traditional practitioners, displays both integration, implying flexibility or 'openness,' and 'closedness' when confronted with a new body of knowledge and practice. On exposure to external cultural elements, new medical knowledge may either be fitted into already existing categories of knowledge, or be considered useful only for specific sorts of ailments, or be rejected. In other words, Tswana medicine is an open or inclusive system to the extent that it allows new external knowledge to be assimilated without replacing existing notions of 'reality' and 'truth' but 'closed' in so far as existing truths are monitored or new elements rejected.

Allopathic medicine has already been shown to be a 'closed' system in respect of so-called complementary or alternative medical systems. It is, however, 'open' to new elements from outside the system to the extent that the new knowledge is compatible with the existing system.

It may, therefore, be deduced that traditional and western medicine are characterised by both openness and closedness. The point of departure lies in definitions of 'truth' and 'reality' as embodied in a particular world view.

(b) *Scientific versus Non-scientific Systems of Medical Care*

Allopathic medicine is described as scientific whereas traditional medicine is viewed as empirical and non-scientific (Gumede, 1990:154). In contemporary industrial nations, diseases are commonly viewed as natural phenomena which are subject to investigation by scientific methods (Coe, 1978:131). Modern medicine is as scientifically and technologically based as is the industrial society. Conversely, traditional medicine tends to be built upon accumulated as opposed to scientific proof (Elling, 1981:96).

Although the above generalisation holds good in most instances, it should be noted that modern medicine shares the quality of accumulated understanding with traditional medicine (Elling, 1981:96) especially in respect of folk medicine (cf 2.2.3.2). Furthermore, integration of medical beliefs and practices with other aspects of culture is never a perfect fit in either First or Third World societies. The implication being that the degree to which segments of any population are aware of the totality of the medical belief system, much less accept it, will vary (Coe, 1978:131). It is, therefore, possible for different systems to co-exist and to overlap one with the other.

The dichotomy between modern and traditional medicine is understandable in view of the historical foundations on which each is based (Edwards, 1986:1273). In societies where science and technology are poorly developed, human control over the environment is relatively limited. Therefore, what cannot be described in relation to the regularities of the natural world is attributed to supernatural forces (Coe, 1978:131-132).

(c) *Naturalistic versus Magico-religious Systems of Medical Care*

Western medicine, based on logico-deductive procedures of diagnosis, excludes the mystical and religious (Hammond-Tooke, 1989:37; 146). A world view based on the supernatural and other belief systems is incompatible with, alien and incomprehensible to modern sector medical practitioners (Green, 1988:1126).

At the same time, the esoteric qualities of biomedical definitions of disease are not always understood by members of First World communities themselves. Acceptance of a medical system under these circumstances becomes, in itself, an act of faith.

A mechanistic view of disease carries the implication that doctors treat physical symptoms only and misunderstand or disregard causes of ill health stemming from the social environment as well as the symbolic significance and meaning that people attach to illness (Ferreira, 1987:141). None the less, all people continue to seek for the meaning of life events at levels above those of mechanistic laws. ACKERKNECHT (*in*: Boyle and Andrews, 1989:27) states that both religion and magic seem to satisfy an eternal 'psychic' or 'metaphysical' need of mankind for integration and harmony. Religion and magic are both logical in their own way, although not on the basis of empirical premises. Religion (*cf* 3.2.1.17), in turn, remains a social reality, regardless of First or Third World affiliation.

Even in Western cultures, evidence is found of magico-religious belief systems. For

example, Christian Scientists believe that physical healing can be affected by prayer alone (Boyle and Andrews, 1989:27). Laying on of hands and prayer, as an act of faith and healing, is commonly practised in the evangelical as well as the more orthodox Christian religions.

While characteristics of the traditional conception of illness include beliefs that humans are integral parts of an ordered system and that illness is the consequence of some disharmony within the cosmic order (Capra, 1982:335), traditional medication includes many empirically successful treatments that can be explained by Western medicine in a rational and scientific way (Coe, 1978:132).

Not only do medical systems constitute an integral part of the culture of a specific society but in every society the prevention of disease and treatment of illness follow, more or less logically, from beliefs about causation (Coe, 1978:133).

2.2.3.2 Treatment Regimes as Integral Part of the Belief System of Disease Causation

A mechanistic view of the human body precludes the incorporation of philosophical and existential issues within the treatment regimes of contemporary medicine. Treatment is focused on what is wrong. It is symptom or disease specific (Rappaport, 1980:83) as a result of which modern medicine achieves results more dependably than do other systems (Hammond-Tooke, 1989:151) in respect of the rational and the scientific. Con-

versely, traditional healers focus on questions concerning 'why' and address 'anxieties' associated with ill-health in efforts to treat symptoms. The traditional model incorporates a multiple factor concept of disease causation and thus treatment (Rappaport, 1980:83). For these reasons, treatment in Western medical systems is frequently regarded as specific or limited in nature, while that of traditional practitioners as holistic in character (Buhrmann, 1987:44; De Jong, 1991:4).

The conclusion that traditional African healing is holistic, is based on the fact that little distinction is made between body, mind and spirit in keeping with traditional world views. The whole person is treated (Green, 1988:1128). A patient's family and the healer often play a wider social role in the sense of religious, political and legal adviser or marriage counsellor, social worker and detective (De Jong, 1991:4). It is argued that because traditional practitioners know their patients as people and understand their social milieu, their ministrations are bound to be more effective (Hammond-Tooke, 1989:15). However, contemporary villages are modernising rapidly and rural-urban migration is reaching cataclysmic proportions (cf 4.2.5). In settings such as these, traditional practitioners may no longer be said to possess intimate knowledge of the family and community background (adapted from Foster, 1983:23).

On the face of it, it seems clear that there is little similarity between Western and traditional systems of medicine. However, to view the treatment of the former as non-religious and the latter as religious is problematic. In fact, many herbalists, bonesetters, midwives, *et cetera* may operate in a very instrumental purely functional fashion, while

both divination and related treatments could be analysed in terms of psychotherapeutic variables. A significant body of research in biomedicine reveals the positive results of the placebo effect or the fact that inactive substances given to patients, with the false claim that they are active drugs, have significant effects in making people better (Feierman, 1985:106). It is an error to read religious meanings into forms of healing that are not religious or to reduce the religious meaning of sacred healing to mechanical or clinical significance (Csordas and Kleinman, 1990:14; Rappaport, 1980:82).

Folk medicine is not the prerogative of traditional medicine. It has been widely practised throughout the Western world. Folk remedies, constituting the basis for prevention or treatment of ailments, are to be found in household medicines and old-fashioned remedies. They remain in common usage. Today, "... popular medicine is, in a sense, commercial folk medicine" (Spector, 1991:29).

The conventional distinction between scientific and technological and non-scientific and non-technological is particularly apparent in respect of diagnostic and treatment procedures. At the same time, recognisable artifacts are as essential for the Western clinician as for the traditional practitioner. Symbols such as impressive consulting rooms, stethoscopes, diplomas and white coats, all constitute part of a scientific image of power and authority. For the traditional practitioner, artifacts such as masks, animal horns, bones and drums, all serve to project the desired image of charisma (Rappaport, 1980:91). The perceived potency of the medical practitioner, regardless of world view, remains an essential part of the diagnostic and treatment model.

As a result of advances in the fields of sociology, psychology and psychiatry, Western medicine is increasingly paying attention to social and emotional variables in disease causation, while social change is affecting the way traditional practitioners operate. Many traditional practitioners are beginning to adopt the practices of modern health care. Such change reflects change in the content of traditional health care and increasing competition for modern health care providers. Traditional practitioners are also become increasingly professionalised (De Jong, 1991:8).

Although bio- and traditional medicine are based on radically different paradigms, it is important to understand that their practitioners do not constitute homogenous groupings. Each has many different specialities and treats different types of illness. Studies have revealed that people are pragmatic in their health seeking behaviour. They choose therapies which seem to be best for them during different stages of an illness (Good, *in*: Gesler, 1989:129) (cf 3.2.1.9). Beliefs and values underlie choices made in respect of course of action (cf 3.2.1.10).

2.2.3.3 Chains of Referral as Integral Part of Human Behaviour

Remarkably similar procedures are followed in both traditional and modern societies. It is in the folk and lay, or popular, sector that illness is first experienced, labelled and treated within a network of friends and/or family. Most health care takes place in this sector when symptoms are minimal and self-limiting. Decisions regarding the seeking of help and compliance are also made in this sector (Booyens, 1991:484).

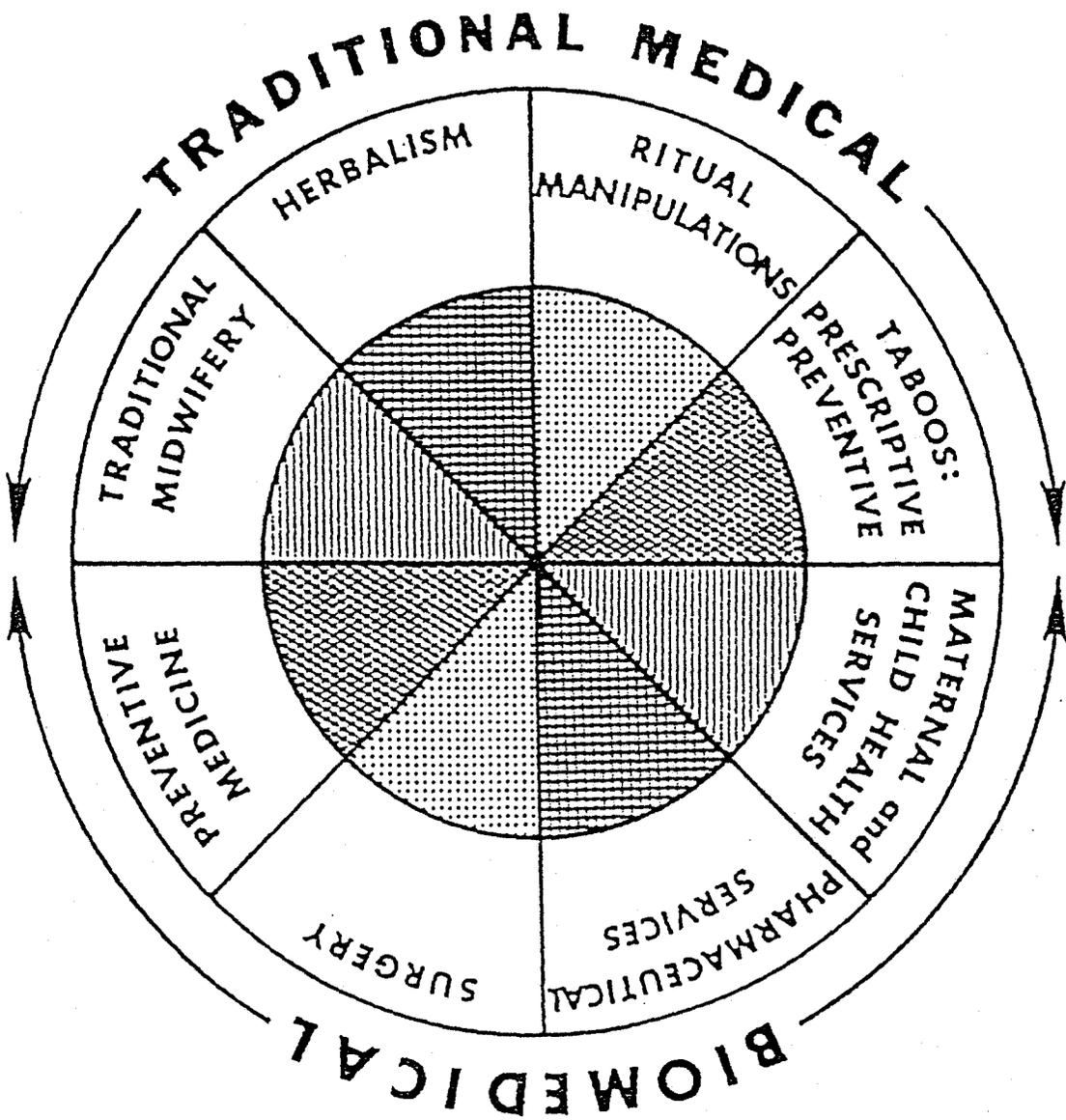
Remedies are closely linked to folk-lore and what is available. If symptoms become worse or new ones develop that cannot be identified, the individual in First World societies will seek the advice of close friends or family. He will make the ultimate decision concerning the course of action to be taken. In Third World societies, primary consensus is sought within the family and family support occurs automatically. Consultation with specialists then takes place, either as an individual or in family or community context (Coe, 1978:134; Conco, 1972:311-312). If the person is unresponsive, the diagnosis and treatment may be reviewed and alternative sources sought either in the direction of bio- or complementary medicine.

An increasing number of authors refer to the pluralistic nature of all medical systems in the world today (Hammond-Tooke, 1989:151; Wolffers, 1990:6; Ulin, 1980:1; Spring, 1980:58). Participation in medical systems sometimes overlap, coincide or are mutually exclusive. A conceptual framework that examines the relationship between biomedicine and traditional medicine may help to illustrate the complex interaction between the two medical systems within a given social group (Spring, 1980:58).

2.2.4 THE BIOMEDICAL TRADITIONAL RELATIONSHIP

The analogical model of the biomedical traditional relationship by HARRISON AND ULIN (in: Spring, 1980:59), as depicted on the next page, demonstrates quite clearly how each aspect of the biomedical system links up with the traditional system and *vice versa*.

Figure 1
Analogical Model of the
Biomedical-Traditional Relationship



Harrison and Ulin, n.d. (in: Spring 1980:59)

The diagramme distinguishes between the biomedical system with its components of maternal and child health, pharmaceutical, surgical and preventive services and the traditional system with its components of traditional midwifery, herbalism, ritual manipulations and preventive and prescriptive taboos . Herbalism corresponds with pharmaceutical services, traditional midwifery finds its counterpart in the area of child and maternal health; surgery correlates with manipulative rituals such as bone-setting, blood letting and removal of foreign objects and finally, taboos are related to preventive medicine (Spring, 1980:58). The prescription of appropriate and prohibition of inappropriate behaviour in respect of taboos may be linked with the prevention of disease in the biomedical model.

The components may not be viewed as polar opposites for a synthesis of both the traditional and the modern is feasible on grounds of the relative openness (cf 3.2.3.1; 3.2.1.5) of all social systems. In addition, regardless of the discrete observable differences between the two systems, the ground structures (cf 3.2) of human existence (cf 3.2.1.2) apply equally to both systems, in that the respective world views confer meaning (cf 3.2.1.5) to the human experience (cf 3.2.1.1) of health and disease within the situatedness (cf 3.2.1.2) of man's relatedness (cf 3.2.1.4) to his world. Man is, furthermore, a being in dependence on co-existential involvement (cf 3.2.1.8) with the members of his society. He is capable of responsible choice (cf 3.2.1.9) giving rise to the ontic characteristic of changeability within unchangeability (cf 3.2.1.13).

2.2.5 RÉSUMÉ

As a generalisation, it is possible to state that traditional medicine rests on a magico-religious foundation and features an all-embracing metaphysical theory of disease causation (Conco, 1972:289). It is a paradigm in which supernatural powers dominate. The fate of the world, and those in it, depends on the activities of a deity/deities or other supernatural forces for good or evil. In some instances, humans are at the mercy of such forces regardless of behaviour. In others, individuals are punished for their transgressions (Boyle and Andrews, 1989:26-27).

A broad outline of the traditional medical system illustrates that supernatural causes are invoked to explain illness, although natural causes are not totally excluded. Representative causes of illness have been shown to include the wrath of ancestral spirits, sorcery in the form of bewitchment and poisoning, spirit possession and a loss of basic equilibrium as a result of exposure to dangerous pollutants in the environment. The patient and his family carry joint responsibility with the practitioner for the cure.

It has been demonstrated that Western medicine views diseases as discrete entities which are open to treatment by means of material artefacts (Hahn, *in*: Feerman, 1985:108). It is a system which disavows the metaphysical (Boyle and Andrews, 1989:28). The frame of reference rests on a mechanistic view in which medical intervention (based on a scientific approach) is carried out with the aim of correcting a particular biological mechanism in a specific part of the body, with the different sub-systems (and/or age

groups) being treated by different specialists. The belief system embodies the notion that cure requires outside intervention through the medium of a practitioner, either in the form of chemicals, surgery or irradiation. It is a system in which the practitioner assumes both responsibility for and authority over the patient (Capra, *in*: Webster, 1989:25) in contravention of the andragogical categories of man as a being capable of responsible choice (cf 3.2.1.9) and one in possession of human dignity (cf 3.2.1.14).

The fact that prevailing causality beliefs lead inevitably and logically to the rationale behind diagnosis and treatment has been illustrated. Cultural values, beliefs and norms relating to health and illness directly influence allopathic and traditional medical systems, the role of practitioners and expectations of patients.

In broad perspective, certain features that traditional and biomedical systems hold in common have been highlighted together with a brief analysis of difference that stems from the mediating influence of culture. Significantly, even within the framework of an acknowledgement of the similarities in medical practice which are now beginning to emerge, no mention is made of the essential 'humanness' of all mankind and the anthropological ground structure of 'communality-in-diversity' (cf 3.2.1.16). These conclusions have been derived from the classification of scientifically accumulated recorded data.

In an attempt to reconcile the demands of the *agein* with the world situated reality of health education in cross cultural encounters, it becomes necessary to reach an empirical

understanding of the historical background of the emergence of health education as a national priority in the delivery of health care in South Africa. Such insights should contribute towards attempts to gain some clarity about the aims (cf 2.4.2) of health education without which guidelines for authentic health education in cross cultural encounters cannot be formulated.

2.3 A HISTORICAL OVERVIEW OF THE CHANGING FOCUS OF MEDICAL CARE AND PUBLIC HEALTH

As far as health care systems in South Africa are concerned, the reality comprises "... a mixed bag of different and incongruent practices and beliefs" (Booyens, 1991:490). Although the health care system has been constructed, both officially and legally, around scientific modern medicine, it has not been accepted as the only health resource (Booyens, 1991:490).

The contextual framework for understanding the different systems of medicine which exist and co-exist, and the place of health education within these systems, goes beyond the realms of culture, traditions and beliefs. Historically derived situational realities are important factors in the facilitation of cross cultural understanding. The economical and political forces which shaped this country's history also established the framework within which medical services emerged (Feierman, 1985:73). A particular trend or drift in health care was laid down decades and, even centuries ago, and with it, the sedimentation of several structural features and problems (Van Rensburg, 1991:1).

2.3.1 THE DEVELOPMENT OF HEALTH CARE IN SUB-SAHARAN AFRICA IN TIME PERSPECTIVE

The development of health care in South Africa cannot be separated from sub-Saharan Africa as a whole. In Africa, the pre-colonial era was a period when traditional practitioners were the sole guardians of the health of the people. They practised their arts in a fashion unrestricted by external forces. Knowledge was passed on through initiation rites and instruction within the same family or clan. Techniques of diagnosis and treatment were kept secret. The only available information has been derived from the inevitably fragmentary reports of early missionaries and explorers (Ramanohisoa, 1983:210).

FEIERMAN (1985:116-118) argues that although there is "... no one characteristic African pattern", a review of the history of healing over the last one and a half centuries reveals that some categories of traditional healers played a fundamental role in organising production during the pre-colonial period, while others were organically linked to the holders of political power or held such power themselves. Healing authority was institutionalised within a limitless range of gradations. Healing was bound up with basic economic and political processes with healers exercising their authority to defend personal interests and those of their allies. According to FEIERMAN (1985:118), institutions for the maintenance of health were, therefore, neither "... impartial or class-neutral". It was an era during which questions pertaining to cultural hegemony (2.3.5) did not constitute part of the existing social reality.

In respect of public health, MAIER (*in*: Feierman, 1985:118) demonstrates a coherent and strong argument for the existence of public control of health in pre-colonial Africa. Living together in large populations, African people had readily available sources of food, water and shelter and possessed an organised social system that regulated aspects such as disposal of refuse and night soil. While people, such as the Zulus, may not have had codified laws of collective hygiene or positive postulated principles concerning public health, rules and regulations governing concepts of public health were entwined and enmeshed in a code of living embodying a complex set of socio-magico-religious beliefs referred to as taboos. Taboos, as a system of avoidances, have served to regulate human conduct through time, to ensure a healthy whole being: physically, morally and spiritually (Gumede, 1990:127-128).

The colonial period was marked by the introduction of the culture of the colonial powers in respect of technology, religion and medicine. The prime aim of Western medicine was to cater for the interests of the colonists in urban areas or in centres associated with colonial enterprises such as mining or agriculture. Priority was given to the health of the troops, civil servants and native labour. Health work was also carried out by the more widely based denominational missions (Ramanohisoa, 1983:210).

Traditional healing was repressed by the authorities by means of severe punishment and negation of public authority. Traditional healers, removed from power and forced to abandon all expectations concerning the control of public health, continued their activities, without the knowledge of the authorities, through the tacit agreement of the

people (Feierman, 1985:118-119; Ramanohisoa, 1983:210). The foundation was laid for the co-existence of two parallel forms of medical care. A small proportion of the population had access to the official form, while the traditional system was used by the bulk of the population in remote rural areas (Ramanohisoa, 1983:210).

2.3.2 THE SCOPE AND PRACTICE OF PREVENTIVE MEDICINE

The early period of colonialism in Africa coincided with preventive health moves in the industrial world during the last century. These moves were directed mainly toward improving sanitary conditions, but did not involve the general public in direct action. Through the diffusion of health related information to administrators, politicians, professional experts and the middle classes, pressure groups ensured the passage of public health legislation in the towns and cities of Europe. Some of this legislation and these laws were exported to the colonies. There was, however, no question of community participation and the public remained passive recipients of environmental services (Walt and Constantinides, 1984:3). This period may be regarded as one of sanitary reforms in Europe and America covering the years between 1840 and 1900 (Ashton, 1991:40).

Although representing the colonial powers, little attention has been paid to the role of military medicine, the practise of which laid the pattern for the subsequent structure and organisation of health systems in Africa. The earliest doctors in most of colonial Africa were military doctors serving the state. Their main responsibility was for the health of

soldiers, followed by service to a widening circle of other government employees, other whites, Africans employed by the government and African prisoners. Military medicine tended to treat epidemic but not endemic diseases and to establish enclaves where tight environmental control was enforced. The basis for the development of future medical services was hereby established. Because colonial health services had, as their earliest mission, the protection of the health of whites, medical services were provided in the cities (cf 4.2.5), not the countryside, for the rich and not the poor (cf 4.2.3). The problems of women (cf 4.2.6) and children were largely ignored unless they were the wives and children of the military. The cities did, however, become centres for meeting the health care needs of large numbers of Africans involved in the process of production. Mission medicine, thinly spread in the hinterland, was frequently expected to offer services for women, children and the poor (Feierman, 1985:120-123).

Between 1880 and 1930, advances in the fields of immunisation and bacteriology created notable opportunities for preventive medical action at the personal level. Some recognition was given to the need for behavioural change in health matters. However, with the advent of the sulphonamides, antimicrobials and insulin, together with the explosion of other therapeutic possibilities (Ashton, 1991:40) that extended opportunities for medical intervention (Walt and Constantinides, 1984:3), this preventive phase was eclipsed by a curative or therapeutic era from 1930 to 1974 (Ashton, 1991:40).

2.3.3 THE SCOPE AND PRACTICE OF THERAPEUTIC MEDICINE

As medicine became grounded in exact scientific chemical procedures, the focus moved from the preventive public health measures of the nineteenth century to the curative systems of the twentieth century. Emphasis shifted from the public, in general, to individuals. Medical technology contributed toward the power and strength of the modern medical profession and an undermining of the role of family and traditional health practices (Walt and Constantinides, 1984:3). Most traditional and alternative forms of health care were, in due course, displaced by the powerful processes of scientification, westernisation, and professionalisation (Van Rensburg, 1991:2). The duty of the physician in the social context was to reduce symptoms by means of diagnosis and treatment and to encourage patients to view themselves as on the path to recovery (Finnegan and Viswanath, 1990:17). Historically, the therapeutic phase marked a weakening of the role of general medical practitioners and public health departments and a shift of resources and power to hospital based services (Ashton, 1991:40).

The focus of health education remained on the individual as in the pre-therapeutic era, but began to endorse the notion of individual responsibility. The prevailing philosophy underpinning health education was that through the provision of information, people would gain knowledge which, in turn, would cause them to change their health related attitudes and, ultimately, their behaviour. Responsibility for behavioural change was placed on the individual. Failure to change resulted in 'victim-blaming' or holding individuals accountable for circumstances over which they had no control (Walt and

Constantinides, 1984:4-5).

During the late 1960's and early 1970's there was growing concern regarding the escalating costs of medical care systems throughout the world (Ashton, 1991:40). Further areas of concern included a growing awareness of polarisation between technological and humanistic advances with a consequential fragmentation and dehumanisation of health care; an increasing dependency on health professions with the concomitant ability of the medical system to manage ever expanding events pertaining to life and death; the growth of consumerism and a belief that neither the goodwill or expertise of the medical profession could be taken on trust (Lowenberg, 1989:53-64). Gradually, it became evident that technical solutions to disease were not always the answer and that the relationship between health and mere knowledge was more complex than had been implied. Focus shifted once again to prevention rather than cure (Walt and Constantinides 1984:4-5) and was accompanied by a growing awareness that improvements in health stem from policy changes in sectors of everyday life other than medical care (Ashton, 1991:41).

2.3.4 THE RE-EMERGENCE OF PREVENTIVE MEDICINE

In Europe and the United States, the post-therapeutic period ran a parallel course with the emergence of independence by the majority of sub-Saharan African states. During the liberation struggles, fighters required their own medical care. At the same time, constraints developed between supporting populations and official government services.

A secondary, but important, concern of the freedom forces became the provision of adequate health services to those receiving inadequate care. In order to serve both sectors, all available medical methods and materials, including traditional approaches, were used (Elling, 1981:95-96). Co-existence and diffusion of cultural traits from biomedical, traditional and even lay health systems was hereby ensured. Health care systems are, in the final analysis "... dynamic inter- and intra-cultural processes" (Booyens, 1991:486).

Medical frames of reference began to change from individual and highly specialised medical systems to those involving community care and community responsibility. Realisation dawned that to ignore the interdependence of human beings, their habitat and their environment becomes a threat to man's very existence (cf 5.3.2.2). Today, this issue is highly ranked on global political agendas as new policies are sought for preventive medicine (Ashton, 1991:41). The question of health education is no longer merely a health matter, but one of social economic and political significance (cf 2.3.4.1; 2.3.6.3). Education and health have become central themes in the ideological and political positioning of nations and interest groups in respect of the socio-economic gap which exists between the First and Third Worlds and between the 'haves' and 'have-nots' in every society (cf 2.3.6.4).

First World approaches to the problem include encouraging higher growth and productivity levels in less developed countries and fostering an awareness of the mutuality of common interests in a global society. Concepts of equity, social justice and humani-

tarianism are integral to the approach and are reflected pragmatically in phrases such as "... a better distribution of resources within a mutually beneficial sharing process" (Navarro, 1984:469). An alternative position, more commonly found in Third World countries and in sub-cultures of poverty, is that a basic conflict is intrinsic to the current world system: a conflict that takes place and is explained within a pattern of class and power relations. It is postulated that class relations and exploitation of those without power are at the root of the poverty, underdevelopment and disease experienced by the majority of the world's population (Navarro, 1984:469) (cf 2.3.5). Both positions have a direct bearing on global ideologies in respect of health care and education systems. Therefore, it may be deduced that both will have a bearing on health education.

Both of the above ideological approaches have a bearing on what have come to be known as the 'Alma Ata Declaration' (WHO: 1978) and the 'Ottawa Charter for Health Promotion' (WHO:1986) which are grounded in the concept of PHC. The former, according to NAVARRO (1984:472-473), rests on principles of co-operation dependent on a First World linear analysis of variables and interventions without reference to the structural elements of the society in which they occur. Conversely, ideologies stemming from Third World nations rest on those of cultural hegemony and are reflected in the Ottawa Charter as a broad empowerment socio-ecological model (Reddy and Tobias, 1994: 21-23). The concepts of PHC and cultural hegemony require further elucidation.

2.3.4.1 Primary Health Care

FERRINHO (1993:36-37) succinctly summarises the emergence of the concept of PHC. During the 1960's and 1970's, WHO played a key role in the development of concepts associated with PHC. As a result of the failure of many health programmes, WHO became aware of the world-wide lack of superstructures to support basic health services. Ensuing debates resulted in the World Health Assembly coining the term 'primary health care' in 1975. A number of principles, summarised below, were accepted.

- * Health is dependent only in small measure, on medical services.**
- * Health systems and politics are inextricably linked.**
- * Health and national development are mutually interdependent.**
- * Community participation in the health system is vital.**
- * Health care systems must remain accountable to the community.**
- * Universal access to all levels of health care must be assured.**

It had become clear that improvements within the social and economic conditions of people are essential to improving health care. This realisation led to the convening of an international conference on PHC in Alma-Ata from which the declaration of Alma-Ata emerged (Welman, 1994:1). The declaration (in: Ferrinho, 1993:37; WHO, 1978:2-6) defined health as a social goal to be achieved, in the spirit of social justice, as part of

development. Therefore, by implication, PHC involves not only the health sector, but all related aspects of national and community development. It is at this point that PHC and community development converge in so far as PHC is a community orientated developmental activity that requires all sectors within a given society or community to work together closely and harmoniously for a common purpose (Mutalik, 1983:286).

The notion of essential health care, as embodied in the concept of PHC, includes the promotion of proper nutrition, adequate supplies of safe water, basic sanitation, maternal and child health care, immunisation against major infectious diseases, prevention and control of local endemic disease, health education and treatment of minor ailments and injuries (Knight, 1990:21). PHC has been acclaimed as a universally acceptable plan of action for health on a global basis. It may be described as

"... essential health care based on practical, scientifically sound and socially acceptable methods and technology made universally accessible to individuals and families in the community (by a means acceptable to them), through their full participation and at a cost that the community and country can afford to maintain at every stage of their development in the spirit of self-reliance and self-determination" (Declaration of Alma-Ata, in: WHO, 1978:3 with insert by Knight, 1990:21).

Community development by way of contrast is the

"... process through which people realize the intelligent management of their interaction with the ecosystem to achieve a better social life in a continuing and lasting way" (Ferrinho, 1993:37).

Progress in disseminating the ideas and practice of PHC was generally slow and led to a growing awareness that public access to health care remained inadequate. The Ottawa Conference was primarily a response to growing expectations regarding the development of global strategies and actions that would advance the progress of health for all by the year 2000 (WHO, 1986:n.p; Welman, 1994:1-2). Delegates committed themselves to advocating

"... a clear political commitment to health and equity in all sectors, to respond to 'the health gap' within and between societies by tackling inequities in health, and to recognize health and its maintenance as a major social investment and challenge" (WHO, 1991:4).

The strategy that evolved was one of health promotion in which the conceptualisation of health entailed a shift in emphasis to include social, political, economic and educational activities and an acknowledgement that interactions between these systems are not unilinear (Reddy and Tobias, 1994:21). The notion of PHC is placed in a wider context through an acknowledgement that health promotion is the process whereby people are enabled "... to increase control over, and to improve, their health" (WHO, 1986:n.p).

The goal of health for all can be realised by promoting healthy lifestyles and community action as well as by creating conditions that make it possible to live a healthy life. The former entails empowering people with knowledge and skills needed for healthy living, while the latter requires influencing policy makers in the direction of health-supportive public policies and programmes. Both need strong social support to maintain and

accelerate health action (WHO, 1991:6). The linchpin for health promotion lies in the successful implementation of health education in all its various dimensions. Education for health empowers through the development of motivation, understanding and skills (Green and Kreuter, 1991:xviii).

The notions of empowerment, community action and creation of supportive environments have their roots in the concept of hegemony and come to the fore in education, health care and the entwined phenomenon of health education.

2.3.5 HEGEMONY

The term 'hegemony' means leadership and control by one country over others within a group either culturally, economically or militarily (Oxford Advanced Learner's Dictionary 1995:553) but has come to assume a more general meaning of the predominance of a nation or group of nations within a given area (New Encyclopaedia Britannica, 1973-1974:991).

Two names, in particular, come to the fore in an analysis of the role of culture and education in the maintenance of domination by elite groups of people over whom they hold power (Alfred, 1984:106). The names are those of Gramsci and Freire.

2.3.5.1 Antonio Gramsci

"... Gramsci was a profound student of the relationship between knowledge and power" (Feierman, 1985:113). GRAMSCI (1971:103) states that, at all levels, scholastic activity has great significance for social structures, economics and intellectuals of all degrees. He used the concept of hegemony to examine the precise cultural, political and ideological forms through which any specific class, in a given society, is able to establish its leadership as distinct from more coercive forms of domination (Bennett et al., 1981:187, Gramsci, 1971:55-61, 80). The hegemony of the dominant group refers not only to the political and economic control exercised throughout society, but to a general acquiescence, expressed spontaneously, by the mass of people in respect of an internalised world view which has not yet gained consciousness of its possibilities and strengths or of how it may develop. It embodies the belief that what exists is natural, should exist and cannot do otherwise than exist (Gramsci, 1971:157, 159; Jones, 1984:63).

While it remains an irreducible fact that rulers or leaders exist, as do the ruled and the led, it is understood that divisions between the two are neither universal nor granted to the continued rule of a given class. Hegemony is a matter of the balance that is struck between contending groups or classes. It is a historical process which may be viewed as a relation of forces, including social, political, military and economic forces, that are either favourable or unfavourable to this or that tendency of the same problem. At a certain point in historical time, social classes become detached from their traditional

organisational structures which then manifest in situations of conflict or a crisis of authority. Conflict and the character of class can only be established by looking at concrete situations and historical moments (Gramsci, 1971:55, 144-145, 180-184, 210-211). In relation to the hegemony of the dominant class, the working class, by definition, becomes a subordinate social and cultural formation (Benett et al., 1981:61).

Although Gramsci did not focus his attention on Africa, health or doctors, it is not surprising that his work has been linked to questions relating to the degree to which health systems serve the interests of the dominant classes within society as well as to the place of health professionals within the structure of class, production and power (Feierman, 1985:113-114).

GRAMSCI (1971:4, 33-35, 258, 342, 350), in his preoccupation with education, stresses the democratic nature of the intellectual function as well as the class character of the formation of intellectuals through schooling. According to JONES (1984:65), Gramsci viewed the change in and challenge to cultural hegemony as arising principally through education, more specifically through adult education, which he saw as politically motivated.

While Gramsci highlighted the significance of the dominant culture in the industrialised world, Freire notes similar conditions operating in the colonized countries of the Third World (Jarvis, 1985:112).

2.3.5.2 Paulo Freire

EWERT (1989:89) succinctly summarises the philosophy of Freire. Disadvantaged people are trapped in a 'culture of silence' in which they lose hope and internalise the low opinion society holds of them. However, through an act of critical reflection (cf 5.3.2.7) and the discovering of a new consciousness, people are able to define and address specific problems by proposing particular courses of action. They then gain a new belief in their own capacity to transform the conditions in which they live. Learners become conscious of the forces controlling their lives and become empowered to act. Such actions are often political thereby making government agencies responsive to their needs (Shaull, *in*: Freire, 1978:12).

The social significance of Freire's educational philosophy is that education is viewed as the means whereby people are enabled to deal creatively and critically with reality and discover how to participate in transforming their world (Shaull, *in*: Freire, 1978:14). It is a philosophy of social change, in which a radical link is drawn between education and politics.

Freire's view of man, knowledge and education is that "... every educational practice implies a concept of man and the world" (Stanley, 1973:62). It was his involvement in adult literacy programmes in Brazil that spurred FREIRE (*in*: Alfred, 1984:105) to create a powerful and wide ranging theory of man, knowledge and education in which concepts of democracy (Freire, 1978:20-33; *in*: Pai, 1990:15), conscientization (Freire,

1978:15, 71-77), praxis (Freire, 1978:60-67) and dialogue (Freire, 1978:50-57; Shor and Freire, 1987:12-24) play a central role.

FREIRE (1978:45-54) refutes conventional educational aims and methods of education claiming that they are based on a banking model of education which does not admit of partnership between educator and students, thereby negating education and knowledge as a process of inquiry. Implicit in the banking system is the assumption of a dichotomy between man and the world: an assumption that implies 'man in possession of a consciousness' as opposed to 'man as consciousness' *with* and not merely *in* the world. Such an option negates man's ontological vocation to become more fully human and manifests in the dehumanisation of human beings, frequently in the form of oppression.

FREIRE (1978:56) views education not as a static reality but as a dynamic process: a reality in transformation based on the actions of people as a function of how they perceive themselves in the world. Through education, man should be enabled to critically perceive 'the way he exists' in the world 'with which' and 'in which' he finds himself in order to open up critical issues affecting his life (cf. 3.2.1.2). Together with the educator, he reflects simultaneously on himself and the world as he perceives it, without dichotomising reflection from action. An authentic form of thought and action is hereby established. In these terms, knowledge can not be transferred from one person to another, neither can it be said to exist when used as a means of dominating others. Knowledge arises from praxis or the mutual interaction between thinking and doing where man creates knowledge through his own agency and continual experimentation

(Alfred, 1984:106).

The aim of Freire's model of education is to:

"... support the openness of knowledge through dialogue between human subjects mutually engaged in the 'act of knowing'. Both educator and educated are equal 'cognitive subjects' The object of education is the recognition of problems to be posed through critical reflection of the experience of *all* the participants, not the solution to problems which implies a static view of knowledge which some possess and others not" (Alfred, 1984:106).

Freire's theory of education is characterised by dialogue as method, problem posing as content and generative themes relating to the contextual reality of peoples lives which, when analysed critically, make possible a new critical attitude toward limiting factors in the situatedness of man's existence which then become the starting point for cultural action or capacity building (Alfred, 1984:106-107; Freire, 1978:76-77).

The brief discussion of the work of Gramsci and Freire leads inevitably to an elucidation of the concept of adult education in the mode of enabling human beings to gain control of crucial factors that may affect their health status. Before undertaking this task, it becomes necessary to evaluate how global colonial historical trends and the concepts of PHC and cultural hegemony interact and impact on the development of health care systems in South Africa thereby creating the present social reality.

2.3.6 THE DEVELOPMENT OF HEALTH CARE IN SOUTH AFRICA IN TIME PERSPECTIVE

In presenting a global account of the emergence of the health system in South Africa, it will be demonstrated that while the system holds many of its traditions in common with the West and the rest of sub-Saharan Africa, it possesses many facets of its own making which are unique and linked to the history of the people who shaped it (Arthur, 1992:172) and continue to shape it.

2.3.6.1 A Historical Overview of Health Care in South Africa

The organisation of health care in South Africa is well illustrated by what SAVAGE (1979:148) refers to as the 'Law of Inverse Medical Care'. By this he means that the availability of services tends towards an inverse correlation with the needs of the population served. This situation is reflected in a maldistribution of medical officers, health facilities and other health resources in respect of specific population groups, rural and urban areas, preventive and curative services and the public and private sector. In reality, facilities and resources are directed toward affluent, white urban dwellers with curative and hospital services having preference in the allocation of resources (Fourie, 1989:130-131).

The roots of this situation are clearly discernable in the general history of the early days of the colonial period and military medicine. These roots are also to be found in the

process of urbanisation which, in turn, was related to socio-cultural and political change, commencing with the British settlers, followed by Afrikaner urbanisation in the 1930's and that of the Asians and Coloureds in the 1950's and 1960's respectively. Currently, the Black population, until recently prevented from moving to urban centres by influx control laws, is experiencing accelerated urbanisation (Yach et al., 1991:413).

From 1652 when colonisation of South Africa began until 1919, after a serious influenza epidemic, health services received scant attention. Hospitals were founded intermittently for limited and specific purposes on the basis of racial segregation. Medical practice was somewhat primitive and those who could afford it were treated at home. When the four colonies became provinces under the Act of Union in 1910, no mention was made of health services other than to make the administration of hospitals a provincial responsibility. With the development of modern medical technology, hospitals came to be regarded as places where patients received the best possible treatment under the safest conditions. Today, this assumption is coming under increasingly close scrutiny (De Beer, 1986:16-18).

The scene was set for the development of an apartheid society during the first decade of this century when the British Parliamentary Act of Union gave Whites the right to self-determination and removed the right of Blacks to sit in Parliament. With the growth of Afrikaner nationalism, political and economic power, particularly after the National Party won the election in 1948, apartheid flourished. The following four decades were characterised by an ongoing promulgation of legislation that discriminated heavily against the

black people of South Africa (Benatar, 1992:295) in every aspect of their lives including education and health care.

Black opposition movements came into being in 1912 with the founding of the African National Congress (ANC). Significant milestones include the ANC's defiance campaign of 1952, adoption of the Freedom Charter of 1955, the Sharpeville demonstrations of 1960, banning of the ANC and Pan African Congress and introduction of detention without trial in 1963, the conviction and imprisonment of Nelson Mandela in 1964, his release in 1990 (and inauguration as President of South Africa after the democratic election in 1994). Black opposition has evolved from powerful yet peaceful protest into a vigorous political process of potentially peaceful change that is hampered by a growing culture of group and individual violence (Benatar, 1992:295).

Parallel to these developments, South Africa was singled out for opprobrium for its apartheid policies and poor record of human rights, with consequential isolation and economic attrition. As a result the economic growth rate declined from 5,5% prior to 1974 to 1-2% in 1992 (Benatar, 1992:296).

It is against this background that the intense debate surrounding strategies for change are now being transformed into the reality of implementing change (Benatar, 1992:297): a reality in which health education should assume its vital strategic position as authentic education.

2.3.6.2 An Overview of Health Care Policy in South Africa

During the colonial period, as in the rest of sub-Saharan Africa, health care was provided on an *ad hoc* basis, either privately through the agency of the colonial power or by philanthropic organisations. Traditional African medicine continued to exist, standing in juxtaposition to Western medicine by which it was ignored and dismissed. Consequently, two divergent health and medical cultures emerged in which the Western model has come to dominate (Benatar, 1990:441 and 1991:213).

The promulgation of the Health Act of 1919 set the course for the structural features of the current health system in which

- * the tenets of Western medicine have been spread and legitimised amidst continued demands for traditional and alternative health care;
- * health care is provided by a medical profession which retains hegemony over such care in super specialised large hospitals at great cost and at the expense of primary, preventive and community health care;
- * health services have been fragmented structurally, functionally and geographically resulting in rural-urban and racial disparities in the provision of health care; and

- * a complex public sector and equally complex private sector exist side by side: the former characterised by fragmentation and state acknowledged responsibility for the poor, aged and academic teaching hospitals, while the latter has strengthened under the influence of a system tending toward market forces and capitalism and one in which the concept of self-reliance rather than social responsibility is emphasized (Van Rensburg, 1991:2-4).

It should be noted that the system of traditional medicine is largely organised and controlled by tradition. However, present day practitioners consider it desirable to obtain acknowledgement of their skills through the Society of Sangomas which issues certificates of competency (Van Rensburg and Mans, 1987:194-195).

As early as 1942, attempts were made to change the direction of health and social practice in South Africa. A National Health Services Commission was appointed under the chairmanship of Dr Gluckman. The Report, published in 1944, highlighted the unacceptable level of disease throughout the country, the lack of coordination and shortage of services, the problems associated with private practice in relation to the needs of the great mass of people and the need for preventive as opposed to curative measures. The proposals, although applauded, were not carried out (De Beer, 1986:18-20; Mills, 1988:13).

An acknowledgement of the need to develop primary and community health services was reflected in the Health Act of 1977 and the National Health Facilities Plan of 1980

(Benatar, 1990:441). The Health Act was proclaimed as a serious attempt to improve the health services while the Health Plan provided details of how improvements should take place. Both subscribed to the enlightened notions of preventive medicine and community health. The Health Plan recognised four main requirements fundamental to the provision of a basic level of health. These included access to safe drinking water, sufficient nutritious food, sewerage and waste disposal and adequate housing. Further proposals included limiting the size and number of hospitals and the establishment of a network of community centres (De Beer, 1986:37-39). However, insufficient funds were injected into a badly planned health care system (Benatar, 1990:441). Responsibility for the provision of the basic necessities for health was placed on local authorities, administration boards, the Departments of Agriculture and Community Development and the private sector. The Health Plan stressed the role of voluntary organisations in the provision of basic levels of health care and the official guide to the Health Act of 1977, the idea of community participation. The implication being that the community must look after itself in the absence of state assistance (De Beer, 1986:39-40).

VAN RENSBURG (1991:4-5) describes most changes within the health system, including the more recent ones, as being evolutionary in a uniform direction that sustained and fortified the major structural disparities identified as marked differences in expenditure on preventive and curative services and in the *per capita* expenditure on different population groups.

On a socio-political level, there is a growing universal recognition of the fact that health,

ill-health and medical care are collective matters and that society has a responsibility for the health and welfare of all its people. It is acknowledged that any society which does not meet the first order biological needs of its people for food, water, clothing, shelter and sanitation as well as the second order needs for health care, education and the franchise, will generate a growing disadvantaged class and an escalation of violence (Benatar, 1991:214).

2.3.6.3 An Overview of the Emergence of Primary Health Care in South Africa

Historically, the seeds of the concept of PHC are to be found in the Gluckman Report on Health Services of 1944. South African medical science, however, turned almost exclusively to teaching hospitals and laboratories as health workers, seeking recognition, concentrated on urban First World problems with the result that the early initiatives of PHC "... spluttered and died" (Gear, 1989:1353).

South Africa, a founder and active member of WHO, had already been expelled from the body at the time of the Alma Ata statement. As a result, the country became increasingly isolated from mainstream global developments in public health, but maintained and strengthened links in the field of clinical medicine. Consequently, the most technologically sophisticated approaches to patient care were increasingly practised and global strategies for public health, as promoted by WHO, largely ignored (Yach, et al., 1989:1309). Clinic services, dependent solely on professional doctors and nurses, were not founded on the principle of empowering communities to deal with their

problems collectively (Kelly, 1988:127).

Non-governmental organisations in PHC work tended to be suspicious of liaison with or participation in official health structures. Reasons given included a fear of being co-opted into bureaucratic structures which would then render community participation in health services null and void, the undemocratic nature and perceived illegitimacy of official bodies and an unwillingness on the part of the state to recognise existing efforts (Kelly, 1988:127-128).

By way of contrast, according to MAHLER (in: Wolfers 1990:preface),

"Primary Health Care has been accepted as the most relevant policy basis for developing strategies towards improving the health of the global population in the spirit of equity inherent in the vision of 'health for all by the year 2000' ... 'Health for all' implies involvement for everybody: not a health care system for the sake of health alone but for the sake of the people. It means an integrated approach based on priorities understood and felt by people, which may often be in conflict with the priorities set by health care staff".

If what has occurred in South Africa is analysed against the above statement, it may be deduced that the health authorities, medical schools, nursing colleges and professional councils have failed to respond to client and community aspirations in the pursuit of technical excellence. In failing to promote the non-technical aspects of PHC, the official health system has denied people opportunities for self-determination and self-reliance which are inherent in the concept of community development (Gear, 1989:1354).

In reaction to the prevailing situation, concerned health workers, recognising that the essence of PHC lies in the fact that it is a health strategy and not a system, coined the term progressive primary health care (PPHC) to set themselves apart from the official interpretation of PHC by the State (Gear, 1989:1354; Wolffers, 1990:3). If PHC is essential health care that is universally accessible and acceptable to individuals and families within the community at a cost they can afford and arrived at through their own participation (Wolffers, 1990:4), then according to GEAR (1989:1354), PPHC is about priorities, sharing, consultation, participation, redistribution and political will. It is a concept related to a change in life-style of all South Africans. Effecting life-style change, in turn, is related to the acquisition of knowledge, development of new attitudes and behavioural change (cf 1.2.2).

In the parallel time span, health emerged as a political issue because it is materially inseparable from problems such as education, housing and environmental issues requiring urgent redress (Kelly, 1988:115). PPHC networks, comprising five regions, were organised countrywide. Each region incorporated various groups, often displaying somewhat differing political perspectives. The PPHC concept at this level involved attempts to develop and co-ordinate the efforts of civic organisations into a coherent national body with the ultimate goal of transforming the country's health system into "... a national health service structured on democratic control at the local level ..." (Kelly, 1988:129).

Currently, "South Africa stands on the brink of major social and political changes" (De

Beer and Broomberg, 1990:119). Subsequent to the ANC gaining political power after the April 1994 elections, the health care system is evolving in the direction of equity in the provision of health care services and community participation.

Whether in terms of education or health care, the notion of empowering people to assume control over the circumstances of their lives has been gaining momentum. The concept of empowerment as political ideology, or as an enabling educative event, co-exist within a narrow divide: all that separates them is realisation of agogical criteria against which the education event can be measured.

2.3.6.4 The Health Care Policy in South Africa Today

The vision for health care in South Africa is laid down in a National Health Care Plan prepared by the ANC (1994(a)). The plan is based on the Primary Health Care approach. PHC is to form an integral part of the National Health System (NHS) and the overall economic and social development of communities in keeping with international thinking and practice (ANC, 1994(a):9, 59).

The aim is the total transformation of the health sector in South Africa (ANC, 1994(a):7) which, in turn, is congruent with the basic principles and key programmes of the RDP with its special emphasis on education, health, social welfare, housing, job creation, democratisation and basic services such as water, electricity, telecommunications, transport and a safe and clean environment (ANC, 1994(b):4-13).

While the State is to assume responsibility for a single comprehensive, integrated and equitable NHS within which health will be promoted and health care delivered, one of the aims of the Plan is to decentralise management of the health services to provinces, districts and institutions with a view to increasing efficiency, empowerment, accountability and local innovation. The structures for the Provincial Health Authorities of the nine provinces are already in place while those of the District Health Authorities (DHA) are in an advanced stage of planning. The DHA's are to constitute an integral part of local authorities and will be accountable to elected political authorities (ANC, 1994(a):9, 59, 62, 65).

Community Health Services, providing comprehensive health care, including promotive, preventive, curative and rehabilitative services to individuals, families and communities, will be part of the District Health Systems (ANC, 1994(a):9, 59-62). Emphasis is laid on the fact that "... promotion and protection of health constitutes a major component ... of every health activity ..." and that "... healthy living and healthy lifestyle rather than curative care ...", is the main thrust of the plan (ANC, 1994(a):33). To this end, education is stressed as one of the mechanisms whereby the health policies of 13 of 23 priority health issues can be implemented: Education as an aspect of health promotion is implied in two more areas. The issues identified are care of the elderly, control of communicable and non-communicable disease, disaster preparedness and humanitarian action, environmental health, health promotion, HIV/AIDS and sexually transmitted diseases, maternal and child health, mental health, nutrition, occupational health, oral health, palliative care and rehabilitation (ANC, 1994(a):33-57).

The constitutional framework within which the restructuring of the Health Services will take place is embodied in the Constitution of the Republic of South Africa (Act 200 of 1993). Health legislation is in the process of being promulgated by the Government of National Unity with a view to implementing the recommendations embodied in the National Health Care Plan.

2.3.7 RÉSUMÉ

The brief historical overview reveals that nations, like individuals, do not stand alone and that from the earliest days of African colonisation by Western nations, South Africa's health and medical history has been shaped by events occurring in the West and subsequently shared by the rest of sub-Saharan Africa. Within the context of communal experience, the unique socio-political position of South Africa has been demonstrated.

It has been shown that the seeds of PHC were sown almost two centuries ago in calls for improved environmental sanitation. PHC, today, includes the notion of improving the total situation of communities. Such improvements are recognised as being consequential to basic changes in the social and economic situation of specific groups and related to issues of equal access to available resources and social justice (Heggenhougen, 1984:217).

During the past three decades, the most significant development in health care in the developing world lies in an acknowledgment that a society's health care programme must

be designed within the context of its economic, social, cultural and educational milieu. Acceptance of this notion has resulted in a changing focus in terms of health care planning - away from strategies simulating Western models to those favouring primary and family health care and preventive and community medicine (Smilkstein, 1982:386-387).

As health care continues to be an increasingly important political issue in South Africa, it appears that the thrust will be away from sophisticated complicated curative systems which are available to only limited segments of the population, to those systems in which the need is met for cheap, easily organised, preventive services that are available and accessible to large sections of the population (Smilkstein, 1982:387). It becomes increasingly clear that such a health care system cannot be achieved through services delivered by technically competent health workers alone, at whatever level, nor by means of clinical treatment or injections. It requires change within the structure of the community itself and active engagement on the part of the people themselves (Heggenhougen, 1984:218) in conjunction with efforts to enable people to build the necessary capacities to improve their health status.

The elucidation of the history of health care in South Africa has been necessary because it clarifies differences in world view which will increasingly emerge as health practitioners, functioning within the public and private health sectors under the old regime, confront the existence within the new order, of an overriding view of the world in which concepts of cultural hegemony, PHC and community development play a significant role.

In compliance with the ground structure of man as historicity (cf 3.2.1.12), just as the historical events over the last three and a half centuries culminated in the socio-political and health systems of the apartheid era, so it may be deduced that the present points to a future in which the principles of liberal education will increasingly come to the fore.

This social reality, in respect of health education, leaves little room for philosophising about the relative position of liberal education in relation to the empirical meaning of education. It is a social reality in which the trend, as an integral aspect of social change, needs to be managed, in accordance with criteria that will permit education, as authentic education, to occur. Failure to do so carries the risk of indoctrination and manipulation.

It is at this point that the concept of adult education becomes apparent: the juncture at which the concept of PHC merges with that of health and education, in the form of health education, to enable people to increase awareness of their own situation, to help them recognise problems and to develop reasonable and mutually agreed upon plans of action (Heggenhougen, 1984:218) as an aspect of decision making and problem solving.

2.4 ADULT EDUCATION

The concept of education may be the same whether dealing with children or adults, but the answers to certain questions may differ in respect of adults as opposed to children. The close links between health, especially in terms of PHC, community development, and education has been and will continue to be demonstrated in this work. However, the

concept of adult education, as health education in particular, is not synonymous with these processes and remains in need of justification as education on its own terms. Adult education has a claim to public support not because it makes people happier, but because it is a system for teaching and learning. What is taught and learned, how it is taught and why certain things are taught are questions that require consideration (Lawson, 1979:9-10).

It is from this premise that the arguments put forward in the following section and chapter evolve. At the same time, it may be discerned that Lawson's statement links up with the focus of health education in the era of therapeutic medicine and the re-emergence of preventive medicine (cf 2.3.4) during the 1970s. It is an approach summed up, some thirty years ago, by VOGELAAR (in: Katus, 1989:28) in the sense of the Dutch word *voorlichting* which translates into English as 'public information'. At that time, the concept was defined as

"... an intentional process of transmission of facts and, or, opinions, initiated by someone in order to influence directly or indirectly the behaviour of someone else" (Vogelaar, in: Katus, 1989:28).

Education and health can be seen to move in a parallel course through history reflecting a particular apprehension of meaning by Western societies in linear perspective. Today, public information exists as a separate scientific discipline in Holland. According to VAN GENT (in: Katus 1989:32) the discipline comprises

"... activities, in which one intentionally and systematically attempts to be of use to someone else by providing him with knowledge and insight in order to enable him to take as independently as possible a decision in respect of a concrete situation".

VAN GENT (in: Katus, 1989:32) continues by making distinctions between public information and similar modalities of influencing people such as education in the sense of teaching and training, public relations, advertising and propaganda. The difference between education and public information is that the former is limited to concrete situations while the latter is wider in scope. Public information, in turn, differs from public relations, advertising and propaganda in that it primarily benefits the receiver(s) and the latter the sender(s) or initiator(s) of the communication.

The question concerning 'who benefits' is of prime importance if public information is to foster the freedom of human beings to act as autonomously as they can by means of broadening the possibilities on which their choices rest, as well as improving the action processes on which the choices are based (Van Gent, in: Katus, 1989:32). It appears that it is in notions of 'being-of-use-to' and 'who benefits' that contemporary definitions of adult education are displaying subtle changes in focus, and therefore, in goals. Such an approach highlights the ethical responsibilities (cf 5.4.6) of adult educators.

VAN GENT (1991:15-16) points out that andragogic activities are social activities. The integrative application of already proven knowledge from other disciplines in the social sciences should minimise the danger of removing people from the context of their social reality and community problems. When working with adults, it should be recognised that

their lives are made up of multiple integrating forces and many variables stemming from types of work, interests and personal history, so that there is little consistency or continuity in their collective activities. On these grounds, Van Gent pleads that no limits be applied to the terrain of andragogy by limiting it to pure educative events. In these terms, androgogics should display insights into educative aspects of information giving, rehabilitation and counselling: in other words social renewal as opposed to welfare work. In this sense, the science of political information in Holland may be equated with andragogy or health education today, while Van Gent's conceptualisation of adult education may be viewed as analogous with educational movements founded on the works of Gramsci (cf 2.3.5.1) and Freire (2.3.5.2). Increasingly it appears that 'intent' will determine whether education occurs within the framework of social renewal or not (cf 5.3).

MEZIRROW (1981:3-23) has drawn upon the work of critical theorists, and Habermas in particular, in his assertion that adult educators should enable adults to free themselves from dependency producing constraints to research their own problems, examine alternatives for action and gain control of the circumstances of their lives. HABERMAS (1978:19, 301-315) postulates that phenomenological experience moving in dimensions within which transcendental (cf 3.2.1.6) determinants take form, contains no fixed points. He asserts that critical consciousness, through the experience of reflection, may be explained as a self-formative process in which present positions may be reconstructed.

A brief elucidation of the three generic domains of adult education in which human

interest generates knowledge as posited by HABERMAS (1978:191) and interpreted by MEZIROW (1981:3-23), may present further insights into the current expansion and functioning of adult education programmes worldwide and assist in the formulation of guidelines for professional practice.

2.4.1 THE DOMAINS OF ADULT EDUCATION

The domains of human cognition and interest are 'knowledge constitutive' as they determine what is interpreted as knowledge, modes of discovering knowledge and models for establishing whether claims of knowledge are warranted. The existence of three interrelated learning domains or primary cognitive interests are propounded: the technical, the practical and the emancipatory. Differences in the nature of cognitive interest call for fundamentally different methods of systematic inquiry. By extension, each learning domain suggests different learning needs and a different mode of personal learning.

The empirical-analytical level of cognitive interest refers broadly to the way in which individuals work to control and manipulate the environment. It involves 'instrumental action' based upon empirical knowledge, as governed by technical rules. This domain of knowing necessitates an analysis of events and objects into dependent and independent variables and an identification of regularities between them. Premises are ultimately confirmed through systems that monitor feedback (Habermas, 1978:191, 311-312. Mezirow, 1981:4). Particularly suited to this domain of learning are models of adult

education that set educational objectives in respect of specific behaviours needed to accomplish certain tasks. It is the domain that encompasses concepts such as needs assessment, task analysis, behavioural objectives, competency based education, criteria reference education and skill training (Mezirow, 1981:17-18).

The learning domain of practical interest involves 'communicative action' or interaction governed by consensual norms that must be recognised and understood by at least two interacting subjects because they define reciprocal expectations about behaviour. As a mode of knowing, it has as aim, the clarification of conditions for communication and intersubjectivity and not that of technical control and manipulation through the establishment of causality. To this end, it is the historical-hermeneutic sciences, which interpret the meaning of communicative experience, that are appropriate. Access to the facts is provided by an understanding of meaning. The rules of hermeneutics, therefore, "... determine the possible meaning of the validity of statements of the cultural sciences" (Habermas, 1978:309). It is postulated that interrelated but distinct psychological, social and cultural phenomena within this domain hold the key to problems (cf 4.2; 4.3) and the potential solutions (cf 5.3) to health education encounters within the situatedness of multi- and cross cultural education.

According to MEZIRÓW (1981:18), any assumption that educational approaches suitable for 'instrumental' action may be broadened to incorporate activities such as role play to render them more effective in 'communicative action,' is wrong. An educative approach is required which focuses on helping learners interpret ways in which they and others

construct meaning, how they stereotype one another and what they say and do in the process of interaction while involved in common endeavours (as an aspect of communality-in-diversity (cf 3.2.1.16). Adults can be assisted to develop empathy and gain competency in activities such as conflict resolution, group discussion and dialogue, leading learning groups, differentiating between 'in order to' motives from 'because' motives and theorizing about symbolic interaction. 'Grounded' theory strategies of comparative and phenomenological analysis appear to be particularly suited to educational strategy and evaluation in this regard (cf 5.3.2.5 - 5.3.2.9).

The final mode of inquiry, identified as emancipatory, turns to the critical social sciences such as psycho-analysis and the critique of ideology

"... to determine when theoretical statements group invariant regularities of social action as such and when they express ideologically frozen relations of dependence that can in principle be transformed" (Habermas, 1978:310).

Critical theorists maintain that the individual must become critically conscious of how ideology reflects and distorts social, political and moral reality in order to identify material and psychological factors that sustain and influence the *status quo* especially in respect of powers of domination. The learning domain classified as emancipatory, therefore, incorporates an interest in self-knowledge to which psycho-analysis provides a method for achieving such knowledge (Mezirow, 1981:5-6).

Self reflection, as determined by an emancipatory cognitive interest (Habermas, 1978:310)

provides the methodological framework through which social and personal change becomes possible. The emancipatory and learning process whereby the individual becomes critically aware is that, of 'perspective transformation' (Mezirow, 1981:6, 18) (cf 5.3.2.8). As a result of new understandings, people are able to reconstruct prevailing psycho-cultural structures to permit a more discriminatory and inclusive interaction of experience so that new insights can be acted upon (Mezirow, 1981:6). According to HABERMAS (1978:314), "... *in the power of self-reflection, knowledge and interest are one*" and that

"... the unity of knowledge and interest proves itself in a dialectic that takes the historical traces of suppressed dialogue and reconstructs what has been suppressed" (Habermas, 1978:315).

It is at the level of communicative action, perceptive transformation and emancipatory education that Van Gent's (cf 2.4) interpretation of social renewal and Freire's concept of 'conscientisation' may be seen to converge in respect of adult education.

In conclusion, it is important to draw attention to two factors. Firstly, in everyday life, few situations involve only one cognitive interest. Learning domains, irrespective of classificatory intent, remain inextricably intertwined. Secondly, for many, unlike Van Gent, the proponents of PPHC, Habermas, Freire and Mezirow, learning refers to a "... *process of acquiring skills and knowledge rather than an internal change of consciousness*" (Brookfield, 1983:15). This becomes one more point of difference in the world views that go into making up the multicultural frames of reference of the South African popu-

lation whether educators, health workers or lay persons.

Having reached the conclusion in Chapter One (cf 1.3.5) that the problem area of health education in cross cultural encounters falls more appropriately in the mode of the andragogic, it becomes appropriate to identify the aims of health education.

2.4.2 AIMS OF HEALTH EDUCATION

Health represents the goal of all health education activities (adapted from MacDonald, 1984:234). It has been demonstrated that education and health systems are integral structures of all societies that change over time, are not value neutral but reflect the world view of the era in which they are anchored. Not only do these systems reflect national ideologies, but, in turn, help to create new ones. Self-perpetuation of a particular world view is broken only by the advent of innovation which in itself is not arbitrary, but a reflection of social conditions (Jones, 1984:94; Tones and Tilford, 1994:1, 11). The aims of health education as presented are founded within global as well as local present time in relation to the past and future. The goals are in many ways a reiteration of statements concerning and definitions of health education cited under 1.3.3.3. The dividing line between pure ideology and health education lies in the 'intent' with which programmes are developed and the degree to which they are evaluated in accordance with the categories and criteria delineated in Chapter Three.

According to SMEDLEY AND MARSICK (1989:508-509), empowerment is at the heart

of international health education because of the commitment made to PHC at the Alma Ata Conference. Based on concepts of equity, social and economic self-reliance and community self-reliance, PHC requires a total restructuring and decentralisation of services so that people in underserved areas are enabled to define their particular needs and develop self-help services to meet them: a philosophy that is keeping with that of the Government of National Unity today (cf 2.3.6.4).

The concept of empowerment in the sense of community empowerment has reference to the process whereby health educators attempt to enable people to increase control, or a sense of control, over their lives in keeping with the recommendations cited in the Ottawa Charter (cf 2.3.4). The empowerment process is viewed as an interactive relationship involving mutual respect (cf 5.3.2.4) and critical reflection (cf 5.3.2.7) through which both controlling institutions and the people are changed so that this control is realised (Clabots and Dolphin, 1992:75-76).

At this point, it becomes important to clarify clearly the fundamental difference between health education and health promotion. Health education has a central role to play in the promotion of health for it is a practical endeavour which focuses on improving insights into the determinants of health (cf 4.2) and helping people to develop the capacities they need to bring about change. Conversely, health promotion is a conceptual device that enables health workers to understand the diverse interacting elements within society which have the potential to promote health (French, 1990:8-9). Health education programmes have recently moved from information orientated toward behavioural-change

strategies and those aimed at individual and social empowerment.

If health education is viewed as a combination of intentional activities and experiences designed to facilitate permanent adaptations in human behaviour that are conducive to the promotion of health and prevention of disease (cf 1.3.3.3), then it may be concluded that the first of the two major aims of health education is to increase

"... individual and community capabilities for involvement and self-reliance in health and to promote healthy behaviour, particularly regarding family health and nutrition, environmental health, healthy life-styles and disease prevention and control" (WHO, 1983:10).

The implication being that people should be empowered through the cognitive domains of interest, knowledge and capacity building to gain control of those areas of their lives which are detrimental to health.

The second equally important aim is to strengthen multi- or intersectorial approaches toward health and to increase co-ordination of health education efforts with other development sectors: education, social welfare, community development, housing, industry, communications and non-governmental organisations. An intersectorial approach acknowledges that, at community level, the lives of people are integrated and that change in one aspect of life affects all other aspects (Feurerstein, 1982:31; Mahler, in: WHO, 1983:15).

In these terms, health education is an intentional activity designed to achieve health or

illness related learning that results in a relatively permanent change in the disposition or capabilities of people. Effective health education may produce changes in knowledge and understanding or ways of thinking. It may clarify or influence values, bring about shifts in attitudes or beliefs, facilitate the acquisition of skills or effect change in life-style or behaviour (Tones and Tilford, 1994:11). Health education as

"... adult education enables people to become producers of change rather than consumers, agents rather than victims" (James, *in*: Pilley, 1990:1).

Furthermore, health education has an important role to play in placing health issues on the agendas of policy makers and supporting them in the development of policies that will promote health (French, 1990:9). In turn, community development, of which health education is an integral part, creates an arena within which political, social, cultural, environmental and economic determinants of health can be influenced in close collaboration with professional and public systems, rather than remote from or antagonistic toward them (French, 1990:9; James, *in*: Pilley, 1990:1).

All definitions of adult education, regardless of how narrow, wide-ranging or abstract they may be, are crafted within a particular philosophy of practice. So, too, with health education which is not a technical operation, but reflects the philosophies held by various practitioners in respect of their personal values and definitions about what is believed to be worthwhile in relation to health and the means whereby goals may be achieved (Tones and Tilford, 1994:1).

The domain of health education has expanded to include objectives relating to social and economic change, the construction of problem centred educational programmes, education for raising the social and cultural consciousness of communities, training and educating the disadvantaged, clarifying methods in support of educational programmes at community level and increasing an understanding amongst educators of the worldviews of culturally diverse adults.

It is not the intention of the author to enter into the debate as to whether *educational criteria* exist as distinct from *social criteria* or whether *educational need* is identifiable independently of *social need* rather than following from *social need*. The intention is to identify educational criteria against which the proposed guidelines for authentic health education may be measured (adapted from Lawson, 1979:41) within the context of the concept of multi- or cross cultural education as presented under 1.3.6.5(b).

2.4.3 RÉSUMÉ

The previous section briefly explored the concept of adult education by placing it in historical context and showing how it evolved from a discipline with strong emphasis on the individual and psychological mode of learning to one in which the social mode is reflected. The concept of adult education has been compared with the discipline of public information in the Netherlands. The emergence of the philosophy of liberal education, based on the work of Gramsci and Freire has been noted. It appears that the concept of adult education in general, and health education in particular, is becoming

increasingly associated, in theory and in fact, with concepts of social renewal and shifts in consciousness that enable people to perceive "... themselves and society in completely new and more productive ways" (Beder, 1989:44).

An attempt has been made to demonstrate how the functions of adult and health education may be interpreted from both a radical and conservative perspective. Both sets of interpretations may be valid from whatever ideological stance the interpreter adopts and, yet, may be incompatible - one with the other (Jarvis, 1985:149). As no consensus has been reached on which theoretical perspective is correct, it remains valid to state that education must be justified on its own terms on grounds of universally valid educational criteria. In the case of health education, criteria as mediated through the prism of culture.

A brief overview of the critical theory perspective of adult education drawn from the work of Habermas and Freire, and interpreted by Mezirow, has been presented. Although implied, the extent of the problems related to this approach have not been spelled out. In the first place, a dualistic image may be portrayed of critically sophisticated facilitators, in full possession of an authentic objective perception of the nature of reality, versus critically naive learners who are constantly duped and bemused. Such an image is untrue and undermines the dignity (cf 2.2.1.14; 5.3.2.4) of adult learners. Secondly, there may be an unacknowledged ideological bias underlying the concepts of critical thinking and awareness (Brookfield, 1989:205). Evaluative educative criteria are requirements in both areas to ensure that education is practised as education and not as

ideological propaganda.

2.5 CONCLUSION AND FURTHER PROGRAMME

Nowhere are contrasts in interpretations of health greater than in developing countries. Historically, the Western biomedical system has been layered on top of indigenous health systems, with each retaining different explications of health and disease. Values of scientific objectivity underlying the efforts of the dominant group to provide health services, clash with local values. In recent times, the issue of health reform has become intertwined with that of social justice (Marsick and Smedley, 1989:508).

An elucidation of the two major healing traditions in South Africa, which respectively reflect a magico-religious and scientific world view, reveals that each one is value-laden and contains its own brand of rationality, scepticism and pragmatism (Booyens, 1991:487). The scene has been set for misinterpretations of meaning arising from radically different views of the world. However, this is only the source of the problem, for the interplay between modern and traditional medicine is dynamic and the distinction between the two arbitrary. In the attribution of meaning (cf 3.2.1.5), consideration must be given to the fact that personal, interpersonal and community variables affect the situatedness of each individual and community (adapted from Edwards, 1986:1273).

It has been demonstrated that not only do different systems of health exist in South Africa, but that they are inextricably linked with social and political issues especially

those related to power differentials. Gramsci's conceptualisation of the cultural hegemony of the ruling classes has been linked to the disparity of access to the pool of health care resources by the different population groups. Freire's philosophy of education has been adapted and applied to a variety of liberating models of adult education. Here, too, the educator is confronted with diverse frames of reference: frames of reference which are unlikely to be linked to macrocultural but are rather linked to micro- or sub-cultural world views and personal experience and philosophy.

Adult education is increasingly viewed, not only as a means to achieve personal goals, but as a means of realising social renewal. Health education, as adult education, is directly affected by the sweeping changes taking place in society today. Changes that are inherent in the transformation of a health system in a multicultural society, from one dominated by curative medicine to that of PHC and a philosophy of adult education in which people are encouraged to understand and assume new meaning perspectives for taking action.

If, in these terms, education is not to become indoctrination, it becomes necessary to give consideration to the anthropological grounding of categories of the androgical phenomenon as they pertain to the *agein*. From these categories, universally valid criteria for the realisation of education can be identified. Education can hereby be evaluated on its own terms.

In the cross cultural encounter, problems associated with viewing health, illness and

disease from a cultural anthropological perspective cannot be ignored. In the attribution of meaning, meaning itself is mediated by culture. Meaning, intentions to act and actions themselves are socially and culturally constructed. For this reason, the degree to which categories may be mediated or interpreted through the agency of culture should be explored and explicated.

An attempt will be made in Chapter Three to penetrate the ontological foundation of man and reflect radically on issues pertaining to the andragogic phenomenon as universal anthropic and cultural phenomenon.

CHAPTER THREE

THE ANTHROPOLOGICAL-ONTOLOGICAL FOUNDATION OF THE AGOGIC

3.1 INTRODUCTION

The main purpose of this study is a systematic, conscious, penetrating reflection and evaluation of an ontic reality as part of man's original life-world in order to present guidelines for health education practice and to determine the permissibility of these practices in terms of the demands of pure humanness. As the presence of education must be regarded as an irrefutable fact of experience which can be observed and known (Oberholzer, *in*: Du Plooy *et al.*, 1987:6-7), it may be stated that this original life-world constitutes that of the *agein*. It is a world which reflects the perennial need of man in the mode of the *aner agein*: his interdependence with beings of equal dignity in equality in the face of a hidden future bringing about demands on both learners and health educators. These demands are, in turn, bound by the world situated reality of all who are engaged in the practise of health education in cross cultural encounters.

Research undertaken to uncover a valid understanding of education must be based on a study of the beings who are educated, who educate, who are open to education and who must be involved in education. In other words, education has reference to man and his relationship with his world (Chesler, 1983:36).

In seeking answers to the wonderment of man in order to understand his needs and yearnings and why he does or does not initiate and participate in certain activities, the fundamental thinker recognises that the human condition and by implication education, as a distinctly human activity, defies absolute and final comprehension. It cannot, therefore, be the subject of final or exact description (Higgs, 1993:27). That which is revealed will lead to further questions in the wake of deeper penetration into that which constitutes the mystery of man.

Penetration of the ontological foundation of man and his true nature rests on the necessity of asking about the role of the anthropic in human existence and reflecting on the essential nature of man's *eidos*. Answers to these questions cannot be substantiated in any other way than in terms of the anthropological-ontological: the *andragogic perennis* which denotes the ontic, essential, perennial, constant, ever-recurring companionship between adults and adults, as an expression of their interdependence (Higgs, 1984:13).

In this chapter, the author seeks to uncover the universally valid reality of man and his world on which the agogical is grounded and becomes meaningful. Identification of fundamental structures constituting preconditions for actualising education occurrences, in cultural context, follow. The verbalisation of categories and formulation of criteria, as standards of measurement, with a view to evaluating the authentic actualisation of pedagogic (more specifically agogic) appearances (Kilian, in: Du Plooy et al., 1987:258-259), is hereby made possible in the final chapter.

3.2 ANTHROPOLOGICAL GROUNDING OF THE AGOGIC

Justification of the research about man and *agein* is dependent on the essential structures of the agogic reality being revealed. The agogic or human reality must be made present in that it constitutes an object of consciousness (adapted from Oberholzer, 1979:187). As basis for scientific practice, the fundamental pedagogician (as agogician) is obliged to take as starting point, the phenomenon of education itself as revealed in the concrete education situation (Gunter, 1988:2) and establish, by means of radical fundamental reflection, the essences of the agogic phenomenon as universal phenomena (Higgs, 1984:29) to reveal the apolitical (Kilian, 1970:22) or the necessary pre-conditions, indispensable conditions and intrinsic characteristics of the agogic (Van Rensburg *et al.*, 1994:378). The approach is of significance in respect of the phenomenon of health education in cross cultural encounters where complex problems have not been resolved in spite of the voluminous and frequently contentious research carried out in related fields of study.

The fundamental agogician attempts to conceptualise, verbalise, categorise and disclose the nature of agogical ground structures through the enunciation of agogical categories. He does so in order to formulate certain agogical criteria, in this instance in the andragogical mode, against which specified educational occurrences or propositions may be evaluated as andragogically accountable and acceptable. In order to claim universal validity and inevitability, these criteria must be derived from an authentic understanding of man based on the demands of the authentic *agein*. That which is agogically accountable is not based on personal or ideological points of view and does not conflict with anthropological onticities revealed about

man and *agein* in the course of radical scientific reflection. Once authentic andragogical criteria have been obtained, guidelines for the practice of health education in cross cultural encounters may be evaluated in accordance with the norms and demands implied in the *agogica perennis*.

The essence of the *agein* is rooted in the eidetic nature of man: that which constitutes man as human being and the role of the *aner-agein* in his existence (Higgs:1984-29). Therefore, agogical categories, by implication, stem from the anthropic phenomenon. It is the task of the fundamental andragogician to restructure the anthropological categories from the perspective of the *agein* to ensure that the andragogical structures are not merely transferred from fundamental anthropological reflection in general and that they are accounted for from an agogical perspective.

Since this study is both anthropologically and andragogically orientated, being related to the nature of man on the one hand and, more specifically, the education of adults in health related matters on the other, the researcher intends to name and describe a number of ground structures which reveal the essential nature of man. These categories originate from, and are inextricably linked with the *eidōs* of man and reveal that the *agein* is separate and yet an essence of his very nature. The ground structures which follow as structural verbalisations are in accordance with those structured by OBERHOLZER (1979:114-132), STAPLES (1987:65-85) and ARTHUR (1992:74-132).

3.2.1 THE NATURE OF MAN AND ASSOCIATED ANDRAGOGICAL CATEGORIES

The focus of the work remains centred around a single question, namely, what makes it possible to teach adults from different cultures? Pivotal to this question is the self evident truism that for all human beings, learning remains "... *a process of experiencing that which is different or unfamiliar*" (Barer-Stein, 1987(a):88-89).

The ensuing description of anthropological and andragogical structures is neither comprehensive nor exclusive. There is no intention on the part of the researcher to imply that they are mandatory, neither should they be seen in isolation but as an integrated totality for "... human reality is a complex dialectic of open possibilities" (Higgs, 1993:24). This section involves a phenomenological description of man as totality in relation with his world. He is viewed existentially. From these findings andragogical categories and criteria will be extrapolated, taking into account that culture constitutes the matrix of human experience.

3.2.1.1 Man as Biological Exception

The Greek word *anthropos*, meaning man, reveals the humanity of man and something of the nature of man which is purely human. It is the humanity of man which distinguishes him from the non-human, from animals, plants and inanimate objects. Human reality is demarcated and distinct from non-human reality, giving expression to the humanness of man and revealing his unique position within that reality (Higgs, 1984:32-33).

Although indisputably a biological being, man is exclusively human, a biological exception in the realm of the living who is free from the dictates of any closed system (Oberholzer, 1968:150). OBERHOLZER (1968:142-151) reflects systematically and critically on man as the only being who can be viewed and recognised as subject, as concrete existential-ethical subjectivity, and who qualifies as subject. Man is wholly human, a person in possession of human qualities, who strives towards self-explication and who may not be reduced to an evolutionistic or theological world view. Neither may he be reduced to the status of a natural object, absolutised and explained in terms of physical-chemical stimulus-response mechanisms. As human being, man is a dynamic whole or totality in communication. He is ever present in the world, an active participant in everything he does so that each of his transactions, whether in individual, group or occupational context, is an expression of his unique totality in communication.

BUYTENDIJK (*in*: Van Zyl, 1980(b):142) records that the world of man constitutes the meaningful fundamental structure of the whole of those situations, occurrences and cultural values to which he directs himself, of which he is conscious and in which he is involved. It is a world which is personally selected and significant: a world which is the outcome of a creating, constituting, designing function of the conscious mind. The outcome is not only a gnostic, cognitive, differentiating function, but one that is pathic, normative and allocating (Oberholzer, 1968:161).

The primordial fact of man as being in the world constitutes the nucleus of a phenomenological vision of man as human being, freed from the constraints of a scientific world view.

Man and his world lie at the core of any attempt to reveal the onticities of who man is, where he is and what he does.

(a) *Man as Biological Exception in Cultural Terms*

As biological exception,

"Man alone among the forms of animated nature is the creature that has moved into the adaptive zone which is an entirely learned one. This is the zone of culture, the man-made, the learned part of the environment" (Montagu, in: Barer-Stein, 1987(a):89).

Man alone develops systems of thought, based on the coherent use of human reason through which cultural reality is experienced maintained, developed and transmitted either verbally or non-verbally. These systems of thought are translated into social systems and structures, including those of health care, in which members of society participate.

(b) *Man as a Biological Exception as Andragogical Category*

Without man as being in the world, the world loses its meaning, but conversely, man is only man when he is situated (cf 3.2.1.2) in and constitutes his world (cf 3.2.1.3). He has no choice as to his presence in the open (cf 3.2.1.5) and unlimited world by which he is confronted and called upon to find his way. In responding to the call, he simultaneously reveals and acquires humanness which involves a reciprocal getting-to-know his world (Viljoen and Pienaar, 1976:3): a world in which each group, and individual member, incorporates its, or

his, own version of reality.

One of the more fundamental characteristics of man, according to LANGEVELD (*in*: Gunter, 1988:74), is that he is a "... being who educates, is educated and is dependent on education". In any education event, learner and educator occupy the same ontic status in that they are beings in possession of human dignity (cf 3.2.1.14) and are fully human. As human being, man's consciousness and individuality is neither intelligible nor explicable outside the context of the public world of which he is conscious, in relation to which he grows and matures and onto which he imprints his own pattern of being and individual style (Peters, *in*: Hamm, 1989:47).

Therefore, it may be stated that being human, as a structure in function of education, is not only a fundamental agogical category, but also forms the cornerstone of all andragogical categories as they manifest as part of the integrated totality of the human world. Man as biological exception should be reflected in all andragogical criteria against which educational guidelines may be measured.

Man possesses an existential need to be acknowledged as a human being and to be accorded respect as a being in bodiliness (cf 3.2.1.15) in possession of human dignity. The need manifests as insecurity and a yearning to be accompanied by a trusted fellow being *en route* to an unknown future (Oberholzer, 1979:111). In seeking health care, man is sensitive to being treated as a collective mass or object: depersonalisation and dehumanisation constitute a threat to personal integrity, self-respect and human values.

In cross cultural encounters reality is difficult to grasp, but this fact does not mean efforts to understand should be abdicated (Houle 1984:43). Cultural differences exist and must be understood and accepted, for not to do so is contrary to the ideals of human equality, freedom (Quillen, 1971:30) and dignity. Understanding the event from the point of view of the learner becomes crucial.

In this regard, although referring to pedagogics, LANDMAN (*in*: Landman *et al.*, 1977:13) states that educator and learner stand in a special relationship embodying relationships of trust, understanding or knowing, and authority. This statement also holds good for andragogics. Without the presence of this relationship structure, education is not possible. Essences of the trust relationship include acceptance, support, emotional security, protection, and respect for the human dignity of the individual (Landman *et al.*, 1977:18). The relationship of understanding entails an understanding and respect for the person as unique and cultural being.

As an expression of pure humanness, it cannot be denied that both learner and health educator are existent in the world.

3.2.1.2 Man as Existing Being

LUIJPEN (*in*: Higgs, 1984:35) describes man as existent in reference to his unique mode of being that differentiates him from all other forms of life, for his "... humanness is expressed in his existence" (Viljoen en Pienaar, 1976:30). The term 'exist' is derived from the Latin

ex meaning 'out' and *sisto* meaning 'stand', together signifying 'standing out' and 'going out' (Oberholzer, 1979:114) which reveals that man is more than a static presence in the world, being both encountering and encountered and, therefore, an active participant in his world. The essence of the very being of man lies in his existence (Heidegger, 1988:67).

As an existing being man is situated in the world, his situatedness being defined as the whole of the data regarding which action should be taken (Langeveld, in: Viljoen and Pienaar, 1976:46). He is able to position himself within his specific circumstances so that he can confront or stand up to other people with a view to realising something by thought or deed. He is a transcending being (cf 3.2.1.6) able to go beyond himself and constitute a relationship between himself, others and things (Du Plooy and Kilian, 1990:71).

Man's being existent, or situated in the world as primordial comprehensive ground structure, is inextricably entwined with conceptual verbalisations and an understanding of man and world and man and fellow-man. Attempts to conceptualise man's essential humanness in terms of his existence must be grounded in his relationship with the world in which he exists and is involved (Higgs, 1984:36).

(a) *Man as Existing Being in Cultural Terms*

According to BERGEVIN (1984:24-25), "An individual cannot really become a person outside the social order". Each individual exists in a complex social, physical and personal milieu which changes constantly and influences all his experiences. In broad terms, the

social order provides direction as to what he can do vocationally, socially, spiritually, politically and physically. At the same time, there are always influences that constrain the growth and development of individuals and communities or negatively influence levels of health. Some of these influences may be environmentally or socially inclined, while others may be self-imposed. It is frequently difficult to distinguish one source of influence from another. Learning, as an act of understanding, discovery and volition, enables the individual to gain clarity about his problems and by choosing responsibly, to challenge obstacles standing in the way of his expectations.

(b) Man as an Existing Being as Andragogical Category

Adulthood is a mode of human existence. Health educators and learners are existentially concerned with learning activities and are situated within the totality of their circumstances at a given time and place. Their situatedness is not static, but is evidence of interaction within and between themselves and the world in which they are placed. Any episode of learning occurs in a particular situation and is profoundly influenced by this fact (Houle 1984:42). Situatedness can, therefore, be described as a fundamental andragogical category.

Health education implies the giving and accepting of educative guidance in a situation of reciprocal interaction in which the adult is enabled to gain insight into the forces shaping his health in order to achieve a specific way of life and level of health in his world. By implication, effective guidance permits the adult learner, as independent, self-directing being, to make decisions about and accept responsibility for his personal inputs and actions in respect

of those circumstances which have an impact on health related matters. The education situation, in all its modes, may be said to be learner, goal, future and norm orientated (Gunter, 1988:35).

The situatedness of man as existing being is closely interwoven with the conceptual verbalisation of man as being in the world.

3.2.1.3 Man as Being in the World

HEIDEGGER (1988:78) states : "Dasein exists" thereby equating existence with being in the world. He (1988:80) continues to observe the being-in as a formal existential expression for the Being of Dasein that has Being in the world as its essential state. The German word *Dasein* means 'existence', but Heidegger breaks it down into its component parts, *Da* and *Sein* meaning 'there' and 'being'. Thus the term gains a particular meaning, namely, man's conscious, historical existence in the world that always projects into a there beyond its here (Mannheim, *in*: Heidegger, 1964:9). In this context, "being there implies awareness of being" (Heidegger, 1964:29), a consciousness of and an involvement (cf 3.2.1.8) in the world within the confines of time and space as it relates to past, present and future (cf 3.2.1.12) and man's transcendental presence in the world.

BUYTENDIJK (*in*: Viljoen and Pienaar, 1976:188) describes the concept of world as the meaningful basic structure of the totality of situations, events and cultural values to which a person directs his attention, of which he is conscious and in which his behaviour, thoughts

and feelings are involved. It is the world in which man exists and finds meaning in the course of his personal history. Each individual, as conscious, existing being, creates his own world through the meaning he assigns to it (cf 3.2.1.5). Man cannot, therefore, be reflected upon as entity separate or distinct from his world.

BUYTENDIJK AND VAN DEN BERG (in: Viljoen and Pienaar, (1976:188-189) postulate that man may only be understood in an ontological sense if he is observed in his relation with his world which he is able to transcend (cf 3.2.1.6). He is able to exceed his world, reach beyond it and, by so doing, reach his fellow man and God. A description of man's relations with his world and his fellow man is necessary to understand any anthropic need, deed, action or activity, including education.

(a) *Man as Being in the World in Cultural Terms.*

"... being human profoundly means being engaged and entangled in a situation, and confronted with a world whose objectivity and reality is in no way detracted from by the subjectivity of that 'being' who 'is in the world'" (Frankl, 1966:102).

The world for man, whether reflecting a First World technological frame of reference incorporating notions of Cartesian duality, the more holistic world views of the Third World, or representations in between, is created by man and finds expression in the culture of man.

(b) *Man is a Being in the World as Andragogical Category*

OBERHOLZER (1968:151) states that being human means being in the world as active participant. Man in the world is a dynamic presence. He must be seen in his essentiality from the perspective of his being in the world, of his being in time and his being with others (cf 3.2.1.4). It may, therefore, be stated that being in and engaged in the world is both an anthropic and andragogical category.

The andragogical category of in the world reveals an existence and an encounter with the world and an involvement of the world in the situatedness of health systems, health educators and learners. Engagement reflects the dynamism of man's existence and reveals the adult as a non-static being who is reciprocally encountered by and encountering the health care system. He is consciousness in any health education occurrence, actively engaged in it and, as adult, his need for direction in understanding and gaining control of the forces affecting health, is balanced by his need to participate in uncovering potential solutions to his problems. Only with the guidance of an empathic other (cf 5.3.2.6), who knows and is able to understand and accept the world view of the learner, will the adult be enabled to know and to do that which may assist him in realising his expectations and goals.

One of the most essential structure conditions of the educative event is the spontaneous willingness and continuous readiness of the health educator to be accessible to and to respond to the need and expectations of the adult learner (adapted from Oberholzer, *in*: Du Plooy *et al.*, 1987:8). A learning encounter in the field of health education entails a relationship of

mutual trust (adapted from Van Vuuren, 1990:115).

In the light of the above, the pedagogic (or, in this case the andragogic) encounter, as structure in function, may be said to embody the andragogical criteria of trust and understanding as components of the relationship structure, encounter and engagement (Landman *et al.*, 1982:71), in the sense of active participation in the educative situation and knowledge or understanding as it relates to the attribution of meaning (cf 3.2.1.5(b)).

As being in the world implies man and his relations with his world, it may be stated that man is a related being.

3.2.1.4 Man as Related Being

The conceptualisation of 'man as human being, existent in the world', implies someone who is involved in or related to reality. A reality referred to by OBERHOLZER (1979:32) as "... the whole of all that is", a reality which is so all embracing and inclusive that it is only by becoming involved and asking probing questions that a person may begin to unravel the coherence of that reality.

According to STELLWAG (*in*: Du Plooy and Kilian, 1990:72), man is always engaged in dialogue through which his specific situation is expressed at a particular moment. He thereby gives meaning to a world which he designs and inhabits and, by so doing, changes a situation into a situation for him as integral part of his life-world. In this regard

BUYTENDIJK (in: Kruger and Whittle, 1982:11) states that man is not something with fixed attributes, but an initiator of relationships with a world which he chooses and by which he is chosen.

As an initiator of relationships, man can never be designated as the product of heredity, culture, or environment. He initiates relationships and thereby initiates and participates in change through personal action (Van Zyl, 1980(a):168). The concept of relationship, therefore, implies mutuality (Pienaar and Viljoen, 1976:61) and reciprocal creative participation (Van Zyl, 1977:202, 308).

Man's relational situatedness in the world is not only known, but is also both pathic and dynamic. It is a relationship which is experienced emotionally and one which involves action and change (Oberholzer, 1979:33).

As a primevally related being, man is never so situated as not to be related to life and the world. Situatedness in and dialogue with the world are preconditions for the creation of educational relationships.

(a) *Man as Related Being in Cultural Terms*

Man's continuous involvement in specific relationships with every aspect of his world, his engagement in dialogue with the things and persons around him, his God or gods and himself is initiated through the frame of reference of his culture. However, while influenced by his

culture and the associated norms and values, the relationship he evolves with the world is uniquely his own. He is unity in totality and, therefore, totality in function. He must be understood as such and not merely as somebody with separate characteristics and attributes (Kruger and Whittle, 1982:11-13). In matters relating to health, as in every other aspect of man's relatedness to his world, the ground structures of diversity in communality (cf 3.2.1.16) and personal and social change (cf 3.2.1.13) come to the fore.

(b) Man as a Related Being as Andragogical Category

The child (and adult) as initiator of relationships is a being who moves out and towards, as well as one who is encountered and wanting to be encountered. He experiences present reality (Oberholzer, *in*: Du Plooy *et al.*, 1987:54) and by so doing, selects his dialogue with the world and responds in terms of his dynamic relationship with that world (Pienaar, *in*: Du Plooy *et al.*, 1987:62).

In the health care system, the adult experiences his situation dynamically and pathically. He is confronted by the physical environment and cultural milieu of the health care setting, by the health educator, the health programme and other adults. Just as the pedagogic encounter, the pedagogic relationship and pedagogic activities (Landman *et al.*, 1982:71-72) may be described in terms of pedagogical categories, so may they be translated into categories of the andragogical.

The people who are mutually situated and actively involved in the pedagogic (or andragogic)

encounter are the learner who is in need and the health educator who is able to alleviate the need. Either the educator or learner can be the initiator of relationships. The task of the educator is to initiate changes through actions which should challenge the learner to respond in unique ways in accordance with what is acceptable in society (Du Plooy and Kilian, 1990:7-8).

The essentials inherent in pedagogic (and andragogic) encounters, relationships and activities constitute an integral part of other pedagogical (and andragogical) categories. Essences include goal-directed and future orientated guidance (Gunter, 1988:35-36), pedagogic (or andragogic) dialogue which manifests as an appeal hear answer relationship (Du Plooy and Kilian, 1990:80) and knowing, understanding, and accepting the adult in his own life-world in an act of participatory dialogue (cf 5.4.2). Further categories include the relationship of trust or confidence which includes the essences of an acknowledgement of the uniqueness of the individual, respect for his human dignity (cf 5.3.2.4), genuine empathic dialogue (cf 5.3.2.6) and authority (cf 5.3.2.3) in the sense of knowledge, credibility and integrity.

The relatedness of man to his world signifies not only a consciously directed pathic and dynamic involvement with the world, but one that is characterised by his openness to and for the world (Viljoen and Pienaar, 1976:61).

3.2.1.5 Man as Open Being in a World of Meaning

The elucidation of the ontological ground structures so far, reveals that the world in which

man lives is a human world, and a world with which he forms relations. It is a world to which he needs to attribute meaning in order to create a life-world for himself. He achieves this as a result of his existential openness (Landman *et al.*, 1975:19). The human world is a world of meaning and man himself attributes that meaning (Van Zyl, 1977:145).

Man's existence is ontologically open. OBERHOLZER (1979:117) and VAN ZYL AND DUMINY (1980:32) define man as possibility. As ontic openness, he possess a multitude of possibilities which must be actualised (Gunter, 1988:70) and which necessitate the implementation of freedom (cf 3.2.1.9). As possibility, he is also fallibility (Oberholzer, 1979: 117) for he is not an object or thing, but an inalienable subject of thinking and choice, of decision and action. As subject, man is a conscious and rational being, a free and open being in his particular situatedness in the world. As existence he is not closed and completed, but continuously steps out of himself, is involved and intentionally directed towards the world of people and things (Gunter, 1988:69). His mode of existence represents an active continuity in which he constantly shifts his horizons by perpetually establishing new situations, thereby realising his possibilities (Du Plooy *et al.*, 1987:85). As the horizons of his life-world are expanded, new meaningful situations are created in terms of the norms (cf 3.5.1.10) and values he considers valid (Buytendijk, *in*: Du Plooy and Kilian, 1990:37-38). He gives meaning to his world and brings about change in accordance with that which he values (Van Zyl, 1980(b):112).

FRANKL (1964:99) records that man's search for meaning is a primary force in life and that this meaning is specific and unique in that it can, and must, be fulfilled by him alone. Only

then will it achieve a significance that will satisfy his own will to meaning. Man attaches meaning to everything coming his way. He experiences willingly, pathically and knowingly that which confronts him to the extent that he becomes involved and these matters acquire meaning for him (Du Plooy and Kilian, 1990:133). The significance and purpose of education lie in enabling children (and adults) to actualise their potential (cf 3.2.1.7(b)), as an outcome of what others have previously attained (Liebenberg, *in*: Du Plooy and Kilian), 1990-138).

(a) *Man as Open Being in a World of Meaning in Cultural Terms*

To be human is to inhabit a world composed not of 'things', but of meanings: of occurrences which, in some way, are recognised, identified, understood and responded to in relation to these meanings (Oakeshott, 1972:21). "Cultural meaning is symbolised meaning" (McLeod, 1987:69). The larger culture in which people function may be thought of as "... webs of significance ..." humans spin about themselves (Geertz, 1973:5) that define how political, social and even scientific reality is understood. Because scientists, (health workers and, indeed, all people in general) are part of larger political and social cultures, they are never quite free from the perspectives and influences of these cultures (Kempner and Makino, 1993:186). There is, therefore, an important link between the substance of what constitutes meaning and the process of making meaning. Consequently, the process of making or developing the meaning of events and actions results in an affirmation and renewal of the cultural frame in which the process occurs (McLeod, 1987:69). Hence the features of both openness and closedness displayed by allopathic and traditional medical systems respectively,

as discussed earlier in this work (cf 2.2.3.1(a)).

(b) Man as an Open Being in a World of Meaning as Andragogical Category

The will to meaning may be regarded as one of the basic structures of being human (Oberholzer, *in*: Du Plooy *et al.*, 1987:55). Meaning does not exist as a commodity or entity. It is continuously coming into being, shaped and reshaped by the circumstances in which it is sought and is transformed into personal relevance. Meaning is "... sought by individuals and discovered through personal reflection" (Barer-Stein, 1987(b):27). Personal reflection, therefore, constitutes an andragogical category, an essence of which may be said to be discovery.

As people of all ages are open beings who want to attribute meaning to the world by which they are confronted, the education situation may be regarded as an open space: a space in which human beings stand opposite and next to each other with their potentialities and hopeful future anticipations. The openness of knowledge implies the creation of new meanings, of confronting the unknown, of taking risks. Personal openness as pedagogical (and andragogical) category, reveals the unpredictability of the course of education (including health education), and emphasises the responsibilities inherent in the pedagogic (and andragogic) situation for both educator and learner (Van Vuuren, 1990:115). Educator and learner are mutually engaged in an act of learning, in an incomplete and incompletable world of meaning which entails the freedom to choose (cf 3.2.1.9(b)) between many alternatives. Choice, made on the basis of expectation founded within the constraints and possibilities of both culture and

man, generates tension, for the realisation of expectations lies in an unknown and unable to be a guaranteed future. Therefore, openness as expectation may be regarded as an andragogical category.

Expectation and the ensuing insecurity associated with tension requires that health education be characterised by security which, in turn, implies security as andragogical category. The need for security is pathic in nature and manifests in the adult's yearning for a fellow being who is prepared to approach and accompany him towards the unknown future while at the same time responding to his need for acceptance, freedom, dignity, recognition as a person, preservation of intimacy, empathic guidance and a meaningful existence: all of which constitute essences of the andragogical category of openness as expectation.

Expectations cannot be realised without exploration as revealed in the intentionality of man. VAN RENSBURG ET AL. (1994:419) state that " ... man's intentionality is particularly revealed in his existentiality". He is directed towards someone or something as intentionality which corresponds to being open to someone or something as existentiality.

3.2.1.6 Man as Self-Transcending Intentional Being

The term 'transcend' is derived from the Latin word *transcendere* meaning to 'surmount', to "rise above in excellence or degree; to ... exceed a limit" (Van Rensburg et al., 1994:556). NIJHOFF (in: Husserl, 1964:xx), states that the world cannot be thought of except as being knowable or constituted through the intentional acts of the transcendental ego and that the

transcendental self is not existentially dependent on anything else, because all else is relative to or existentially dependent upon it. Husserl hereby poses intentional consciousness, or consciousness as intentionality.

Intentionality represents man's alignment with his world which, in turn, is closely related to his consciousness. Man and world are not disconnected entities (Du Plooy and Kilian, 1990:37), for as a transcending being and an existing being, man is able to situate himself beyond himself and the world. Man's capacity for self-detachment and self-transcendence, according to FRANKL (1966:97), enables him to reach out to something other than himself and project himself towards a perception of that which he is capable of becoming. In actively and consciously striving to actualise his possibilities and potentialities, man discovers the meaning of and gives meaning to his life and his world. "Self-transcendence is the essence of existence" (Frankl, 1966:104). Consciousness of reality is characterised by activities which are pathically, dynamically, cognitively and conatively focused, allowing reality to be constituted as a human reality.

It is as ontological self-transcending intentional being that man's activities constitute an integral part of education and culture.

(a) Man as Self-Transcending Intentional Being in Cultural Terms

The essence of culture is that it is learned, socially transmitted, dynamic and cumulative over time. The basis of culture lies not only in its highly complex social structures, but in man's

capacity for transcending what is learned, his potential for innovation, reorganisation, creativity and change (adapted from Barer-Stein, 1987(a):89). Man is able to question the nature of his own being, his relationship to his world and, ultimately, to examine the nature of his own questions and reflections (Chesler, 1983:39).

Change, as social reality, emerges from the conceptualisation of man as self-transcending intentional being. Meaning unfolds bringing about shifts in levels of subjective consciousness and the possibility of behavioural change, as man strives towards the realisation of potential in all areas of his life. Culture changes as does man's potential responses to health care systems.

(b) Man as a Self-Transcending Intentional Being as Andragogical Category

According to HEIDEGGER (1988:223), "Dasein exists factually". This means that man is born into a world which is not of his choosing (Higgs, 1984:41). However, " ... as conscious beings, and consciousness as consciousness intent upon the world" (Freire, 1984:108), men are called upon to act, to design and unfold the meaning of their world. Man's existence constitutes opportunity (Van Zyl, 1980(b):143-144). As intentionality, the adult must constantly increase his knowledge of the world to be able to live in it. The *umwelt* becomes the *welt* through attribution of meaning (Du Plooy *et al.*, 1987:73). Knowing the world, or addressing the self to the world and discussing it, functions as primary mode of being in the world (Heidegger, 1988:85). To know and address the world of health related matters implies exploration and discovery, in the physical, social and mental modes

of inquiry, as an act of reciprocal communication with the world. Understanding the world and exploration of and communication with the world constitute interrelated primary andragogical categories. As active participant in the intentional self-transcending act of the attribution of meaning, the adult wants and needs to be encountered with a view to the realisation of opportunities for improved levels of health care. He cannot, however, be compelled to action. Understanding, discovery and participative communication enhance feelings of security, esteem and confidence in a broader vision of 'what might be' in the future. Therefore, andragogic intervention and andragogic engagement by a willing, knowledgeable, empathic and understanding adult become related andragogical categories. The adult yearns for assistance in making choices as he attempts to constitute a world of meaning for himself. What he requires is not a ready made interpretation of reality but an introduction to an independent understanding of the world order, so that he not only understands the world while being in it, but also lives in it with understanding (adapted from Du Plooy *et al.*, 1987:75). In the task of constituting a meaningful world, the attribution of meaning becomes a fundamental andragogical category. Essences inherent in the above categories may be said to be choice, decision-making, empathy, questioning and answering, doing, discovery, freedom, accompaniment, and guidance.

Man as a self-transcending intentional being and becoming are jointly founded ontological concepts.

3.2.1.7 Man as Being in a State of Becoming

Dasein, as being placed in the world and life, is always face to face with definite potentialities, some of which man allows and continues to allow to pass, while others he seizes and materialises for good or bad. *Dasein* is thus man's innermost potentiality of becoming free for its own and innermost potentiality of Being (Heidegger, 1979:36). Being man may, therefore, be described as essentially becoming man (Higgs, 1984:39).

From birth every individual is truly human. Throughout his life, he is engaged in becoming a more worthy human being by responding to the demands of pure humanness. Part of the reality of being human is man's being cast in a world not of his own choosing, but none the less a world with a past which will determine his future (Du Plooy and Kilian, 1990:37). In this connection, OBERHOLZER (1979:36) views man as a dialogical-dialectical being whose total involvement in becoming someone, from the time of birth to death, is a dialogical concern with all he encounters and by which he is encountered.

Becoming is a term which is widely applied in literature to illustrate the dynamics of man's co-existential involvement in the project of the already or present and the not yet or future, which is made possible by an act of the *agein* or the agological in man's existence (Staples, 1987:73). This becoming clearly implies the dynamic nature of man as he continuously progresses towards a better *Dasein* and a more complete future. CHESLER (1983:43) states that man is a being who is continuously aware of that being which he should and wants to become. Each act of becoming " ... represents a distinct change or shift from what was

previously experienced" (Barer-Stein, 1987(b):29).

(a) *Man as Being in a State of Becoming in Cultural Terms*

Mankind has evolved over the ages through the creation of culture, while at the same time being dependent on culture for survival, satisfaction of needs and actualisation of potential or possibilities for himself and/or the group. Human evolution has taken place as a result of an interplay of the inner and outer worlds of individuals and society, and the interaction between nature and culture (Capra, 1982:324). In similar fashion, as man interacts with his world, a continuous interplay and mutual influence takes place between his inner and outer world of being. Psychological aspects of perception (cf 4.3.1.2) are based, in a fundamental manner, on patterns established within the individual's symbolic interpretation of his human world including that of health, illness and disease. Responses to his environment are determined, not so much by the effect of stimuli on his biological system, but by past experience, present and future expectations, a sense of purpose and his individual symbolic interpretation of perceptual experience (Capra, 1982:320-321). Being and culture are hereby inextricably linked in respect of both the macro- and microcosms of human life.

(b) *Man as a Being in a State of Becoming as Andragogical Category*

The author is in agreement with HAMM's (1989:50) statement that the identification of education with 'becoming a person' is too strong. However, it may be claimed that education (*per se*, and education as health education), helps people to become more fully the

persons they are capable of becoming through the acquisition of knowledge and understanding. In this sense, education can be thought of as development, growth or the maturation of persons. In gaining an education " ... one is becoming a different person while still remaining the same person" (Hamm, 1989:50).

Once it is understood that education involves ongoing discovery, growth and maturation, it can be inferred that the learner is actively involved in and wants to understand and assign meaning to the situations with which he is confronted. The act of becoming that which the individual is capable of becoming may, in itself, be referred to as actualisation of potential or possibilities. Realisation of potential, in turn, implies that the individual becomes that person whom he can respect and accept by his own standards. Becoming as andragogical category does not imply the moulding of self into a common pattern, the forsaking of autonomy or a cessation of dreams about a personal future (McKenzie, 1984:88). Every individual is unique (Van Zyl and Duminy, 1980:27) and constitutes his personal lifeworld in normativeness (cf 3.2.1.10(b)) and in culturality (cf 3.2.1.11(b)).

The andragogic encounter takes place when the adult becomes aware of a need for support in achieving that which he desires to become or when a health educator motivates him to become actively engaged. The stage is hereby set, not only for an encounter between two people, but for something that will be actualised in the future, enabling the adult to understand and do things correctly in order to maintain and/or improve his level of health. In other words, the adult's increased expertise, knowledge and understanding should enhance his confidence in controlling circumstances affecting his health. Self- or community respect

and esteem is hereby enhanced. Active engagement, support, motivation and activity as involvement and participation may be viewed as essences of the andragogical category of becoming, as actualisation of potential, in the sense of capacity building (cf 5.3.2.1).

The health educator in initiating andragogic events, is confronted by a double reality, namely, the reality that is and the reality of action as change, in which change should represent improvement (adapted from Oberholzer, 1968:74) in the mode of becoming. The dynamic aspect of becoming is hereby illustrated (cf 3.2.1.13(b)).

The andragogic encounter, involving both health educator and learner, is an integral aspect of the anthropological ground structure of man as a being-in-dependence of co-existential involvement.

3.2.1.8 Man as Being in Dependence of Co-existential Involvement

From an ontological point of view, man is inconceivable without the world and *vice versa*. Being in the world represents a world that the self always shares with others. The world of *Dasein* is, therefore, *mitwelt* or a 'with-world' and 'being-in' represents being with others (Heidegger, 1988:155). The Being of human existence is being-in-community. The essence of man is co-existence: to be human means participation. "To be a person is not a given fact, it is a movement towards others" (Marcel, *in*: McKenzie 1984:87). It is to function in mutual involvement and concern with human beings through a committedness to a dependence on one another (Oberholzer, 1979:25). Interhuman involvement is a matter of appeal and

response, as each person is able to exert a reciprocal existential corrective on the life of another.

Interdependence or co-existence is vested in the *Dasein*. Being in the world " ... implies ontologically a relation to entities within-the-world" (Heidegger, 1988:238). Being authentically one-self does not rest on the exceptional condition of self as subject, but as a condition detached from the 'they' as others, in so far as the 'they' articulate the referential context of significance and prescribe a way of interpreting the world (Heidegger, 1988:167-168). Man gains an understanding of his world by means of weaving a network of relationships with that world.

Although man, as being in the world, exercises an ontic freedom in his intent to constitute a world of meaning for himself, the fact remains that he cannot constitute his life-world without the acceptance, assistance, purposeful intention and responsibility of well-disposed fellow-men (Staples, 1987:76). His encounters with fellow beings are different from those with animals and physical objects, being characterised by interpersonal mutual dialogue, encounter, engagement and presence (Higgs, 1984:43).

Man's existential yearning for supportive guidance manifests in every level and mode of the agological and is of particular relevance to the *agein*. Engagement occurs when man assumes a co-responsibility for his fellow man (Viljoen and Pienaar, 1976:58).

(a) *Man as Being in Dependence of Co-existential Involvement in Cultural Terms*

Culture has the effect of drawing people together. Because cultural symbols are public and communicable, the spaces between individuals can be filled with meaning. Culture hereby "... mediates personal meaning and social structure" and "... acts as a bridge to allow individuals to participate in society" (McLeod, 1987:69). Culture is central to understanding human relationships. Being human is to recognise the self as related to others by virtue of participation in multiple understood relationships and in the enjoyment or fulfilment of the symbolic expression of sentiments, feelings, imaginings, religious and moral beliefs, practical and intellectual enterprises, customs, conventions, practices and procedures, principles of conduct, rules denoting obligations and offices specifying duties (Oakeshott, 1972:20-21). Cultural competence may be said to include the "... ontological assumption that conduct, meaning and cultural membership are interdependent" (Collier, 1989:291).

Whether participating in biomedical or traditional African health systems, human beings participate in, and are in dialogue with, a world of mutually understood events, actions and relationships. Within this world, there exists a common need for participants to engage in a mutual process of discovery of meaning which, in turn, requires interpretation. As with any dialogue, however, "... there is not a single or objective truth to be discovered (McLeod 1987:69). The nature of expectancy for both the Western and traditional patient is "... bound up with the nature of the assumptive systems they share with their healers" (Rappaport, 1980:89). Co-existential conceptualisations of self, within the context of social relationships, may be highly individualised or collectivistic (cf 4.3.1.2(d) in nature.

(b) *Man as a Being in Dependence of Co-existential Involvement as Andragogical Category*

Man experiences his life circumstances as meaningful events in which he is involved as a total person (Vrey, 1979:42). He is constantly involved in dialogue with his world. Meaning is sought in life events. Problems relating to life, health and disease generate tension which manifests as anxiety. Adults, confronted by an existential need for security in the face of the unknown, call for assistance. The educator, in response to an appeal as existence in need, engages the adult in mutual dialogue as an 'act of knowing'. Both educator and learner are equal cognitive subjects from whom meaning is mutually derived, in that knowledge is not a commodity to be possessed and passed on, as object, from one to the other (Alfred, 1984:106). In this sense, the criteria of mutual appeal or address, listening and response pertain (Gunter, 1988:49) equally to child and adult. An existential dialogue occurring between educator and learner is realised on pathic and empathic levels in which all persons, by virtue of being social and human beings, can make contributions to their own understanding of themselves, others and the world (Alfred, 1984:106). In these terms, interhuman dialogue constitutes an andragogical category.

As with the child, so for the adult, the answers to questions culled from the reality of life, which are acceptable to him, will be incorporated into his life-world. A conception of man as *homo dialogicus* refers to the individual's capacity to question and reconstitute meanings previously taken for granted. By implication, man is capable of questioning a given situation, is open to alternatives, can make choices and is able to revise his life-world in the light

of an understanding of alternating positions (Hölscher and Romm, 1989:111). The adult should be enabled to ask questions and seek answers concerning the circumstances of his life so that he becomes a questioning-answering being in a situation where the potential for shared dialogue is acknowledged. Question and answer, as well as volition and action are essences of andragogic dialogue.

Andragogical assistance demands that the adult learns to help himself. Such assistance can only be rendered and accepted in a relationship of mutual confidence, trust and understanding that rests on a respect for, and an acceptance of, the roots of each person's cultural and personal identity. The individual, as *homo dialogicus*, accepts opposing positions as an inevitable aspect of human existence. Failure to do so would result in placing human existence within rigid confines, in dehumanisation of human society and in alienation of persons (Hölscher and Romm, 1989:111). Respect, trust, acceptance and a belief in the capacities of the learner to make relevant decisions as he attempts to manage the circumstances of his life, are essential features of the andragogical category of man as a being in dependence of co-existential involvement. Mutual confidence and mutual understanding are, in turn, interdependent essentials of andragogical dialogue. Respect and concern come about through dialogue between men acknowledging their common humanity (Alfred, 1987:105). Concern about health and well being may be said to constitute universal human issues.

The designing of a life-world is for man always a matter of choice in response to the original appeal that he become what he ought to become. Therefore, it may be stated that to exist implies striving to be responsible.

3.2.1.9 Man as Being Capable of Responsible Choice

Man, in his relationship with the world, gives meaning to that which he experiences to be meaningful, as an act of his own free will and choice, in an open world that is constantly changing. He is not driven by the blind mechanical forces in which the behaviour of animals is embedded and secured. As human being he, therefore, " ... has to make choices" (Frankl, 1964:108).

Man is the only being who can fashion and inhabit the world. He not only designs his world, but is also engaged in self-design (Oberholzer, in: Du Plooy *et al.*, 1987:57). Because of his ontic openness to the world, he is free to constitute his own world and as being in dependence on co-existential involvement, he becomes co-designer and co-creator of the world.

Dasein, which " ... has *Being-in-the-world as its essential state*" (Heidegger, 1988:80) manifests in its own potentiality for being and implies man's own freedom to give meaning to his personal world (Reeler, 1985:126). In other words, man is free to make choices in the realisation of his possibilities.

According to Heidegger (1988:68-69), man as possibility in the actualisation of *Dasein* may choose and win or choose and lose. However, *Dasein* in determining itself as an essential being, always does so in the light of the possibility which it is and which it understands. As possibility and in freedom, man not only has to, but is constantly called upon to make

choices. Because man is a being called upon to realise his possibilities and make choices in the face of an unknown future, anxiety is made manifest in *Dasein* (Heidegger, 1988:232). This is an anxiety which is revealed in man's existential need for accompaniment by a fellow being.

Freedom as the counterpart of personal openness is not an absolute freedom, but becomes freedom in responsibility. That which is realised by the ontological explication of man as an open being in a world of meaning, assumes an ethical character over time, which implies that freedom must be earned and that man is accountable in the actuality of his situatedness (Oberholzer, 1968:163). " ... freedom cannot be freedom without restraint" (Reeler, 1985:126).

(a) *Man as Being Capable of Responsible Choice in Cultural Terms*

According to OAKESHOTT (1972:19), "Human beings are what they understand themselves to be ..." in respect of beliefs about themselves and the world they inhabit. They live in a world of intelligibles as determined by culture: a world composed not of physical objects, but of occurrences that have meanings to which there are potential alternatives. Man's contingent situation in the world is what he understands it to be and he responds to it by choosing to do 'this' rather than 'that' in relation to wished for outcomes in respect of needs or wants. Man's needs and wants are not genetic urges or biological impulses but imagined satisfactions that have reasons, but not causes and are eligible, within an understood and normative frame of reference, "... to be wished for, chosen pursued, procured, approved or

disapproved" (Oakeshott, 1972:20) (cf 5.2.1). The decisions and choices a person makes do not take place in isolation from the rest of society.

Research reveals that health care decision making is marked by a great many factors such as social and economic costs, prestige factors, distance, convenience, reputation of practitioners and belief systems (Foster, 1983:24). In the final analysis, in times of illness, no single model can predict care-seeking behaviour, for every course of action is dictated by personal choice within the context of the situatedness of the individual.

(b) Man as a Being capable of Responsible Choice as Andragogical Category

Man, as being capable of responsible choice, reflects more an andragogical aim structure than andragogical category *per se*. The aim structure relates to the human capacity for autonomy which enables man to be creatively active through his ability to formulate beliefs and aims, to choose to put them into action and to accept responsibility for the consequences in the knowledge of at least the immediate results. Autonomy, in this sense, does not imply a radically free individual. Meaning itself is socially constructed so that intentions to act and the action itself can only be meaningful within the context of rules which the individual chooses either to obey or to break (Booyens, 1991:481). The identification of an act as normatively meaningful presupposes a group of persons who accept certain conventions and agree upon certain constraints that have to be continually reproduced or enacted. At the same time, without interpretation and re-creation of meaning, persons remain isolated and potentially worlds apart (McLeod, 1987:69).

Freedom, as autonomy, is not primarily a freedom from but a freedom and prerogative to choose and attribute meaning (Reeler, 1985:126). Man is free to choose according to his convictions. Freedom implies voluntary acceptance of responsibility on grounds of accountability (Van Zyl, 1980(b):257). Man makes his choices under the authority of norms and values. Freedom, responsibility, authority and accountability, therefore, all constitute andragogical categories.

Being capable of responsible choice and becoming, as realisation of possibilities, are inextricably related. The freedom the individual possesses is a freedom within limits because, as human being, he is situation bound: thinking, judging, interpreting, choosing and acting from his situation (adapted from Gunter, 1988:25). Born into a certain cultural milieu, he cannot break through the boundaries of his situatedness at will. He does, however, have the freedom to choose between all the possibilities which every actual situation presents to him (Van Vuuren, 1990:116). Man is also perpetually bound by unconscious and unacknowledged circumstances and, frequently, confronted by unintended consequences of his actions as a result of which he is in need of a feeling of ontological security (Giddens, 1993:7-8). He is in need of accompaniment by another adult who knows and is able to guide the learner to realms beyond what he already knows in respect of health and well being and one who forms a link between the world of personal and public thought. A paradoxical situation emerges in that what is not yet learned is not yet known and the potential learner can, at best, only dimly perceive what he wants to know and do with such knowledge. It becomes the responsibility of the educator to choose between the range of possibilities to be presented (Lawson, 1979:25-26). Expectation, however, remains an essence of the andragogic

relationship and the learner retains the choice of engaging in, or withdrawing from, the andragogic activity in terms of his estimation of the relevance and worth of those things by which he is encountered.

Authentic andragogically accountable assistance does not imply a relationship of authority as in pedagogical guidance, but one of human fellowship and mutual freedom (Grundtvig, *in*: Warren, 1989:216) in a relationship of trust which presupposes expertise, understanding, participative dialogue, reflection, acceptance of difference and the presence of norms.

Health education, as adult education, is not an act of acquiring a ready made stock of ideas, sentiments, beliefs and practices, but it is learning to listen, look and think, to imagine, feel and believe, to understand, choose and act (Oakeshott, 1972:22). By choosing to learn something, the learner is demonstrating that for him it is worthwhile. Learning to act and choosing whether to follow, modify or break the social conventions or rules are essential ingredients of being a human and cultural being (Booyens, 1991:481).

KANT (*in*: Du Plooy *et al.*, 1987:80) points out that man is and remains within society and that it is through society that he learns to think and attain freedom. Man is confronted by meanings to be fulfilled and values to be realised. He lives by ideals, values (Frankl, 1966:104) and norms.

3.2.1.10 Man as Normative Being

Man's exceptional position in the world must be ascribed to the normative nature of his existence. It is this qualification which distinguishes him from non-normative beings. By postulating personal openness as an ontological anthropological ground structure, normativeness is acknowledged (Oberholzer, 1979:118).

The term 'norm' is derived from the Latin word meaning carpenter's square which, when used in a metaphorical sense, implies to measure or to "... establish to what extent *something* is true" (Van Rensburg *et al.*, 1994:455). Norms serve as criteria and guidelines for man's decisions and provide him with a frame of reference with which to face the future.

Involvement in the world "... presupposes a valued objective" (Vrey, 1979:37). Norms and values constitute the directives by and in which man can determine the course, quality and the meaning of his existence (Staples, 1987:80). They are an integral part of decision making in the sense of actualisation of potential and personal meaningful fulfilment. Man is pre-eminently a decision-maker. Before he decides what to do, he has to visualise the possible outcomes of his decisions. This is done against the background of norms and values. His decisions change the situation opening up new vistas in life for which he is accountable (Du Plooy and Kilian, 1990:103).

Man intentionally chooses and directs his life in accordance with an acquired philosophy of life which is directed towards the future. The actualisation of a meaningful life would not

be possible without authentic co-existence and the guidance of a fellow human being in response to man's need for the *agein*.

(a) *Man as Normative Being in Cultural Terms*

Norms and values are deeply embedded within the cultural framework of human existence. Man's human strivings, norms and values have guided him through critical life and death matters in the past and will continue to determine his day to day life in the future. Norms and values are subject to change over time, but are resilient to change because of their shared importance to individuals, groups and societies (Leininger, 1978:199-200). Because of norms and values, education can never be regarded on purely personal terms for "... it is essentially one of many social processes" (Lawson, 1979:50). Therefore, to focus on the individual in order to change behaviour has limited effectiveness, because the individual continually confronts cultural premises derived from family, friends (Spradley, 1990:141) and the community. It is in terms of norms and values that what is to be learned will be regarded as worthwhile and desirable. Norms and values constitute the foundation on which justification for a course of goal directed action rests.

Cultural norms and values play a role in the arena of health care by the definitions and priorities they provide (Shuval, 1981:339). Normative orientations influence perceptions of physical, social, emotional, intellectual, developmental and spiritual well-being (Potter and Perry, 1993:40), patterns of behaviour in seeking health care, styles of practitioner-client-educator interaction and degrees to which suggestions will be accepted and acted upon

(Chrisman and Johnson, 1990:107). Furthermore, when confronted with a choice between health related and other goals man is "... not logically obliged or psychologically predisposed to put health first" (Graham, 1988:105). Where the educator's conception of what is worthwhile differs from that of learners, knowledge of such matters is not only critical, but a culturally sensitive matter (cf 5.3.2.10).

(b) Man as a Normative Being as Andragogical Category

An answer to KANT'S question (in: Du Plooy and Kilian, 1990:103): "What should man do to be regarded as a human being?", perhaps lies in the individual's ability to realise norms and values. Every adult has been socialised through involvement in, understanding, orientating himself towards, accepting and constituting his human life-world. Man, as dependent being in independence, has constituted his life-world through the implementation of freedom of choice, based on values and norms internalised during childhood in response to normative human guidance.

As adult, man is a being in self directed independence, who continues to constitute his world through the implementation of choice under the authority of norms and values, while remaining in need of authentic accompaniment by a fellow adult as he strives toward actualisation of possibilities in the face of an unknown and changing future. In this sense, adult education may be said to be a goal directed activity under the authority of norms.

Implicit in the concept of adult education, is an encounter between people who, as adults, are

equals and yet by implication, the aim of education constitutes a conscious attempt to change persons in some way, however slight, to become different from what they were. The question is, how can this be achieved while at the same time maintaining respect for personal autonomy (Lawson, 1979:14-15) as manifest under the guiding influence of norms. Conflicts between norms, values and interests are bound to occur in homogenous as well as heterogeneous groups (cf 3.2.1.16) on grounds of both personal and communal meanings ascribed to the world.

On what grounds does the adult engage in the andragogical encounter? The essence of such an encounter lies in the voluntariness of the engagement. Adults, possessing an awareness of their weaknesses and limitations, must have some trust in the knowledge, expertise and educational judgments of the educator. The essences of an andragogic relationship of trust include acceptance of, and respect for, difference and the humanness of the other, responsibility and accountability for decisions in respect of what is presented and for the quality of guidance (Lawson, 1979: 26). PATERSON (in: Lawson, 1979:23) speaks of a common search for meaning through discussion as "... an activity of mutual address ..." which is realised through a discussion within an educational setting that is "... consciously experienced as inviting verbal exchanges of a completely free and open kind" in an attempt to get behind the facts, to penetrate to the meaning behind the meanings that are conveyed (cf 5.3.2.5). The contributions of all members of the group are taken into account, but what each person learns is uniquely personal. Involvement in becoming, in this sense, is an existential, ethical and normative occurrence in which the norms themselves may undergo a shift in meaning.

The norm images which are unlocked through andragogic engagement include the meaningfulness of existence; accountability for life choices; self-collective judgement and self-collective understanding arrived at through the application of norms to arrive at ethical judgements; a critical interpretation of human potential and an awareness of each individual's value as a human being (adapted from Landman *et al.*, 1977:51-52). These norm images constitute essences of the andragogical categories of normativeness, freedom and authority within the context of the ground structure of man as cultural being.

3.2.1.11 Man as Cultural Being

Conclusions, drawn from the definitions of culture in Chapter One, reveal that the term refers to a complex, integrated, holistic way of life embodying meanings, values and norms which are shared, learned and transmitted by the members of a specific group, are historically determined and subject to change.

The use of the term 'cultural norms' reveals the close ties between normativeness and man's cultural nature. The reference to man's nature in this context is not natural in the sense of nature, but in that of culture (Oberholzer, 1979:125). Man's existential openness, his desire to actualise potential and the freedom which permits of his placing himself under the jurisdiction of cultural norms and values demonstrate, in part, the holism of human existence.

Man responds to his world in accordance with his own culture (Chesler, 1983:66). He is a cultural being from the moment of birth, concerned, as ontic openness, with cultural pro-

gression (Oberholzer, 1979:124). As cultural being, he is engaged in becoming someone in accordance with the demands of the culture of which he is a bearer. At the same time, personal subjective experience reflects his evaluation of the situation (Vrey, 1979:42). The *Gestalt* of his meaningful relationships constitutes one dynamic interacting whole in which genetic potential, psychological abilities, emotions, perceptions, interests and desires are brought into play in a particular culture where norms and values are aligned with ideals and expectations (Vrey, 1979:15). In this regard, TEN HAVE (1968:10) refers to man's internal situation (or psychosomatic nature which reflects the very core of his experience and action) and his external situation (or relationship with his human and cultural environment) which constitute two sides of the same coin, part of the holism of man. It may, therefore, be stated that man is not only culturality but that he experiences his culturality.

Language, as an aspect of culture, is the means through which the individual is brought into relationships with his world. It is the medium through which knowledge, beliefs and values are transmitted and thoughts and feelings exchanged. Language manifests as culture and is of man, for, according to HEIDEGGER (1988:47), man's being "... is essentially determined by the potentiality for discourse ... (which constitutes) ... *the existential-ontological foundation of language ...*" (Heidegger, 1988:203).

(a) *Culture as Overarching Ground Structure of Human Existence*

The interrelatedness between culture and the anthropological ground structures of human existence has become evident, not in the sense that the one may be deduced from the other,

but in that each structure, as ontological fact, throws light on and brings greater clarity to the other. Each illuminates the other and is, in turn, illuminated within the overarching context of culture. Because culture not only provides a common way of knowing the world, but is the focal point at which the interwoven skeins of all the ground structures are drawn together and reflected outwards once again, it provides the dynamic framework within which man, as social and human being, constitutes and reconstitutes his world of meaning.

From both a phenomenological and anthropological point of view "... health and illness are dynamic and functional components of a culture" (Leininger, 1978:118). The cultural dimensions of an individual client are as important to assess as are his physiological and psychological states. So great is the link between culture and health, that various groups will not necessarily agree about what constitutes 'absence of disease' and many, despite evidence to the contrary, may perceive themselves to be healthy (cf 1.3.4.1).

(b) Man as a Cultural Being as Andragogical Category

Through an acceptance of normativeness as andragogical category, culturality is acknowledged as a structure in function of the andragogical event and lies at the source of the problems surrounding authentic education in cross cultural encounters. The essences of knowledge, understanding, trust and goal directed activities as delineated by LANDMAN (in: Landman *et al.*, 1980:1-2, 41-52, 83-89) are not in dispute whether in respect of child- or adulthood. What is problematic is whether the creation of a meaningful life-world and acts of mutual address, as conditions of the relationship structure, are possible in cross cultural

encounters. It is to this end that this study has been undertaken. Any guidelines that emerge for the conduct of health education in cross cultural encounters will be evaluated against the andragogical categories that have been revealed in this chapter.

Culturality or cultural creativity as andragogical category is closely related to normativeness, openness and becoming, together with relatedness and co-existential involvement and the capability of individuals for responsible choice as intentional self-transcending beings. The conditions inherent in the phenomenon of culture and its associated structure, language, which may be destructive of, or conducive to, the realisation of empathic agogical guidance of adults, as bearers of a cultural mission, are to be discussed in Chapter Four.

It has been demonstrated that culture is not static, but changes over time as past becomes present and the present merges with the future. Health education cannot occur if the individual's present situation is not taken into account. He belongs to the present which in turn rests on the past.

3.2.1.12 Man as Historicity

The roots of the individual stem from the past, his potential becoming lies in the present and his actualised becoming in the future (Du Plooy and Kilian, 1990:145). Man exists in time. Each person must create his own present from the past (Van Zyl, 1977:154). According to HEIDEGGER (1988:39-40), the temporality of man indicates his existence in time and constitutes the horizon for understanding him, because Being, in all its modes and characteristics,

- has its meaning determined primordially in terms of time.

Not only is human life characterised by temporality but also by temporariness or transience, in that temporality is futurity. It points to the not-yet which lies ahead, which then becomes an event with a beginning and an end, but survives in man's memory and is thus perpetuated. The future becomes a fulfilment of the past so that temporality and transience are interlinked (Oberholzer, 1979:126-127).

HEIDEGGER (1988:431) states that "... *Dasein is historical in its Being*" manifesting as a synthesis between temporality and transience (Oberholzer, 1979:127). As openness, the future holds a challenge for man. He is not historicity because of the past, but specifically because of the call of the future. He is historicity as futurity in normativeness. Every decision is an answer to the demands of the future in the course of the implementation of freedom and an acceptance of responsibility for the future (Oberholzer, 1968:163). Although man plans today for what he aims to do later, the future is uncertain, unpredictable and unknown. (Du Plooy and Kilian, 1990:148).

In time perspective, society today is a technological society characterised by complexity, polyvalency and rapid change. It is a truism that today's man lives and works in a cultural milieu that is, to a great extent, different from that of his elders. Man as historicity or man as futurity becomes a fundamental structure in the andragogical occurrence.

(a) *Man as Historicity in Cultural Terms*

Man, as subject, is able to make decisions and constitute the circumstances of his existence through his creation of society and, therefore, of history (Alfred, 1984:105). The reworking of the past and rethinking of the present go hand in hand for each is "... a condition and a symptom of the other (Scheffler, 1980:406). The centrality of culture in the history of man is summed up by the statement of BURKE (*in*: Franklin, 1983:3) that

"A people will not look forward to posterity who never look backward to their ancestors".

While the Africans' (for whom substitute all people's) political and social world view must take cognisance of the traditional past, the present and future cannot be ignored. The experiences, beliefs and ideas of people change over time and, as human consciousness, are an important instrument for social, political and scientific change. People in the twentieth (and twenty first) century cannot be expected to think in terms of the past (Makinde, 1989:61). In the final analysis,

"Nations are formed and kept alive by the fact that they have a programme for tomorrow" (Gasset, *in*: Franklin, 1983:3).

(b) *Man as Historicity as Andragogical Category*

The nodal point between past and future is the present, in the sense that living in the present implies experiencing the past and providing a vision of the future so that the goals set can be

re-evaluated in terms of changing circumstances and demands of the present. Past and present are known, but what is about to happen in the near and remote future is unknown (Du Plooy and Kilian, 1990:147-148).

Every new situation confronting the individual offers possibilities which can be actualised into reality by the creativity of the learner and others. The present creates opportunities on which the future is founded (Van Zyl, 1977:221). Living properly now and in the future is dependent on constituting a meaningful life-world, choosing responsibly from the alternative options available and acting accordingly (Du Plooy and Kilian, 1990:149).

In a polyvalent cultural milieu, it is impossible to actualise all the possibilities. The individual must make a choice. When incorrect decisions are made, the possibilities for degeneration are great, but the possibilities of attaining higher levels of human achievement are correspondingly greater when a person is capable of choosing propitiously (Du Plooy et al., 1987:78).

In the face of the rapid changes of the present era and the mature status of the adult learner, it is not possible to extrapolate specific material from the escalating knowledge explosion on his behalf and instruct him precisely in that knowledge and those skills which will equip him to deal with his personal, as yet, unknown future. It is, however, possible to equip the adult with the means of searching for meaning and understanding the conditions of his life in order to apply unfolding knowledge and skills to the demands of his own circumstances, past and present, and to his future.

Andragogic engagement, in which new meanings are realised and responsible decision making for the realisation of potential is made possible, increases feelings of worthiness and self-esteem. Confidence is increased and hope raised in confronting a concealed future, which even if threatening, impels man to persevere and search for further meaning in the light of unfolding meaning. Confidence and hope, in this context, may be translated into expectation of a meaningful future (adapted from Van Zyl, 1977:27). Such expectations are crucial in enabling persons to take control of specific conditions relating to levels of personal and community well being.

Essences of the andragogical category of man as historicity include change, expectation, concealed future and creativity for both educator and learner. Creativity, on the part of the learner, manifests in the manner he sets about the task of realising his present possibilities in a meaningful way, and creativity, on the part of the health educator, is demonstrated by the degree to which he is able to modify and adapt educational strategies in accordance with the demands of authentic health education.

Futurity, as andragogical category, is closely linked with those of openness, responsible choice and interhuman involvement. It also brings to the fore, for further elucidation, the question of change in the life of man.

3.2.1.13 Man as Unchangeable Being in Changeability

TOFFLER (1981:11) refers to the present era as one in which the current of change is so

powerful that it overturns institutions, shifts values and shrivels the roots of individuals and groups. It is change which is not only observable from the perspectives of history, but change which is experienced by persons living today. Since the Renaissance, concepts of permanence, constancy and invariability have made way for the concept of change (Oberholzer, 1979:120). VAN DEN BERG (in: Oberholzer, 1979:121-122) postulated a concept of metabletics or doctrine of change indicating that change is the focal point of human affairs and that man is different in all times and all places, for he is both events and history. The postulate of unchanging man is hereby rejected, because he is both changed and changing as a result of his dialogue with a world which he designs and redesigns in response to differing and changing circumstances. As man continuously constitutes his world, it has a reciprocal effect upon him. Consequently, neither man nor world are static concepts (Staples, 1987:69). At the same time, while man's situatedness in the reality of his world is subject to change, the essential nature or *eidos* of man as human being is unchanging. A situation of unchangeability in changeability or immutability in the midst of change, therefore, exists (Oberholzer, 1979:122).

Man's dynamic interaction with the changing world by which he is encountered and which he actively designs, is and remains a ground structure of human existence and manifests in the educative occurrence.

(a) *Man as Unchangeable Being in Changeability in Cultural Terms*

Culture exists as social reality and as ontic construct of human existence. Man is born into

a culture and is a cultural being. To this extent culture is an unchangeable ground structure of human existence. Conversely, according to GRUNDTVIG (*in*: Warren, 1989:215) "... the state must be seen as a creation of its citizens". By implication, and in terms of its very definition and the doctrine of metabletics, culture is changeable. Culture, therefore, becomes an unchangeable construct in changeability.

All systems of health care are creations of their histories that exist within specific cultural and environmental contexts. As circumstances keep changing in accordance with the unfolding of new meanings and changing social, economic and religious influences, so health care systems also change (Capra, 1982:333). It has been demonstrated that Western biomedical and traditional African health systems display characteristics of both openness and closedness (cf 2.2.3.1(a)) as features of the unchangeability in changeability of culture as a human and social construct.

(b) Man as an Unchangeable Being in Changeability as Andragogical Category

If changeability represents a change in expression, but not in form (Higgs, 1984:53), it becomes possible to refer to the adult as a person who, as cultural being and bearer of a cultural mandate, is constantly engaged in action-laden change in his encounter with his surroundings (Oberholzer, 1968:72). In a technocratic society, where man is subjected to so many changes, he loses confidence in himself, does not feel safeguarded and experiences difficulties in discovering that which is meaningful. Rapid change has andragogical implications in that the adult is in need of accompaniment in the unfolding of meaning and

the decisions he is called upon to make in confronting a world of change. He is called upon to act in order to realise his potential within the boundaries of a culture that cannot be viewed as static. Not only is he expected to reconstitute a world for himself in accordance with norms, but all forms of adult education have to enable him to give expression to his humanness in compatibility with the vast changes taking place around him. He needs to be able to take advantage of change through the attribution of meaning, effective decision making and the assumption of responsibility, for "Man, world and education are inseparable entities" (Du Plooy and Kilian, 1990:54). Unfolding meaning in respect of health care generates expectations of improved future well-being.

As the learner faces an unknown and changing future, it is the task of the adult educator to meet the yearnings of the learner to be recognised as a human being, to be understood within the context of his personal world of meaning and aspirations for the future in the face of a changing present. The adult has a need to engage and be engaged in a relationship that guarantees to preserve his human dignity through the exercise of empathic guidance, a recognition and acceptance of his potential to become that which he ought to become through the realisation of his possibilities within the framework of personal decision making and the guiding influences of personal and cultural norms.

In the light of the above, it may be stated that man as unchangeable being in changeability constitutes an andragogical category and that the concepts highlighted in this section reflect associated andragogical criteria. The essences of constancy and durability endure within change.

Against the background of changeability and individual and unique differences inherent in the situatedness of each person, a recurrent concept of unchangeability has emerged, namely, that of respect for the individual as a bearer of human dignity. When man's uniqueness is recognised, his human dignity is also honoured (Reeler, 1985:160). This is a concept which requires further elucidation.

3.2.1.14 Man as Being in Possession of Human Dignity

OBERHOLZER (1968:166) states that man is the bearer of invaluable worth or dignity and PIENAAR AND VILJOEN (1976:72) conclude that "Human dignity is one of the indispensable characteristics of man". Man experiences an existential need to be recognised as a person, as a human being, which, in turn, represents a need for recognition of human dignity. The establishment and maintenance of human dignity is essentially a matter of co-existential concern (Oberholzer, 1979:128).

Human dignity may be described as "... the acquisition of the authentic image of man" (Higgs, 1984:47). To be a bearer of human dignity implies not only rights and demands, but also duties and responsibilities (Oberholzer, 1968:167). As an open being in a world of meaning, man must realise his own dignity, but in accordance with the exercise of freedom and authority as a being who is capable of choosing responsibly.

All men have equal ontological status as an expression of authentic humanness regardless of age, creed, colour, race or status. Therefore, all persons "... should live with human

dignity" (Reeler, 1985:161) and are equal in dignity (Gunter, 1988:64). However, every person is unique and singular in that he lives a singular existence and, as person, is not interchangeable or repeatable (Viljoen and Pienaar, 1976:187). In his uniqueness, not only has the person constituted his own personal life-world, but he has done so from within his situatedness in that world. A situatedness which includes circumstances such as culture, religion, social class, race, family life and available opportunities. For this reason, equal dignity amongst all people does not imply equal distribution of experience, expertise and ability between people. GUNTER (1988:64) records that people are qualitatively unequal because of these differences. Hence, it may be concluded that equal dignity in inequality is a fundamental structure in function of human existence.

It is in the context of the ontic fact of inequality stemming from personal circumstances in the face of an unknown future, that each person is confronted by a perennial need of support from another person. This need, in turn, constitutes the foundation of agological support in all its modes. Inequality in the sense of ability, expertise and experience, but not in that of dignity, is a reality which is an essential feature of enabling dialogue (adapted from Oberholzer, 1979:129) and, therefore, a category of the andragogic event which may not be denied.

(a) *Man as Being in Possession of Human Dignity in Cultural Terms*

"Because cultural meaning is part of the symbolic/expressive aspect of human behaviour, it is not easily confined to the tenets of linear logic" (McLeod, 1987:69).

Culture, both personal and public, plays an important role in setting limits and/or generating opportunities in respect of each individual's attribution of meaning to his world and, in openness and as transcending being, to realise his possibilities. Conceptions of knowledge and truth, that have been generally accepted and articulated until recently, have been shaped throughout history by dominant cultures. Drawing on its own visions and perspectives, the dominant culture has constructed prevailing theories, written history and set values that have become the guiding principles for action (adapted from Belenky *et al.*, 1973:5).

It is on these terms, and within the situatedness of stereotypes and prejudices surrounding age, gender, creed, ethnicity, race and social class, as well as within the context of family life, personal attributes and potentialities in conjunction with available opportunities, that culture interacts with the ontological ground structure of man as being in possession of human dignity.

(b) Man as a Being in Possession of Human Dignity as Andragogical Category

All persons are equals in dignity because each person possesses his own absolute and intrinsic value. Qualitatively, adults are unequal, differing in respect of capabilities, tendencies, attitudes and opportunities and life experience. It becomes necessary for adult educators who are themselves unequals in equivalence to take note of individuals as they are revealed qualitatively (adapted from Gunter, *in*: Du Plooy *et al.*, 1987:67). The andragogical relationship is one which may be categorised as one of inequality in equivalence (Du Plooy and Kilian, 1990:79).

The adult educator should acknowledge, respect and regard each learner as a person of original and irreplaceable personal value and dignity. Learners may not be reduced to the level of objects by sacrificing them in any way to a system of beliefs, rigid institutionalised goals or ideology. In order to achieve this, the educational goals and means whereby they are achieved must be adapted to the adult learner as he is: a unique human being in possession of a particular point of view and personal aspirations, who is capable of responsible choice with a measure of control over the circumstances of his life and one who has a need to be both accepted and needed as an expression of his being in co-existence with his fellow-men.

Such an approach goes beyond considerations of the cognitive level of the learner and includes the essences of respect, tolerance, patience, understanding, honesty and a demonstration by the health educator, both by precept and example, that it is feasible for two adults to reach mutual understanding of each other's points of view without necessarily being able to agree with or disprove the stance of the other. Grasping the other's logic makes communicative discourse and the unfolding of further meaning possible. Although these qualities are important in all communication, they become critical in intercultural exchanges (Hufford, 1992:17; Hamm, 1989:125; Gibbs *et al.*, 1988:3). To listen actively and respond appropriately, not only to the cognitive, but also the affective components of the learner's communication (Coulehan, 1987:174), are further essences of respect for human dignity.

Dialogue, as communicative discourse, implies encounter and communication. An encounter takes place in the form of a physical meeting of person and things and/or between two or more persons in their physical form. An encounter, therefore, constitutes dialogue in

bodiliness (Van Zyl, 1977:225).

3.2.1.15 Man as Being in Bodiliness

Man constitutes and inhabits his world with his body or in bodiliness. His corporeality constitutes the mode through which he mediates with his world (Van Vuuren, *in*: Staples, 1987:77). The body is the bearer of the human being and, at the same time, the expression of man's economic, political, social, cultural and environmental or existential situation (Erben *et al.*, 1992:359). The interrelatedness between man's ego and his body is revealed through his involvement with his world. He experiences his body subjectively so that each intentional act of orientation is a contributory factor in experiencing the body as representative of self (Pienaar, *in*: Du Plooy *et al.*, 1987:62). OBERHOLZER (1979:223-224) argues that "... we are our bodies and that our bodies are ourselves", therefore, man is "... dialogue in bodiliness and bodiliness through dialogue". According to MERLEAU-PONTY (1970:95), the actual existence and representation of man's body is indispensable to that of his consciousness. Therefore, as intentionalised consciousness, man is his body and as bodiliness, he is consciousness. To man his body is his centre of orientation and experience, his medium of movement, dialogue, exploration and of constituting his world (Pienaar and Viljoen, 1976:181).

MERLEAU-PONTY (1970:90-97) refers to man not merely as 'body-object', but 'body-subject' in which the structural characteristics of the body become consistent, affective experienced contents of consciousness. As body-subject, man is encountered by others as

body-subject, although the possibility exists of being encountered as body-object should he be stripped of and denied human dignity. Dependent on his acceptance or rejection in bodiliness by others, man may experience feelings of security or insecurity.

Man as being in bodiliness and culturality are closely interwoven ground structures of man's social reality.

(a) *Man as Being in Bodiliness in Cultural Terms*

The individual body as understood in the phenomenological sense of the lived experience of the body-self lies at the primary and perhaps the most self-evident level of the body-self. It may be assumed that all people share some intuitive sense of the lived experience of the embodied self as existing apart from other bodies. However, constituent parts of the body, namely, mind, matter, psyche, soul, self and the relationship of each to the other and the ways in which the body is experienced in health and illness, are highly variable (Lock and Schepers-Hughes, 1990:50).

Cultural differences constitute the source of such variables. It has been demonstrated, for example, that the Western biomedical system views body, mind and self as distinct and separate entities while social relationships are seen as partitioned, situational and segmented (Manning and Fabrega, in: Lock and Schepers-Hughes, 1990:63). Conversely, traditional African medicine tends toward inclusiveness of body, mind and self and an understanding of social relations as key contributors to the health of individuals and communities as a whole.

The link between health and culture is two-fold. People whose health is good can function efficiently. They possess the energy to be constructive and creative (in the realisation of potential and possibilities) and can contribute (responsibly and meaningfully) to the well being of their families and society at large. For those who are continuously in poor health, little more than survival may be possible. Their condition may be accompanied by indifference to the welfare of the wider society and the possibility of their children sliding into the same vicious cycle of poor health, impoverishment (Pohl, 1981:3) and disadvantage.

In the health education situation, man as bodiliness constitutes an andragogical category.

(b) Man as a Being in Bodiliness as Andragogical Category

When a successful andragogical encounter occurs, educator and learner are with one another in the fullest sense of the word and an existential dialogue becomes apparent (adapted from Oberholzer, 1968:172). Both are present not purely as bodiliness but in the sense of an experiencing, intentional, appreciative, normative expectant and trusting encounter (Oberholzer, 1968:71). Bodiliness in communication is thus indicative of the totality of that which is man in his situatedness and as intentionality.

Rejection of the physical appearance of any human being on grounds of disability or racial features constitutes a denial of his ontic dignity and a concomitant dehumanisation and de-personalisation of the individual concerned. Learning is unlikely to take place under these circumstances.

3.2.1.16 Man as Being in a State of Homogeneity in Heterogeneity

Culture has been shown to "... act as the fabric of shared meanings which exist between different people ..." (Courtney, *in*: McLeod, 1987:69) in and through which the notion of cultural diversity is both acknowledged and affirmed and a sense of national identity construed. For this reason, most writings and the majority of educationalists consider culture as an institutionalised group phenomenon and assume homogeneity within a given cultural group. GOODENOUGH (1976:4), however, points to the fact that multiculturalism or heterogeneity is playing an increasingly prominent role in the affairs of complex societies, and is to be found in simple societies as well. It is difficult to find an example of a homogenous culture because almost all societies are culturally plural with many displaying religious variations and all, but the smallest, display regional variations such as rural and/or urban industrial features (Craft, 1984:13), in addition to gender, age and ability. One of the characteristics of twentieth century urban dwelling is that there are major divisions of social roles and functions as well as major differences in lifestyles, social expectations and aspirations (McLeod, 1987:70). All groups may, therefore, be said to display characteristics of communality in diversity or homogeneity in heterogeneity: the ontic ground structures referred to by GOODEY (1989(a):86) as universality and individuality, cohesion and diversity, generality and speciality and by LIEBENBERG (1988:iii) as communalness in diversity and particularity in multiculturalism.

(a) *Man as Being in a State of Homogeneity in Heterogeneity in Cultural Terms*

The notion of a common cultural core as universal cultural phenomenon (cf 4.4.2) constitutes an important concept within the category of man as being in a state of homogeneity in heterogeneity. At the same time, differences amongst individuals in the same culture may not be ignored. GOODENOUGH (in: Camilleri, 1986:46-47) points to the fact that as societies grow more complex and interpenetrate each other, cultural reality becomes increasingly relative: less and less a total entity attached to a specific group, ethnic or otherwise and even less, an essence taking possession of individuals. In speaking about the learning of culture, emphasis is placed on the activities of people within the actual scope of their interrelationships. No individual comes into contact with culture *per se* but rather with other culture carriers. These carriers of culture never carry the totality of the culture attributed to the group intact, merely that out of which each has carved his own mixture. Implicit in a recognition of individuals acquiring some cultural knowledge in at least one major system, is the fact that "no one ... is going to acquire all of it" (Wolcott, 1987:33). In respect of health care, major differences concerning the distinctions and meaning attributed to health and ill-health exist between medical practitioners and lay persons in the same culture, not to mention differences inherent in individual, family and community experience.

Therefore, it may be concluded that each individual within a culture selects content from the cultural capital, sub-cultural capitals or multicultural capitals available to him and, in turn, becomes a bearer of that which he has learned in the situatedness of his interrelationships. Important to note, is the fact that individuals do not build their personal cultural 'reservoir'

or 'pool' on a whim and randomly, but within the structures, organisation and value systems of their cultural milieu. Man is a normative and cultural being: his adaptations to his human world, including the world of health, and the decisions he makes are influenced by this world. In his turn, adjustments, essential for survival and attribution of meaning, are related to the decisions he makes (Arthur, 1992:296-297).

It should be noted that the traditional assumption of homogeneity in populations frequently camouflages the reality of heterogeneity within human populations and by so doing distorts the thinking and findings of researchers and practitioners alike.

(b) *Man as a Being in a State of Homogeneity in Heterogeneity as Andragogical Category*

The concept of homogeneity in heterogeneity lies at the root of any educative discourse between adults. Initial andragogic engagement, in all its facets, rests on the basis of communality, whether stemming from a shared core culture or founded, in instances of cross cultural encounters, on the basis of shared humanness. Difference, in all its modes, manifests as the means through which options and possibilities unfold. Engagement implies involving learners in open ended discourse enabling them to reflect on and make sense of their lives and experiences. The creation and re-creation of the aspects of man's culture, including health care, is related both directly and indirectly to the personal experiences of people (McLeod, 1987:73). It is an act of personal choice and influences the degree to which people gain competencies in areas that influence their affairs as well as their potential access to privilege

and power. Each person's cultural 'reservoir' or 'pool' depends on the manner in which he directs the interaction (Camilleri, 1986:47), thereby reflecting individual choice within a socio-cultural context.

Not only does homogeneity in heterogeneity and cohesion in diversity have reference to the culturality of persons versus their individuality, these aspects also possess equivalent relevance to man's culture itself.

Yet another significant ground structure that has not been touched on thus far is that of man's religiosity.

3.2.1.17 Man as Religious Being

"Religions are to a large extent moulded by culture" (Higgs, 1983:17). Human existence is incomplete and incompletable, characterised by tension and expectancy, transience, vulnerability and temporality. Man needs to know that the life he leads is meaningful, he needs security and stability and a knowledge that his values rest on a sure foundation. OBERHOLZER (1979:130-131) claims that science provides no final answer as regards these matters. Religion, as an attitude of belief, value judgement and acceptance of meaning, offers answers, not in what man believes, but that he believes (Van Vuuren, 1990:299-300): that he seeks answers to the imponderable questions related to life and death and the meaning of life itself.

(a) *Man as Religious Being in Cultural Terms*

Although not a special function of man's spiritual life, religion remains "... the dimension of depth in all of its functions" (Tillich, *in*: Higgs, 1983:5). CHESLER (1983:67) established that both moral and religious components of pure humanness are delimitations of specific areas within the normative activity. Religiosity, a ground structure in its own right, may be regarded in conjunction with normativeness and culturality.

(b) *Man as a Religious Being as Andragogical Category*

For all who yearn for security and stability in their encounter with the future, faith in the form of religion supports and strengthens their view on the meaningfulness of life, gives added significance to their cultural and intellectual activities and their morality (adapted from Oberholzer, 1979:131). Religiosity is, therefore, an andragogical category. The associated andragogical criteria are those embedded in normativeness and culturality.

2.3 CONCLUSION AND FURTHER PROGRAMME

An attempt has been made to penetrate the ontological foundation of man and reflect radically on the essences of the andragogic phenomenon as universal anthropic phenomenon with special emphasis on the overarching influence of culture. The revelations which have emerged are to be used in an endeavour to elucidate aspects of the problems surrounding health education in cross cultural encounters and to bring to light the universally valid reality

of adulthood on which the agogical is grounded and may or may not become meaningful in the situatedness of a health system characterised by multiculturalism.

Disclosures concerning the nature and structure of the anthropological grounding of the agogic, in association with the reality of health education in the cross cultural encounter as revealed in the forthcoming chapter, are to form the basis of the conclusions and guidelines concerning authentic health education. Evaluation concerning the andragogical acceptability of these conclusions and guidelines will be in accordance with the categories and criteria constituting the universal, interrelated and ontologically guided verbalisations as revealed under Section 3.2.

The ground structures and associated andragogical categories and criteria cannot, as has been attempted to illustrate, be viewed in isolation, as they become only truly meaningful when viewed as an integral totality and, for the purpose of this study, in cultural terms. In this connection, the fact that many criteria or essences are directly associated with different categories has been clearly revealed.

In an attempt to reconcile the demands of the *agein* with the world situated reality of adults in the cross cultural health education encounter, it becomes necessary to reach an empirical understanding of the key issues in health status and health education which are influenced by the previously mentioned factors of race, ethnicity, language, religion, class and gender in cultural context. These are human activities in which aspects such as student-lecturer cultural orientations, perceptual frames of reference, modes of communication and parti-

ipation and cognitive and learning styles manifest.

An elucidation of these matters and related philosophical issues will be attempted in Chapter Four.

CHAPTER FOUR

CROSS CULTURAL ANDRAGOGICAL ENCOUNTERS IN THE HEALTH CARE SYSTEM

4.1 INTRODUCTION

In the previous two chapters an attempt has been made to demonstrate that health systems do not exist in a social and historical vacuum and that culture constitutes the single overarching anthropological-ontological ground structure of all such anthropic-ontic structures: not in the sense of culture as static entity nor exclusive of notions of the communality and the uniqueness of human action and experience.

It is precisely because culture influences life-style and life-style influences health that life-style, health and culture have become focal concepts in health education. One of the most intractable problems facing health education in cross cultural situations relates to the historical and current complex situational aspects of social, economic and political forces where life-style is reflected in differences in sub-cultural values, belief and action systems as well as in differences in standards of living and health status, unequal power relationships and opportunities together with inequalities in health care services and man's perceptions of such differences.

While historical forces have been identified in respect of the above, an assessment of any

educational action requires an understanding of social phenomena to which educational responses are made (McLean, 1983:180-181) and health status is influenced. In an attempt to penetrate the relatedness of facets of cultural or group life to man's *eidōs* and health education outcomes, key issues such as race, ethnic group, social class and gender will be explored. These facets will be grounded on the individuality of persons and on their group interpersonal relationships in the human world of health and health education.

In this chapter, the aim of the researcher is to focus on those issues most frequently identified as responsible for the health status of communities and success or failure in learning outcomes and to examine their influence on human actions and interactions in the situatedness of health education and training. The issues to be addressed include those areas of behaviour and human relations that are influenced by the previously mentioned factors of race, ethnicity, social class and gender. Furthermore, culture as overarching ground structure of human existence contributes toward the dimension of divergence and similarity in health educator-client orientations, perceptual frames of reference, cognitive and learning style as well as in respect of language and communication style.

4.2 KEY SOCIAL ISSUES IN HEALTH STATUS AND HEALTH EDUCATION IN MULTICULTURAL SOCIETIES

According to GROSSE (1982:105-106), there has been a revolution in areas of life expectancy and educational coverage since World War II. It has become evident that education, however measured, and health status, usually measured in accordance with dimensions of

morbidity, mortality and life expectancy, are closely linked. How they are linked and what activities will make a real difference require clarification. Each may be caused by the same set of circumstances or be mutually interactive. Examination of either health or education in the absence of consideration of other social variables implies that we may only learn about the net effect of the sum total of these life events in isolation from the total human reality constituting the life-world of health educators and learners alike.

VAN RENSBURG AND MANS (1987:1-2) state that in any review of South African society, it is vitally important not to lose sight of its divergent and complex composition and to specify the sharp sub-divisions existing within the population. It has been noted, generally accepted and indeed substantiated that certain segments of the population are notably more susceptible to disease in general and certain diseases in particular and are, therefore, exposed to a higher risk of morbidity and mortality. This is partly due to the fact that membership of a specific social group often implies adherence to particularly distinctive behaviour patterns dominated by distinctive socio-economic and cultural factors. Members of such groups follow a typical life-style and are exposed to typical stress situations that may inhibit or enhance the individual's chances of coming into contact with certain pathogens which, consequently and commensurably, increase or decrease the individual's risk of disease, disability or death. Membership of such groupings may also influence access to health and other facilities and services, as well as the allocation, availability and quality of such services. In South Africa, the most important sub-groupings of the population which are directly or indirectly linked to disease, in general or in particular, include racial and ethnic affiliation, rural/urban differentials and socio-economic sub-groupings such as those linked to education,

occupation, income, age and gender. Studies worldwide indicate that this situation is not unique to South Africa and that these differentials have equivalent outcomes in formal education systems.

In an attempt to attain a greater understanding of the issues involved and gain insights into educator and learner actions and interactions, these concepts will be examined as separate entities, but the reader should keep in mind that they are inseparable. Each kind of disparity may be treated separately for analytical purposes, but in reality they tend to be indivisible (Coombs, 1985:217).

4.2.1 RACE AND RACISM

The term race is an anthropological concept developed during the eighteenth century. It was derived from a system within the natural sciences for the classification of animals and plants, and used for the purpose of dividing mankind into categories on the basis of physical characteristics such as size, shape of head, eyes, ears, lips, and nose and the colour of skin and eyes. These hereditary characteristics are not exclusive to any racial group, but rather overlap from one racial category to another. (Bennett 1990:43).

Race is thus a concept with a precise meaning exclusive of culture, religion, language and ethnicity. The concept of race as defined has little or no relevance to an understanding of social, economic and political differences amongst men. As a concept, race takes no cognisance of the fact that genetic diversity within racial groups is probably as great as that

between groups and that all men are members of *homo sapiens* (Cohen and Manion, 1983:12) who may not be reduced to organic and inorganic properties, to the principles and laws of the world of natural sciences. All men are human beings and present as consciousness in the world (Oberholzer, 1979:115).

While race remains part of human reality as a single facet of the bodiliness of man (cf 3.2.1.15), its social significance lies in the fact that, frequently, racial and cultural differences are linked in the minds of men and provide a primary basis for the categorisation of self and others. The importance lies not in the characteristics themselves but is based on evaluations associated with them (Hobbs, 1987:19). The equation of the concepts of race and man as culturality carries with it the attendant risk of diminishing the essential dignity of those persons who are racially different, when it manifests as racism. Racism or an attitude that one racial group is inherently superior to another (Garcia, 1982:79) may be defined as

"... the combination of discriminatory practices, unequal relations and structures of power and negative beliefs and attitudes which hold that black people are essentially inferior to white people either biologically or culturally or both" (Freer, 1987:7).

In South Africa race and culture are often viewed as synonymous (van Zijl, 1987:187). Both the health and education systems have been based on a racial foundation. That disease and morbidity is highest in the Black and not the White population is reflected in the following demographic data.

- * Total fertility rates or number of children per woman in her fertile years during 1990 (Race Relations Survey, 1994:129) are presented as 4,7 for Blacks, 2,8 for Coloureds, 2,3 for Indians and 1,7 for Whites. These figures reflect not only the status of women in the respective race groups (cf 4.2.6), but also standards of living (cf 4.2.3) and associated standards of health.
- * According to COETZER (in: Race Relations Survey, 1990:421), 61 per cent of deaths among Black children during 1988 were due to malnutrition, prematurity and related infections, particularly gastro-enteritis. Corresponding figures for the Coloured, Indian and White groups were 41, 16 and 9 per cent respectively.
- * THE DEPARTMENT OF NATIONAL HEALTH AND POPULATION DEVELOPMENT (in: Race Relations Survey, 1994:128), in turn, reported that the infant mortality rate or deaths per 1000 live births per year for 1990, excluding the 'independent' homelands, was 52,8 for Blacks, 39,4 for Coloureds, 10,6 for Indians and 8,6 for Whites. The figures for Blacks are an estimate as birth and death registrations remain incomplete.

These figures are used to illustrate the *status quo* and not as departure point for further in depth analysis. They are, however, of potential significance in reviewing the issues of ethnicity, social class and gender as aspects of the cross cultural health education encounter. At this point, it is not inappropriate to note that religico-magical or traditional medical systems, as an aspect of culture, have been viewed as indications of racial difference and used

as a basis to accord differential treatment to people and groups.

GRANT (1988:561) argues that race is an important aspect of schooling in that it is "... a historical and contemporary determinant of life chances and opportunities." Education or the lack thereof not only influences the life-style and, hence, health status of different sectors within a population, but also carries potential implications for any barriers which may be raised in respect of participation in, and outcomes of, health education programmes. The low literacy rate of Blacks in South Africa is due to the fact that, to date, there has been no compulsory education system for Blacks, while that for White and Coloured pupils has been compulsory from the year in which they attained the age of six years until 16 years or a pass in standard 8. For Indians, the school leaving age has been 15 years (Race Relations Survey, 1990:808). In spite of radical educational reforms introduced by the Government of National Unity toward the end of 1994, the legacy of the apartheid policies of the past will continue to influence formal and non-formal education in the future. There are, however, no easy solutions to the issue, because many cases of underachievement are not necessarily connected with schooling (Watson, 1985:82).

The proponents of anti-racism maintain that underachievement of Blacks in all walks of life has, at source, the classification and evaluation of human beings on the basis of their physical appearance. These classifications, in turn, are associated with unflattering, hostile prejudices and stereotypes held about these groups by non-members. Racism may develop into racialism when accompanied by acts of discrimination, intimidation and violence (Jeffcoate, 1984:145). Many ethnically linked values tend to favour the dominant group, as an aspect

of hegemonic control, resulting in a combination of institutions in which discrimination and preferential treatment lead to greater success amongst those belonging to the dominant group. The implications of prejudice, stereotyping and discrimination in the situatedness of cross cultural education will be discussed further on in this chapter.

JEFFCOATE (1984:147) warns that preoccupation with racism to the exclusion of all else results in obfuscation and potential misidentification of real problems. Education does not occur in isolation and learners bring to adult education programmes their experience of the outside world (adapted from Bullivant, 1987:15-19), in essence, that which constitutes their personal life-world and the meaning they have attributed (cf 3.2.1.5) to it. In the world outside the school, for instance, discrimination remains a significant barrier to advancement in both housing and labour markets in the United Kingdom (Jeffcoate, 1984:17). A disproportionate percentage of West Indian adults are unskilled and semiskilled workers and suffer a higher level of unemployment than other minorities, while West Indian men hold fewer qualifications in general (Craft, 1986:84). Very few Jamaicans occupy professional, clerical or managerial positions and are constantly aware of being Black (Foner, 1977:131-133). Race in this context becomes linked with the lower social class and poverty (cf 4.2.3) even in countries where racism has not been encoded in the legislation of the land. Race and social class have, therefore, been incorporated into a theory of cultural deprivation, based on the assumption of deprivation in the home and community background of individuals. Compensatory education programmes have been built on this pathology model to cater for so-called life-style and cognitive defects in both formal and non-formal education programmes.

The links between social background and learning outcomes, as with ethnic groupings, are highly complex and not well understood and will be further discussed under 4.2.2 and 4.2.3 of this chapter because there is a danger in speaking of people in an undifferentiated way (Foner, 1977:129) whether referring to race, ethnicity or class.

ROSS-GORDON (1990:7-8) cites findings that point to the fact that education and income level is more important than race in predicting participation in adult education programmes. She (1990:11-12) notes that an examination of the past schooling experiences of many ethnically and racially defined minorities neglects alternative reasons for withdrawal from educational programmes and suggests that a plausible alternative interpretation may be that of passive or active resistance as a response to hegemonic forces existing in society.

With the socio-political changes that have occurred in South Africa, and, in the light of the experiences of the rest of the world, it is reasonable to assume that the social realities embedded in the concept of ethnicity will increasingly come to the fore and be seen to play a role in health education in the cross cultural encounter. Therefore, in an attempt to bridge the overlap between race and ethnicity, an exploration of ethnicity in socio-educational context becomes necessary.

4.2.2 ETHNICITY AND ETHNIC IDENTITY

The term ethnic is one frequently encountered in the literature on multi- and cross cultural education and is a term frequently confused with that of race. The essential difference

between the two is that racial groups, despite anthropologically based classificatory systems, are distinguished by socially selected physical traits, while ethnic groups are distinguished by socially selected cultural traits (Cohen and Manion, 1983:12) which may include race. Many definitions of 'ethnic group' exist, but in none of these is there general agreement (Banks, 1977:75). According to Bennett (1990:39), an ethnic group constitutes a group of people within a larger society which is set apart or socially distinguished by others and/or by itself, primarily on the basis of racial and/or cultural characteristics such as language, religion, and tradition. The central idea is that of being set apart, based on either physical or cultural attributes, or both, and having application to everybody in that group.

GARCIA (1982:7) links ethnicity with the concept of culture in his statement that ethnicity represents the perceptions, values, assumptions, feelings and physical features which are associated with ethnic group affiliation. Ethnic group membership generates a sense of belonging, so that alliances based on ethnicity tend to function like informal interest groups and may, therefore, be seen as political, as well as economic interest groups (Cohen, *in*: Watson, 1977:9; Banks, 1988:63-64).

The statement that ethnicity is a cogent factor in American history, life and culture (Banks, 1988:57) has equal relevance to all other multicultural societies including South Africa. Its very complexity, as a feature of human reality, is revealed in the notion that the degree to which any particular nationality, cultural or racial group is ethnic varies over time and in different regions as a result of social class mobility and the socio-political conditions within that society (Banks, 1988:64).

Ethnic belonging is a phenomenon of human consciousness which is subject to multiple influences and multiple transformations (Novak, 1982:25). On one hand, individuals are influenced by factors over which they have no control such as age, sex, religious identity or family of origin and on the other, by shared characteristics in terms of which other aspects of their conscious choices, namely, occupation, success, life-style, education, political points of view and incomes, may be studied in a generalised way. Conversely, on an individual basis, in a culturally plural society, everybody participates in more than one social group and has opportunities to become involved in cultural traditions not their own. Consequently, conscious choices relating to cultural belonging may change over time and in intensity. In the American and, therefore, pluralist context, people participate in a common culture while forging their own individual cultural identity almost always upon more than one tradition (Novak, 1982:25-26). Such an approach appears to be in accordance with the ground structures of universality and individuality in that people have a right to an ethnic culture and the right to choose their cultural affiliation.

APPLETON (1983:43-44) records that social scientists predicted a decline in the significance of ethnicity on the basis of social developmental theories. These theories assumed human-kind would transform nature, causing societies to adjust to meet new conditions through reason, science and organisation with a resultant

"... weakening of primordial bonds, superstition, fatalism and other prerational sentiments and a shift to a more sophisticated social and political organization" (Appleton 1983:44).

This prediction has not come to pass for man is a human being and, therefore, not subject to the laws of science and technology. Today, social and political scientists hypothesise that ethnicity, in technological modern societies, may be the result of a human need for social relationships which are less instrumental and more enduring than those associated with the developmental approaches. Survival of cultural identity, long after traditional functions have been taken over by increasingly impersonal groups, is thereby ensured (Appleton, 1983:44-45). This shift in perspective confirms not only the dangers inherent in relegating human beings to the level of causal-mechanical forces, but gives recognition to the fact that man is a relational being (cf 3.2.1.4) who experiences an existential need for companionship as he searches for meaning in his human world (cf 3.2.1.5) in the face of an unknown future. The question which may be asked is whether man, as a normative being and culturality (cf 3.2.1.11), finds expression in modern society by what KITSON (in: Sizer, 1976:32-33) refers to as neo-ethnicity, where interest groups, resting on racial and ethnic origin, play an increasingly important role in the politics of America as neighbourhood, extended family and church diminish in importance. This is a phenomenon which appears to be gaining momentum in South Africa as rural-urban drift and opportunities for Black upward mobility increase, with a corresponding weakening of traditional family and/or community influences. Although the emphasis may appear to be restrictive, this point of view is important in so far as it suggests to ARTHUR (1992:227), that in complex, heterogenous societies man as culturality could be expressed as man as ethnicity or perhaps, even more accurately, as man as ethnicity in culturality, if one considers the above-mentioned ground structures of human existence and the concept of core culture (cf 3.2.1.16(a)) posed by SMOLICZ (1981:128). The concept of ethnicity in culturality places emphasis on the interdependence of ethnic

groups and carries the underlying implication that all groups can benefit from the creative vitality and uniqueness which each obtains from the other in affirmation of the ground structure unity within diversity (Garcia, 1982:45). It also gives credence to the statement that ethnic minorities are legitimate contributing groups within the overall society and as such "... are worthy of the dignity and respect accorded any citizen" (Garcia, 1982:45).

The above argument is in accordance with BANK'S (1988:64) conclusion that all Americans are members of ethnic groups, an observation which is, in turn, of relevance to all multi-cultural societies. Because of the multi-dimensional nature of the concept 'ethnic' and because ethnic characteristics within a modern society are mediated by technology (cf 1.3.1.5), acculturation (cf 4.4.3.1), the heterogenous composition of the population (cf 4.4.1) and other aspects of modernisation (cf 4.4.3.2), the question becomes not whether a person is ethnic but the degree to which he is ethnic. In other words, the degree to which he, as an open, self-transcending intentional existing being (cf 3.2.1.5; 3.2.1.6; 3.2.1.2), is called upon to choose responsibly (cf 3.2.1.9), to actualise his potentialities (cf 3.2.1.7) and give meaning to his human world (cf 3.2.1.5; 3.2.1.1) (Arthur, 1992:227-228). In focusing on traditional attitudes and behaviours, it must be recognised that the communities concerned are undergoing constant change (cf 4.4.3) as a result of their experiences (Gollnick and Chinn, 1986:71-72).

Of what importance is the above discussion to contemporary South Africa? Regardless of the conclusions drawn, as with race, it is in the context of status, privilege and power or lack thereof, that the concept of ethnic group has been associated. In this respect, JUPP (1984:5)

regards all ethnics to some extent as peripheral to the exercise of political power, because they are excluded from politically significant institutions by those in control. In consequence, the political dilemma of the ethnic is that while legally he may be a citizen, his access to power is restricted by majority prejudice and the preservation of long or newly established elites who tend to view themselves in national, for which one may read mainstream, as opposed to ethnic terms. The concept of marginality (cf 4.3.1), of which ethnicity is only one aspect, is one of the central issues in the debate surrounding cultural hegemony and attempts to empower people to gain control over the circumstances of their lives.

Furthermore, the concept of ethnicity is closely associated with assumptions that ethnic groups are monolithic structures displaying homogenous characteristic features and needs (Banks, 1988:193). It is at this point that the concept of ethnocentrism gains in significance.

Ethnocentrism constitutes a universal phenomenon of appraising the environment and ways of life of others in accordance with the norms and beliefs of the in-group and an intolerance of beliefs and practices different from their own (Zadrozny, 1959:111; Wurzel, 1988:15). Ethnocentrism is reflected in an attitude in which a people's own culture is automatically treated as innate and the only way to function in the world (Gollnick and Chinn, 1986:13), in a denial of the existence of any other frame of reference (Porter, *in*: Mayer, 1984:29). In these terms, ethnocentrism is a potential formidable barrier in cross cultural health services. In addition, in reference to education systems, STONE (1981:37) levels the accusation that social scientists in Western society operate in an ethnocentric trap where they

either ignore Black culture or regard it as a pathological version of White culture.

Increasingly links are being forged between race, ethnicity and social class. Several studies have been undertaken in an attempt to relate peoples' utilisation of health care services with their cultural background. What emerges is the suggestion that it is not ethnicity *per se* that is important, but the fact that ethnicity represents a social experience influencing how people perceive their situation and/or health status (Cockerham, 1986: 84-92). Furthermore, the uneven profile of health among racial groups in American society repeats itself when the health status among different socio-economic groups is considered. Regardless of the health measurements used, being a member of the

"... lower classes carries health penalties similar to those of non-whites. To be poor is by definition to have less of the things (including health care) produced by society" (Cockerham, 1986:49).

This paragraph leads inevitably to the necessity for an examination of the significance of social class to health education.

4.2.3 SOCIAL CLASS

The previous two sections in this research reveal that race and ethnicity are variables frequently associated with low status and diminished access to power, which, in turn, is reflected in a trend towards poor standards of health and marginality. Social class, as a further variable linked with both, is defined as a stratum of people of similar position on a

continuum of social status within a society (Horton and Hunt, 1984:344) that is organised into an overall hierarchical structure (Levine and Havighurst, 1989:2). The individual's position in the social class structure implies a certain life-style, membership of particular groups, attitudes towards life chances, political affiliations, health, child rearing patterns and many other aspects of life (Ballantine, 1983:56). The beliefs, values, actions and patterns of speech of social sub-groups differ sufficiently to create difficulties in interactions across and between social groups (Le Compte, 1985:112).

Social class as a structure of the dominant society has a direct influence on what services are made available to which groups. Whether knowingly or unknowingly, the middle classes dominate the lower classes in many areas of everyday life. When basic services are made available, it is the middle classes who mostly benefit (Tan, *in*: Harpham *et al.*, 1988:36). Community services, including health and formal and informal education programmes are more closely aligned with the values and activity patterns of the middle classes. The reason being that those most directly involved in the management of these organisations are usually public officials, doctors, nurses, health educators *et cetera* who are drawn from the dominant ethnic and social classes. Either consciously or unconsciously, they reflect the interests of the dominant group in the services offered and in how and what they teach (adapted from Arthur, 1992:234-235).

It has been noted by HOLLINGSHEAD AND REDLICH (*in*: Cockerham, 1986:93) that the higher the individual's socio-economic position, the less ethnic the person appears to be. They point to the fact that Black, Mexican and Asian Americans tend to acquire Anglo or

White middle class norms and values as part of their participation in middle class society. Socio-economic status as measured by education and income seems to be a much stronger predictor of health related behaviour than ethnicity. Ethnicity as predictor of help-seeking behaviour is apparently limited to the role of providing the cultural context for decision making within social networks.

According to NORTHMORE (1986:181), despite innovations and significant experiments in adult education, it is still the case that most adult education is associated with middle class value systems which the lower classes do not share. There is a need to ask whether a middle class ethos of adult education is the cause of a predominantly middle class clientele or whether the latter is a cause of the former. Frequently, in adult education, the mode of knowledge presentation is biased towards the middle classes in terms of content and language. Furthermore, the school experiences of adults discriminate between those who are labelled as successful or failures in education. Logically, it should be acknowledged that just because people have experienced education in the past, there is no reason to believe that they will desire it again in the future (Jarvis, 1985:204, 207). ROSS-GORDON (1990:7) points to the disproportionately low participation rates of Hispanic and African Americans in adult education programmes, while DARKENWALD AND MERRIAM (*in*: Ross-Gordon, 1990:7) suggest that education is more important than race in predicting participation, since well-educated Blacks participate at similar levels as do Whites.

Such a point of view is in line with BERNSTEIN'S (*in*: Jones, 1984:20) analysis of the lexical and syntactical levels of speech which reveals degrees of disparity between the various

social classes. He discusses the restricted code of speech of the working classes and the extended code of the middle classes. The different classes use language for different ends with the middle classes having an ability to control verbalised behaviour in a way that helps in producing high achievement and success in planning long term goals. The degree of language disparity, in turn, reflects the different social relationships which exist between people of different social status. Not only do the beliefs, values, actions and patterns of speech of the social classes differ sufficiently to create difficulties in interactions across and between social groups (Le Compte, 1985:112, 113), but JONES (1984:19) refers to findings that different life orientations are to be found between the different classes. The lower classes are characterised, for example, by an immediate time orientation to life in which the present, its problems and notions of immediate gratification, predominate. Conversely, the middle classes tend towards a future orientation in which deferred gratification for the sake of future benefits, constitutes a cornerstone of life. The middle class views nature as capable of manipulation, whereas the working class sees itself as being manipulated by nature, rendering them more fatalistic in outlook.

WHITEHEAD (1988:227-245, 258-265, 297-302) found persisting social inequalities on many fronts in the United Kingdom. Using occupation as an indicator of social position, the poorer health status of the socially disadvantaged was revealed, not only in respect of mortality data but also in respect of morbidity. These tendencies were evident throughout the life-cycle. Acknowledged problems, associated with the use of occupational class as standard, were checked against other measures such as housing tenure and car ownership as indicators of people's command of resources. Higher mortality rates were revealed in groups where

the indicator represented a proxy for poverty rather than for affluence. Unemployment, as another measure for social and material disadvantage, highlighted differences in mental and physical ill-health between the unemployed and those at work. In respect of gender (cf 4.2.6) women were shown to experience lower mortality, but higher morbidity rates than men. A study by ANTONOVSKY (in: Cockerham, 1986:50) on social class and life-expectancy reinforces the importance of these socio-economic differentials. He suggests that on every measure, social class influences the individual's chance for longevity.

Economic status is fundamental to health status. The links between poverty, lack of access to facilities and services and high levels of mortality and morbidity are undisputed. Improvement in social status amongst Blacks in America has been related to significant improvement in health status (Cockerham, 1986:43).

HUBLEY (1988:390) argues that health educators in the West have contributed towards class inequality in respect of health by using educational approaches that are inappropriate to the poor and, hence, mainly reach the more affluent groups. Value systems prevailing in the various classes are very different. The manner in which the poor live and perceive their environment is not considered in the norms and organisation of Western orientated biomedical health services. Assumptions are made by many health professionals that the lives of the poor in some way reflect their own (Cockerham, 1986:50). People from the lower classes are brought up sharply against the differing demands of home, community and health services, including that of health education, as they are called on to adjust to, and comply with, the demands of an alien sub-culture with which they are not able to identify. Breakdown in

communication becomes the inevitable result (Cockerham, 1986:50).

In these terms, it may be concluded that culture clash occurs not only between ethnic groups and the dominant culture but is evident between the lower and middle classes of the dominant culture. In similar vein, Read (1966:53) noted, almost three decades ago, that health professionals frequently have more in common with workers from other cultures with similar training and educational level than with illiterates from their own culture.

BULLIVANT (1987:2), in turn, poses the question how many learners from minority backgrounds manage to 'beat the system' and 'make it' successfully into the dominant group's world of employment and future opportunity. Undoubtedly many experience social disadvantage, but it is equally true that many more than are imagined are successful, despite the socio-economic and ethno-cultural strategies of social exclusion (closure) used by dominant groups to contain the aspirations of minorities.

Social phenomena and aspects of human relationships are not monocausal. An examination of social class throws much light upon many aspects of health and education in any complex society, including ethnically and racially heterogenous societies. However, to accept that any one of these variables in isolation holds the answer to problems associated with health status and learning outcome, is unsatisfactory. In an attempt to bridge the gap, GORDON (*in*: Appleton, 1983:38) presented an important concept which he refers to as ethclass.

4.2.4. ETHCLASS

GORDON (*in*: Appleton, 1983:38) perceives society as segmented and inclusive of a number of social groups which can no longer be categorised. He sees race, religion and national origin intersecting with social class to produce groups which he calls ethclasses, based on the fact that differences in each of these variables constitute significant differences in the nature of each group. For example, lower class Zulus, are different, in important ways, from middle class Zulus, so that in the words of GORDON (*in*: Appleton, 1983:38)

"With a person of the same social class, but of a different ethnic group, one shares behavioral similarities, but not a sense of peoplehood. With those of the same ethnic group but of a different social class, one shares the sense of peoplehood but not behavioral similarities".

The concept of ethclass, in the South African context, could be augmented to include regional differences, more specifically First and Third World differences. Referring to the previously cited example, the lower class, rural Zulu would share class and ethnic characteristics with the lower class urban Zulu, but a different life-style and value system. The underlying part of this concept is that adjustment and adaptation to an industrialised modern life-style is more complex than simple acculturation (Appleton, 1983:38). In addition, the concept of ethclass reveals that low income urban Blacks are different from Whites with regard to cultural values and attitudes. As progression occurs up the social class scale, Blacks and Whites become more similar, even though certain attitudinal differences exist. The significance of these findings to the concept of ethclass lies in the interwovenness of the concepts of race, ethnicity (Levine and Havighurst, 1989:377) and social class.

According to ELLING (1981:96) there is a good deal of evidence that the ruling classes of capitalist countries, whether developed or underdeveloped, have access to modern medicine and that the peasant and working classes are more dependant upon traditional medicine.

Integral to any discussion on ethnicity and social class in respect of health and health education is that of rural-urban drift and urbanisation in developing countries.

4.2.5 URBANISATION

Studies reveal that urbanisation, in the context of the relative increase in the urban population as a proportion of the total population, is one of the most widely discussed social issues of the last three decades (Teller, *in*: Harpham *et al.*, 1988:5). Rapid growth in cities is accompanied by a rapid growth of city dwellers representing all races and ethnic groups living in grossly substandard overcrowded conditions without funds for the necessities of life. Recent international estimates for cities in developing areas reveal that slum and shanty town dwellers, living in extreme poverty, represent an average of 50 per cent of the urban population with figures rising to as high as 79 per cent in some cities (Harpham *et al.*, 1988:11). Poverty and disease constitute part of a vicious cycle of cause and effect linked with the living conditions and attitudes (cf 4.3.1.) prevalent among populations (Sibiya, 1986:168).

Another issue that cuts across those of race, ethnicity and social class in terms of status and power relationships, and one that further illustrates the dimension of diversity in homogeneity is that of gender.

4.2.6 GENDER

It was not until the 1970's, after the emergence of the revitalisation and civil rights movements, that special interest groups, within their cultural group of origin, perceived themselves as discriminated against and disadvantaged and began to demand their rights (Appleton, 1983:5). The researcher suggests that it was the acceptance and integration of these groups within the fabric of their society that militated against their receiving prominence in the discussions surrounding multicultural and cross cultural education. Of all these groups, it is the feminist movement which gained the most prominence.

Gender differences are not often described in cultural terms. Recognition is increasingly being given to the fact that in each culture, male and female sub-cultures exist which differ, one from the other (Hofstede, 1991:16). Culture is normative (cf 3.2.1.10.) and establishes norms of acceptable sex linked behaviour. Culture, therefore determines, in large measure, how girls and boys are socialised. Although both are members of all the other microcultures or sub-groups within society, the culture has different expectations of them, dependent solely on their gender (Gollnick and Chinn, 1986:190). SLEETER AND GRANT (1988:9) record that in spite of recent gains, women are still distinctly subordinate, both economically and politically, in the United states of America. This situation is compounded in Third World countries.

Worldwide, sex discrimination against females has greatly affected the quality of life for women. It has kept women in less prestigious and low paying jobs. Even the amount of

education obtained by girls does little to close the gap between the earnings of males and females which in America runs "... at 59 cents for every \$1-00 earned by men" (Gollnick and Chinn, 1983:191) and in England, in 1983, according to a government earnings survey, the average pay of females was approximately 50% below that of men (Jeffcoate, 1984:16).

In education too, sex bias is international in relation to tertiary institutions, occupations and subject choices (Sutherland, 1985:49-55). Underachievement by girls has been attributed to sexism within mainstream male-dominated cultures (Burtonwood, 1986:70). According to JARVIS (1985:205-207), patterns of adult and continuing education reproduce and reinforce the sexual division of labour in society in that men are more likely to have an instrumental and women an expressive orientation to their education: a situation which reflects the fact that women's opportunities remain linked to notions of the traditional place of women in the sexual division of labour. On the basis of gender differences, even within homogenous societies, diversity within unity can be discerned and may frequently be associated with unacknowledged disadvantage and discrimination at different periods of time and under different circumstances.

A critique of the feminist movement has been that community workers fail to recognise specific forms of oppression suffered by women in the domestic sphere (Northmore, 1986:183). The low status generally accorded to women is one which has its roots in the patriarchal family structures of both traditional and Western societies. WHITEHEAD (1988:243-245, 265-266) demonstrates connections between marital status, employment figures and presence or absence of children *et cetera* amongst women living in disadvantaged circumstances and

the fact that they suffer even worse levels of health than men living in similar circumstances. COOPER ET AL. (in: Yach et al., 1991:414) describe women in Khayelitsha as experiencing quadruple oppression on the basis of gender, social class, race and as new arrivals in an urban environment. MOSER AND SATTERTHWAITE (in: Harpham et al., 1988:12) indicate that the poorest of the poor are female headed households who have the least access to income producing activities and are responsible for most of the household and child care activities. The fact that they have to raise children, manage the home and face discrimination in the job market, greatly limits opportunities for finding reasonably paid secure employment.

4.2.7 RÉSUMÉ

The discussion surrounding the variables associated with circumstances within current health and education systems clearly indicates the complexities of the issues involved and their inter-relatedness in terms of group access to opportunity, prestige and power. In areas of health and education, perceptions of inequality and lack of opportunity related to life-style developed from observations that minority groups, whether in terms of race, ethnicity, social class or gender, underachieved. Such perceptions led to the conclusion that the social forces which advantage some people, disadvantage others and, thereby, enable those who are already advantaged to take further advantage of educational opportunities (Jarvis, 1985:213) and health services. This, in turn, led to theories of social and cultural deprivation resulting in compensatory forms of social and health services including health education and, ultimately, the progressive health care movement and notions of empowerment of the disadvantaged.

Apparent too, is the fact that the more visibly observable the physical characteristics, the more readily identifiable is the group. Because there is a demonstrable connection between the physical and social environment and the internalised, organised behaviour of human beings, deductions concerning the cohesion, communalness and unity of the diverse in relation to the dominant culture are readily explained, as apposed to one that encompasses concepts of cohesion or communalness in diversity and particularity in multiculturalism within society as a whole.

That the simplistic idea of the unity of the diverse is erroneous has been revealed in the complexities, ambiguities and contradictions that have foiled attempts to define, classify and categorise man in absolute terms. Attempts to do so are not in accord with the fundamental ground structure of homogeneity in heterogeneity (cf 3.2.1.16) and serve to denigrate man's humanness and his dignity.

Having established that difference is a factor in intergroup and interpersonal relationships and that over-emphasis of difference by means of categorisation of human beings threatens the realisation of their full potential, it becomes necessary to establish the potential reciprocal effects of designated group status on encounters between educators and learners in relation to health educational outcomes in the situatedness of cross cultural encounters.

4.3 CROSS CULTURAL ANDRAGOGICAL ENCOUNTERS

In the situatedness (cf 3.2.1.2(b); 3.2.1.3(b)) of cross cultural agogic encounters, it should

be recalled that as human beings (cf 3.2.1.1(b)), health educator and learner alike are religious (cf 3.2.1.17(b)), normative (cf 3.2.1.10(b)) and cultural (cf 3.2.1.11(b)) beings, who are existent (3.2.1.2(b)), engaged in (cf 3.2.1.3(b)) and related to their world (cf 3.2.1.4(b)): a world to which each is open and attributes meaning (cf 3.2.1.5(b) and one in which, as intentionality (cf 3.2.1.6(b)), each strives to become that which he is capable of (cf 3.2.1.7(b)) and chooses to become (cf 3.2.1.9(b)) (Arthur, 1992:251).

The relevance of the ontological-anthropological ground structures in relation to this study are situated in the reality of culture. Each human being constitutes his personal life-world in the face of an unknown future within the context of his personal and cultural environment.

If these ground structures are equally valid for learner and health educator alike, questions arise regarding the relevance of the individual life-worlds of both educator and learner in cross cultural learning encounters. The answer lies in the *agein* (cf 1.3.2), during which the lecturer guides the student towards his, as yet, unrealised potential through direct interpersonal encounters and, in the fact, that all educators and learners are culturally whole persons, with a culture and concomitant values, attitudes, beliefs, values and knowledge regardless of race and ethnic group affiliation (Garcia, 1982:21).

Educators and learners are beings in dependence on co-existence (cf 3.2.1.8(b)) of other human beings. In the adult education situation, learners are in positions of inequality within equality (cf 3.2.1.14(b)) in the sense of specific areas of expertise, but not in dignity. They, therefore, require a secure environment, support (cf 3.2.1.9(b)) and acceptance (cf

3.2.1.1.(b)) in order to enable them to accept freedom in responsibility and become increasingly accountable for decisions made, under the guidance of the educator (cf 3.2.1.9(b)) with a view to the actualisation (cf 3.2.1.7(a)) of their human potentialities. The *agein* hereby becomes both an enabling and an ennobling activity.

Educators have been socialised into a particular culture and "... are representatives of a particular configuration of sub-groups" (Hilliard *in*: Hunter, 1974:44). Therefore, the majority are not prepared, in either the cognitive or affective domain, to cope and function effectively in cross cultural encounters (Baker, 1983:44). Under these circumstances, the personality, values and social background of educators become critical cultural traits which may manifest, either consciously or unconsciously, as invisible activities in the classroom that intrude into the transactions between educator and learner (Hilliard *in*: Hunter, 1974:45). These activities include value judgements and stereotypes that are reflected in the expectations and responses of educators towards learners and which elicit, in return, certain responses from learners with potentially negative implications for learning outcomes. It is the intention of the researcher to examine the hidden activities which take place within cross cultural education encounters in an attempt to expose aspects of the reality confronting lecturer and student in the situatedness of their interhuman life-world.

4.3.1 CROSS CULTURAL HEALTH EDUCATION MILIEUS

The atmosphere and emotional tone of the educational environment is determined by the leadership of the educator which is influenced, not only by his level of expertise and teaching

strategies, but also by the cultural perspective of his life-world and his interpersonal competencies. In cross cultural encounters, part of the problem stems from an ignorance of what is meaningful to those who are culturally different because this knowledge is partly entrenched in the knowledge of a personal subjective culture (Triandis, *in*: Brislin *et al.*, 1975:42).

In the situatedness of the health education venue, both educator and learner are beings in the world but in the andragogic encounter, it is the educator who has the authority to make decisions concerning educational approaches which, in turn, may influence learner actualisation of potential. When adults, especially those from minority backgrounds, attend health education sessions, they are expected to adapt to the milieu of that environment and their capacity for adaptation may significantly determine their ability to benefit from the experience. The question that is seldom addressed is the degree to which cultural difference influences their perception of the learning environment (Anderson, 1988:3). In the cross cultural health education encounter, participants are confronted by a triple challenge embracing levels of educational, cultural and linguistic heterogeneity.

Before exploring educator-learner relationships it is necessary to clarify the following concepts:

- * **Perceptions** denote sensory experiences which have gained meaning or significance. The concept reflects a changed relationship between a person and the external world, brought about by assignment of meanings to previously raw and

undefined sensory experiences (Gould and Kolb, 1964:491-492).

- * **An attitude** is a mental state of readiness which is organised through experience and exerts a directive or dynamic influence upon a person's response to all objects and situations with which it is related (Allport, *in*: Mouly, 1973:413). Attitudes comprise affective components, cognitive aspects and behavioural consequences or actions (Mouly, 1973:413) and apply equally to individuals, groups and health related matters. Conceptually, health attitudes have affective, cognitive and conative effects on the way in which a person evaluates a health situation with the intent to act upon it or not (Fosu, 1993:50).

- * **Prejudice** is defined as an emotionally rigid attitude, or a predisposition to respond toward a stimulus or a group of people in a certain way (Simpson and Yinger, 1985:21). A prejudice comprises two elements, namely, an evaluative prejudgement of some referent and an affective attitude of hostility toward an object, person, group, idea, situation or any other referent (Zadrozny, 1959: 260). KITANO (1974:65) recognises prejudice as an attitude that works in many ways, promoting group unity and identification, supplying cues and scapegoats, serving ethnocentric purposes and promoting needed symbols. TAJFEL (*in*: Cohen and Manion, 1983:42) asserts that man, if prejudiced, has an emotional investment in preserving the differentiation between his own group and other groups and that the existence of prejudice provides both additional support and rewards for hostile judgements. It also removes the possibility of 'reality checks' on prejudiced

judgements. Therefore, it may be deduced that prejudice is an intergroup phenomenon, which is negatively orientated and hence undesirable. As an attitude, it is learned rather than innate behaviour (Cohen and Manion, 1983:14). Prejudice is frequently accompanied by stereotyping.

- * **Stereotypes** may be said to comprise both descriptive and evaluative components (Saunders, 1982:95). They are described as sets of over simplified value-laden beliefs held by persons or groups concerning the traits of another group (Garcia, 1982:92).

Perceptions, attitudes, prejudice and stereotyping are closely linked concepts. The process of stereotyping stems from simple, factually incorrect descriptions of persons or groups based on illogical rigid reasoning (Lippman *in*: Saunders, 1982:93) and is characterised by a categorisation of persons, consensus concerning their attributed traits and a discrepancy between their attributed and actual traits (Tajfel and Wilkes *in*: Cohen and Manion, 1983:40). Certain commonly held stereotypes may have some partial substantiation based on the concept of the nodal personality that describes the typical attributes of a member of a particular group. These attributes are derived from a degree of homogeneity within the group and are reflected, in turn, by a degree of consistency of behaviour amongst the members of that group. Stereotyping is thus founded on only one facet of the anthropological-ontological ground structure of homogeneity in heterogeneity and, as such, reduces human beings with a few characteristics in common to a mass, undermining their very humanness and reducing that which is the wholeness of man to a part, in an act of depersonalisation and dehumani-

sation. An associated damaging effect of negative stereotyping is that the subject can come to believe that the description which has been assigned to him is true (Saunders, 1982:98).

Much of the research into stereotyping remains controversial because investigations are difficult to conduct and assess; the subject does not lend itself to empirical research; preconceptions of researchers may influence findings and, in addition, the truth or falsehood of some research claims have been ignored in view of political arguments, especially claims relating to the self-fulfilling role of the victims of stereotyping (Barrow and Milburn, 1986:206; Wurzel, 1988:63).

An important consequence of stereotyping, linked to the processes of modernisation (cf 4.4.3.2) and urbanisation, and hence to health education in the cross cultural encounter, is the notion of marginality.

- * **Marginality:** as people migrate from rural to urban areas in ever-increasing numbers, the concept of marginality is used to describe certain characteristics of the urbanisation process. Migrants are, for example, termed 'socially marginal', because of their rural roots; 'spatially marginal' on grounds of the peripheral nature of where they live; 'occupationally marginal' in terms of their levels of illiteracy and lack of skills and 'politically marginal' in that they are perceived to be outside any political organisation. Assumptions that inhabitants of informal settlement areas are marginal to the well established social strata of cities and their social and political structures are reinforced by the physical separation of the

two and the social and psychological barriers existing between them. People's marginality comes to be seen as a problem of adaptation to the dominant social system and identified as the innate incapacity of migrants themselves (Harpham *et al.*, 1988:18). It is at this point that the question of hegemonic control, power and status comes to the fore once again.

The concepts and the realities of perception, attitude, prejudice, stereotype and marginalisation overlap and contribute to the formation of generalised mental sets which predispose educators and learners to act in a particular manner under specific circumstances within their situatedness. It is, therefore, the intention of the researcher to examine potential implications of educator prejudice and stereotyping in the learning encounter before exploring the nature of student-lecturer orientations and expectations.

4.3.1.1 The Educator-Learner Encounter

In Chapter One, the author subsumed the concept of multi- and transcultural education under that of cross cultural education. The decision remains valid for the purpose of this study. However, further in depth research does seem to indicate that the literature on multicultural education has greater relevance to the multicultural movement in respect of formal and, therefore, primary and secondary school education with limited inclusion of tertiary levels of education. Conversely, studies into cross culturalism appear to pay greater attention to cross cultural communication in the adult mode in all aspects, including those of management and training in respect of commerce and industry at national and international levels. Attention

has also been paid to the translocation of nationals from their country of origin and to cross cultural relationships between communities.

In spite of controversy surrounding research findings in the multicultural agogic encounter, significant trends have been revealed concerning the effects of prejudice and stereotyping on either overtly expressed or unintentionally displayed sets of attitudes and behaviour by educators towards particular groups of learners. Research has revealed that minorities are more likely to experience particular patterns of 'ability' tracking and specified placements within schools while participatory models in adult education suggest that early negative learning experiences may contribute to lowered expectations of personal success and distrust of school environments (Ross-Gordon, 1991:5). Unfamiliarity with formal learning structures may evoke similar responses.

GAY (1989:178-179) reiterates the frequently made point that most educators in knowing little about the life-styles, living habits and preferences of different ethnic groups, believe that they are either culturally deprived or should receive remedial intervention using middle class standards as the norm. Such attitudes and expectations are transmitted in everything they do and say in the classroom. Biased perceptions held by the dominant group culminate in discriminating behaviour against minorities (Saunders, 1982:4). Ethnic minority children come to believe that they will fail and act accordingly so that their responses become self-fulfilling prophecies (Gay, 1989:179). In similar vein, the outcomes of learning activities of adults may be negatively influenced, especially in matters relating to dependency-independency, freedom in responsibility, choices about, control over and accountability for

the circumstances of human life.

According to GROSSMAN (1991:163), most studies in the United States indicate that many educators employ prejudicial and undemocratic education management techniques especially in respect of African Americans and Hispanics. For example, they praise them less and criticise them more, give them routine as opposed to specific feedback for particular achievements and interact more with Euro-American students, especially males. While Euro-American educators do demonstrate concern and interest in the academic work of Euro-American female students, they tend to pay more attention to the social behaviour and skills of their Black counterparts. A combination of verbal and non-verbal codes, based on social criteria substitute for an understanding of the learning difficulties of minority groups. Similarly, GILES (1977:56) found that where children in the United Kingdom were considered to fall into working class or West Indian cultures, many staff members developed expectations and attitudes towards their role and future in British society which differed from those they held towards mainstream students. Educators hold lower expectations of lower class than middle class children, even when intelligence scores and achievements are similar (Persell, 1989:77).

Such behaviours, if replicated in adult education, lead to tension and ultimately to a deterioration of the learning experience in cross cultural encounters. The consequences of such practices lie in diminished motivation, slower learning outcomes, feelings of not counting and resentment and a failure to identify with educational goals (Saunders, 1982:104).

Alienation destroys and dulls abilities and potentialities. If people expect no rewards because of their identity they have few incentives to know or follow dominant precepts (Landes, 1965:45). Adults retain the choice as to whether they continue to attend health education sessions or not. Individuals display improvement in achievement when learning in situations where educators are less biased in respect of their intellectual abilities (Stanton, 1981:84-85).

It may, therefore, be deduced that negative attitudes in the form of prejudice and stereotyping run counter to the agogical category of being human as structure in function of education, the cornerstone of all agogical categories (cf 3.2.1.1(b)). As beings in and engaged in the world, a lack of understanding of the situatedness (cf 3.2.1.2(b)) of the student by the lecturer, negatively influences the nature of the agogic encounter (cf 3.2.1.3(b)) in cross cultural educational milieus and gives rise to withdrawal rather than engagement and involvement. Such a situation may generate mistrust rather than trust in the educator as a fellow human being in agogic association (cf 3.2.1.4(b)): an adult who cannot be depended upon for accompaniment and agogic intervention (cf 3.2.1.6(b)) as the learner strives to attribute meaning to his incomplete and never to be completed (cf 3.2.1.5(b)) human world. As related beings (cf 3.2.1.4) and initiators of action (cf 3.2.1.4(b)), learners, in finding that their needs for support and security in the exploration (cf 3.2.1.6(b)) of their world are not met, may disengage from the education situation, for they remain co-designers and creators of their personal life-world. Failure on the part of learners to explore, reduces opportunities to broaden horizons and may undermine self-assurance and the potential for self-actualisation (cf 3.2.1.7(b)). In denying the learner the support he requires, the educator fails to offer sympathetic authoritative guidance. He fails in the task of freeing learners from ignorance,

leading them to independence, freedom in responsibility and accountability for the normative and ethical choices (cf 3.2.1.9(b)) they will be called upon to make. In instances where physical difference in the form of race, sex, age or disability become the basis for prejudice, the learner, as bodiliness (cf 3.2.1.15(b)) in the visible evidence of being human, is rejected and as such his humanness denigrated. Lack of an acceptance of the learner's existential need to be recognised as a bearer of human dignity (cf 3.2.1.14(b)) prevents elevation of dialogue, for inequality overrides the ontological equal status of all men (Arthur, 1992:261-262).

Minority learners may be further disadvantaged in so far as anthropological research reveals that concepts of personal meaning and interpersonal relationships are diverse amongst different societies. Recent research indicates that group patterns exist in learning style preference in addition to individual learning differences within groups. Both minority groups and women tend towards distinct preferences for particular modes of knowing and learning styles (Anderson, 1988:4-7). FIGUEROA (1984:17-18), quoting Banton's sociological axiom that if social situations are defined by men as real, they are real in their consequences, states that there are two central aspects to the notion of the construction of reality. These comprise the basis of how individuals see or define their situation and the fact that they are always participants in a situation which is not only of their own making. On the basis of this penetrating statement and the revelations of anthropological and educational research, an examination of differences between educator and learner orientations becomes necessary. These orientations are based on personal experiences of a human world and can generate cultural barriers which, in turn, may interfere with the reciprocal transfer of meaningful messages on which authentic education is based.

4.3.1.2. The Cultural Orientation of 'Learners' versus 'Educators'

An attempt has been made by the researcher to illustrate that experiences which learners and educators have outside the school result in perceptual frameworks that vary according to race, ethnic group, social class and gender, amongst other variables, and that these frameworks are used to interpret health, education and life in general. It should also be noted that a gap has always existed between the frames of reference of educators and learners, stemming at least from differences in expertise, role and even gender and age. These differences may be compounded by differences in cultural background (Sleeter and Grant, 1988:26). Both forms of difference are to be investigated in the following sections.

(a) Perceptual Frames of Reference

An important difference between the ethno-cultural life experiences of members of minority and dominant groups is that majority students and lecturers have seldom experienced discrimination, whereas most minority learners have (Gollnick and Chinn, 1986:91). For example, striking as is the range of minority groups in Britain, there is an even more striking uniformity in "... their universal experience of prejudice and discrimination" according to SWANN (Department of Education and Science, 1986:3). The consequence is that having frequently suffered unfairly, minority group members are liable to imagine injustice even where it is non-existent, and the most tolerant majority group member may meet with deep and wounding rebuffs (Bibby, 1960:51). Research suggests that many educators may give double messages to themselves and their students because they are not aware of their biases.

For example, some educators who consciously and verbally praise opposite race learners more than their own, frequently give them less non-verbal positive attention, touch them less often and maintain greater distance from them (Grossman, 1991:164). Such situations may aggravate misunderstanding and generate further negative attitudes, prejudice, stereotypes and marginalisation.

Of tantamount importance are differences and misunderstandings which are generated by differences in the perceptual frames of reference of minority groups and those of the dominant group as is commonly reflected by health educators. Great gaps also exist between how educators and learners perceive one another and themselves (Sleeter and Grant, 1988:24). For instance, when two sets of cultural dialogue are analysed, each participant interprets the situation from within his own cultural framework.

Thoughts, feelings and behaviours, accounted for in biological and sociological terms and set in a religious framework in the West, are seen as located in bodily organs or social systems by some cultures. These and other concepts are of importance in education, for non-Westerners do not necessarily make such clear distinctions between the person and the group, neither are the distinctions between medicine, biology, psychology, sociology and religion replicated throughout the world (Le Vine and White, 1986:38-39).

Perceptual differences such as these are significant, because in Western First World societies, members of the dominant group easily separate intellectual, emotional and physical responses, tend to analyse ideas, mainly in written form (cf 4.3.1.2 (c)) and assume that people can

argue viewpoints in which they do not believe, while traditional Black cultures tend to reinforce holistic approaches (Cooper, 1989:117). Western thinking is characterised by linear thinking patterns (Cohen, *in*: Sleeter and Grant, 1988:45), with everything commencing with a beginning, moving through and progressing to a conclusion, whereas an Eastern mind thinks in a cyclical fashion (Codrington, 1985:153-154). Furthermore, the Afro-American cognitive or perceptual style preference is one that emphasises a person rather than object orientation (Shade, 1989:102).

Differences in educator-learner cultural orientations are a potent force in the learning outcomes of minority students. Because the teaching and lecturing approaches commonly used in First World English speaking societies presuppose cognitive styles prevalent in White middle class culture, they may be inappropriate to students from other backgrounds (Singh, 1988:355). Different ethnic groups having different histories, different adaptations to reality and different socialisation practices may differ concerning their respective cognitive and learning styles (Anderson, 1988:4). It, therefore, becomes important to look more closely at the key areas in which cognitive and learning styles differ as a result of the influence of culture.

(b) Cognitive and Learning Styles

Cognitive style represents a superordinate construct that accounts for individual differences in a variety of perceptual and personality variables that influence ways of thinking, perceiving, organising and interpreting information, remembering and problem solving.

Learning style, on the other hand, is the method by which the individual arrives at a knowledge and understanding of the world: his accustomed pattern of acquiring information, concepts and skills. Although the two concepts are closely related, the difference lies in the fact that people not only perceive the world in different ways, but also learn about the world in different ways under different conditions (Appleton, 1983:172; Shade, 1989:87). Cognitive and learning style does not have reference to difference in general ability or memory, but to the manner in which the learning material is acquired (Lynch, 1986:128; Wieseman, 1986:174).

Perhaps the most important aspect of cognition is the ability to manipulate symbols. The most elaborate use of symbols lies in modes of human communication (cf 1.3.6.1; 1.3.6.2; 4.3.1.2.(c)). A further contributor to cognitive development lies in the acquisition of analytic skills or the means whereby the individual learns to sort out and codify information and then draw conclusions from the information thus organised (Siann and Ugwegbu, 1980:20). Ways of perceiving the world and cognitive style are highly influenced by culture. Children acquire their fundamental cognitive styles for future learning within the family during the period of socialisation. Discontinuities between home and school in modes of communication, participation and value codes may place affected children at a serious disadvantage in terms of learning style, for they are likely to feel frustration and react either with hopelessness, manifesting as apathy and cognitive withdrawal, or rage, manifesting in aggression and physical attacks upon their source of frustration (Singh, 1988: 356-357). It is reasonable to deduce that congruency between childhood and adult cognitive and learning styles will be maintained and/or further entrenched.

Two cognitive styles, field dependent and field independent modes of perception, as identified by WITKIN and his colleagues (in: Singh, 1988:357; Wiese, 1986:174), seem to influence whether the individual encounters the world as a whole or in parts, intuitively or analytically, inductively or deductively. Field dependent or sensitive people have a more global perspective of their surroundings and are more sensitive to the social field, while field independent people tend to be more analytical, focusing on the more impersonal, abstract aspects of their environment. ANDERSON (1988:4) quotes research revealing differences in cognitive style between Anglo-American and minority groups on areas such as perception of movement, linear versus depth perception, learning of disjunctive as opposed to conjunctive concepts, differential responses to the semantic differential, mode of classification of pictures and objects, verbal productivity and character utilisation in story telling and the degree to which the subjective affective self is incorporated into the cognitive evaluation of reality.

Two further components of cultural orientation in which educators and learners, as subjective affective selves, participate are to be examined. These are preferred modes of communication, either verbal or non-verbal, and preferred modes of participation, such as competition and co-operation.

(c) *Modes of Communication*

Communication style represents the manner in which ideas and information are conveyed between individuals. It is a fundamental process in learning interactions and one in which

perception plays a key role. Not all learners prefer print and visual media such as dominates in Western orientated schooling systems and favours the visuoprint learner. Neither are all learners adept at picking up and integrating information via listening or aural channels as is the case with aural learners. Haptic or kinaesthetic learners, in turn, attend to, and acquire, information presented in concrete form that can be touched. They learn better if material can be converted to sensitonic stimuli. Others need to convert material into images that in some way relate to the physical environment, while yet others prefer to find ways in which information is translated into more interactive symbols in relation to the social environment (Shade, 1989:288).

As has been indicated, communication (cf 1.3.6.2) presents in the form of linguistics reflecting the cultural dialogue or concerns of the speakers and in areas of non-verbal behaviours ranging from paralinguistics or vocal quality, vocalisations and the use of silence to proxemics or the use of space; haptics or the amount of touching permissible in interpersonal relationships; kinaesthetics or physical gestures; appropriateness of emotional expression and the nature and implications of eye contact. All carry cultural variations (Irujo, 1988:143-146). Also included under the heading of non-verbal behaviours are aspects such as the use of time, arrangement of the physical environment, appearance in relation to grooming, dress and attractiveness, facial expression and use of materials (Woolfolk and Brooks, 1983:105).

Non-verbal parameters of communication cue messages, delimit the environment and establish exclusion or acceptance behaviour among individuals. The most important and complex of

the non-verbal communication elements are those related to social attitudes that depict belief systems regarding the ways in which society views individual roles in terms of status, gender, age (Yacobacci-Tam, 1987:55-56), race, paradigms of rural urban distribution and the traditional versus the modern. Mounting evidence confirms markedly different communication patterns between men and women resulting in interpersonal misunderstanding within cultures (Dodd, 1987:14).

Culture conflict occurs when the interpretation of cultural patterns of information are not shared. Such conflict is reflected in intra- and interactional tensions which arise when different systems of knowledge confront one another (Wurzel, 1988:2). GAY (1989:179-180) records that American schools prize verbal learning and written demonstration of achievement which is consistent with mainstream student culture, but contrary to the performance style of many ethnic minority groups. Black American socialisation emphasises oral, verbal and participatory learning and American Indians, imitative learning. It is difficult to transform one performance style to another, so that when the contributions and/or achievements of minority groups are assessed, it is against the background of culturally biased criteria and expectations.

In examining the speaker-listener relationship, research indicates that teachers do over seventy five per cent of the talking, while the children remain passive. In middle class homes, parents commonly use question and answer techniques to stimulate their children who enjoy the interaction. For many inner-city Black children, questions and answers may be wrongly interpreted as hostile, because they occur, most commonly, when the adult is angry with the child (Bennett, 1990:60). These patterns may be readily perpetuated in the situatedness of

adult education. Apart from being more holistic, the communication approach of Blacks tends towards the informal. They learn best in settings that encourage active exchanges between speaker and audience and allow for simultaneous response of thought, feeling and movement (Bennett, 1990:60). Blacks and other minority groups have grown up in the oral as opposed to the aural tradition (Bennett, 1989:81).

It has been recorded that, with respect to communication style, mainstream groups usually find meaning in the use of words themselves, whereas style of delivery is of equivalent importance to the words expressed for Black Americans. Lacking the type of power that usually accompanies wealth and privilege, Blacks frequently obtain influence through adeptness with words and skill at performance (Bennett, 1989:81). PHILIPS (in: Sleeter and Grant, 1988:46) found conflicts in the communication styles of teachers and Warm Spring American Indians. Misunderstandings relating to pauses between utterances and the means of gaining attention and acknowledgement that messages were understood caused teachers to regard the children as slow and unco-operative and children to regard teachers as rude and confusing. SAUNDERS (1982:25), in turn, reported that non-verbal cues are often ethnically specific and quoting Driver, identified acts of unwitting discrimination on the part of teachers. For instance, long after identifying British White students by name, educators are still confused over the identities of Black learners. They often interpret ethnically normative behaviours, such as West Indian children looking away from them when reprimanded as bad manners, rather than the sign of respect it is. They do not understand the dialect spoken by students or their non-verbal cues. Understanding can, therefore, be said to involve far more than the simple grasping of cold facts. It implies comprehension of how what is communicated fits

into the world view and cultural perspective of the educand (Codrington, 1985:148-149). Because the cultural, social and environmental mileaus of ethnic and other groups differ, it may be expected that these differences are reflected in their respective cognitive/cultural styles. In view of the paucity of South African based research, it is assumed that similar circumstances apply in this country. At the same time, the dangers inherent in transposing findings from one situation to another may not be underestimated.

A further dimension which may be said to have far-reaching effects on the cultural orientation of learners and educators alike lies in the findings of HOFSTEDE (1991) regarding national cultural differences appertaining to role, role expectation and associated intrinsic value systems.

(d) Hofstede's Theory of Cultural Differentiation

HOFSTEDE (1994:73-78) identified five dimensions of national cultural variables around the world in three different research projects: one among subsidiaries of a multicultural corporation in 64 countries and two among students in 10 and 23 countries respectively. These dimensions are linked to frequently ignored features of everyday life, in that they consist of patterned recurring activities and encounters involving "... the cooperative acting out of well-defined, familiar interaction sequences" (Forgas, 1988:189). According to HOFSTEDE (1994:73), these activities commence at birth and are carried over from one sphere of life into another. For example, the cultural role of educator and learner are reflected in other role forms in society such as parent-child, man-women, boss-subordinate at work and bearers of

authority within the community. Thus students will react to their teachers and vice versa in the same way as they learn to react to other role players in society.

The national cultural differences are outlined in full realisation that the descriptions refer to extremes and that the actual situation may lie somewhere between the two poles.

- * **Power Distance** or the extent to which less powerful members of institutions or organisations expect and accept that power is distributed unequally. Inequality is expressed as 'more' versus 'less' in terms suggesting that a society's level of inequality is endorsed by followers as much as leaders. HOFSTEDE (1994:73) found that parents in large power distance cultures value obedience and respect in children, while children in small power distance societies are encouraged to have a will of their own and are treated as equals by parents. In respect of large power distance cultures, differences in the school are reflected as teacher-centred education in which educators display more authoritarian attitudes and learners value conformity, order and direct guidance from the teacher. Conversely, in small power distance societies, education is characterised by student-centred education where learning represents impersonal truths. In the large power distance work place, hierarchy means existential inequality, with subordinates expecting to be told what to do and the ideal boss is viewed as a benevolent autocrat. This is in direct contrast to the situatedness of the small power distance work place. Here hierarchy means an inequality of roles, established for convenience, where subordinates expect to be consulted and the ideal boss is a

resourceful democrat.

- * **Individualism versus Collectivism** represents "... the degree to which individuals are integrated into groups" (Hofstede, 1994:73). In individualistic societies, the ties between individuals are loose and people are expected to look after themselves and their immediate families, while in collective cultures, people are integrated into strong cohesive groups, frequently extended families, that protect them in exchange for loyalty. In individualistic societies, families educate their children towards a strong 'I' consciousness in which private opinions are expected. Because obligations are to the self, personal characteristics of self-interest, self-actualisation and guilt emerge (as facets of initiative and achievement). Education is viewed as a life-long occurrence with emphasis on learning how to learn. People in individualistic cultures tend to be 'universalistic' and apply the same standards to all: they view others as potential resources and task prevails over relationship at work. Collective societies educate their children towards a 'we' consciousness in which opinions are predetermined by the group, obligations towards the family are paramount and expressions of harmony, respect and shame are fostered. Particularism as a way of thinking prevails in which value standards differ for in- and out-groups and other people are viewed as members of their particular group. Relationships prevail over tasks.

The data on power distance and the individualism collectivism dimension for

South Africa are based on Whites only where the population scored medium on Power Distance and above average on Individualism. The data for East and West Africa reveal regional scores of above average in Power Distance and quite Collectivist. HOFSTEDE'S (1994:75) assumption is that Black South African culture will reveal above average Power Distance and strong Collectivism with the exception of an acculturated intellectual minority.

- * **Masculinity versus Femininity** refers to the distribution of roles and the associated values between the sexes. The multinational corporation studies revealed that women's values differ less between societies than do men's values and that men's values, from one country to another, contain a dimension from very assertive and competitive and, therefore, maximally different from women's values on the one hand, to modest and caring and similar to women's values on the other. The assertive and the modest caring poles have been called 'masculine' and 'feminine' respectively. In feminine societies, women have the same modest caring values as the men, although they are somewhat more assertive and competitive in masculine societies, however, not to the same degree as men, so that these societies display a gap between male and female values. In feminine cultures, family life stresses relationships, solidarity and resolution of conflict by negotiation and compromise. At school, the average student is the norm, social adaptation is rewarded and failure at school is a relatively minor accident. At the work place, assertiveness is ridiculed, people undersell themselves, stress is on the quality of life and intuition. By way of contrast, families in masculine

societies stress achievement, competition and resolution of conflict by fighting it out. In the academic system, the best student is the norm, academic performance is rewarded and failure represents disaster. On the job, assertiveness is appreciated, people oversell themselves, careers are stressed and decisiveness is important.

- * **Uncertainty Avoidance** deals with the extent to which members of a society feel threatened by unknown or uncertain situations which, in turn, lead to emotionality and aggressiveness, to institutions promoting conformity and to beliefs promoting certainty. It has ultimate reference to man's search for Truth. Uncertainty avoiding cultures are characterised by a belief in an absolute truth which they believe is the only Truth possessed by them. Uncertainty accepting cultures are more tolerant of opinions different from themselves, attempt to have as few rules as possible and on the philosophical and religious level are relativist, allowing different currents to flow side by side. Members of these cultures tend towards the contemplative and phlegmatic and are not expected to express their emotions. Strong uncertainty avoidance societies view what is different as dangerous, display higher levels of stress and anxiety and accept displays of aggression and emotion within the family. At school, learners are comfortable with structured learning situations, precise objectives, detailed assignments and strict time-tables with educators seen as having all the answers. At work there exists an emotional need for rules, greater formalisation and standardisation. Conversely, weak uncertainty avoidance societies view difference as curious or ridiculous, display low stress

levels, ease and indolence and do not display emotion or aggression. Students are comfortable with unstructured learning situations, vague objectives, broad assignments and no time-tables. It is acceptable for educators not to know the answers. There exists a dislike of rules and demands for less formalisation and standardisation.

According to HOFSTEDE (1994:77), there is no significant difference in Uncertainty Avoidance between East, West and South Africa, but White South Africans score more masculine than both Black African groups. By way of contrast, many Western and some Latin American and Asian countries score even less masculine. For example, the Netherlands and Nordic countries score quite feminine.

- * **Long Term versus Short Term Orientation** is the dimension found in a study among students of 23 countries using a questionnaire designed by Chinese scholars. The deliberate Chinese bias was chosen because HOFSTEDE (1994:77) was concerned about the implicit bias in existing research. The research produced similar results in respect of the first three dimensions discussed, but does not identify a dimension of Uncertainty Avoidance which deals with the search for Truth. To the Chinese minds who designed the questionnaire, the search for Truth is not an essential issue. A basic difference between Eastern and Western thinking is that in the former, a qualification does not exclude its opposite which, in turn, is an essential element of Western logic. Because there is no assumption

of a single and absolute Truth in the East, questions relating to this particular value were omitted. Included, however, were questions dealing with concerns for the future versus the past-and-present. Cultural values associated with Long Term Orientation are thrift, perseverance, subordination of self for a purpose, adaptation of traditions and concern for virtue, expressed as the proper way of living, as apposed to a concern for Truth from which Virtue tends to be derived. Conversely, features of Short Term Orientation include respect for tradition, fulfilling social status obligations regardless of cost, expectation of quick results, low savings and concern with 'face'.

It is noted (Hofstede, 1994:78) that of the five dimensions, Long Term Orientation is the only one that correlates with economic growth over the past 25 years. The economically dynamic countries of East Asia all score at the top of the scale and most Western countries short term, as do Zimbabwe and Nigeria, the only African participants.

A further aspect of Hofstede's work is that GUDYKUNST AND TING TOOMEY (1988:43-44) believe that the dimensions of individualism - collectivism and low-high communication as formulated by HALL (*in*: Gudykunst and Ting Toomey, 1988:43-44; Bennett, 1990:53-56) are isomorphic.

- * **Low- and High-Context Communication** is a determinant that differentiates between cultures on grounds of the communication that predominates in that

culture. According to HALL (*in*: Bennett, 1990:54-56; Gudykunst and Ting Toomey, 1988:43-44), a high-context communication or message is one in which most of the information lies either in the physical context or is internalised in the person, while very little is in the explicit coded transmitted part of the message. Conversely, a low-context message or communication is one in which the mass of the information is contained in the explicit code. High-context communication reveals greater distinction between insiders and outsiders and holds greater expectations of the participants than does low-context communication. This includes an expectation that the interlocutor knows what is on the mind of the other person without having to be specific. The end result is talking around the point and putting all the critical pieces in place except the crucial one. This is the role of the interlocutor. All cultures labelled as low-context are individualistic in accordance with Hofstede's scores and *vice versa*.

This position also appears congruent with LEVINE'S (*in*: Gudykunst and Ting Toomey, 1988:44-45) approach to cultural variability in the use of directness versus indirectness and certainty versus uncertainty in respect of communication. The former calls for clear and direct communication and is unequivocal in nature, while the latter is characterised by indirect often sensitive conversation abounding with general evasive remarks. The one is designed for affective neutrality and the other conveys a wealth of reciprocal emotional response.

The elucidation under this sub-heading may be reclassified in terms of communi-

cation styles that reflect the moral aesthetic and affective patterns of a culture referred to by GUDYKUNST AND TING TOOMEY (1988:100-115) as direct *versus* indirect, elaborate *versus* succinct, personal *versus* contextual and instrumental *versus* affective styles of communication.

These modes of communication, cultural differentiation, value systems and participation systems are interrelated and overlapping concepts which are examined separately purely in an attempt to gain greater insight into the educator-learner relationship within the health education situation.

(e) *Modes of Participation*

Interactional style represents social cognition and has reference to the focus of an individual's (conscious and unconscious) thoughts upon the human interactions that occur in a particular situation. For some, the focus entails action that facilitates adaptation to a specific situation while for others, action is determined by their specific attitudes and values rather than the situation. Differences in interactional style represent differences in centring on tasks or interpersonal relationships (Shade, 1989:289). HOFSTEDE'S (1991; 1994) research has expanded the knowledge base regarding those cultural factors which may affect interactional style. Rules of discourse, language construction and conversational participation have been shown to be culture specific and are learned from interacting with others (Green, 1983:174).

Individualism and collectivism is very evident in the school. Educators from more indivi-

dualistic cultures complain that students in collectivist cultures do not speak up in class, not even when questions are put to them. When a learner conceives himself as part of a group, it is illogical for him to speak up without the sanction of the group. Collectivist students also hesitate to speak up in a group partly composed of relative strangers. In an individualist society, assignment of joint tasks more easily leads to the formation of new groups than in a collectivist society. In the latter, students from the same ethnic or familial group will expect preferential treatment from the teacher: an attitude viewed as nepotism in individualist cultures and, therefore, as immoral. Values of harmony and maintenance of 'face' reign supreme in collectivist groups so that confrontation and conflict are to be avoided. At all times, teachers are dealing with students as part of the group - never as an isolated member. Collectivist societies lay stress on adaptation to the skills and virtues necessary for becoming an acceptable member of society (Hofstede, 1991:61-63).

Masculinity-femininity, as a dimension describing national cultures, affects participation in the classroom. In masculine classes, for example America, students try to make themselves visible and strive for high grades, whereas in feminine classes, for example Holland, average performance is not only the norm, but more socially acceptable. Criteria for evaluating teachers and students also differ. On the masculine side, the brilliance and scientific reputation of educators and academic performance of students are dominant factors. On the feminine side, the friendliness and social skills of the teacher and social adaptation of students play a more important role (Hofstede, 1991:90-91).

The effects of the dimension of national culture difference of strong and weak uncertainty

societies on classroom participation can best be described by contrasting the expectations of Germans (strongly rated) and English (weakly rated) in respect of the educative event. The German student requires a structured learning environment as detailed under 4.3.1.2(d), has a preferment for only one correct answer and expects to be rewarded for accuracy. Conversely, the English despise too much structure, like open-ended learning situations with vague objectives. The suggestion that only one answer exists is taboo and students expect to be rewarded for originality. The former expect teachers to be experts and respect academic language, while the latter prefer plain language and view intellectual disagreement as a stimulating exercise (Hofstede, 1991: 119-120). In a combined German-English classroom, to meet the needs and expectations of one half is to create intolerable anxiety and/or frustration among the rest.

In similar vein, it is possible to analyse the remaining dimensions of cultural difference on classroom participation. At the same time, it should be borne in mind that sub-cultural variations as discussed under 4.2 remain key issues. Empirical studies continue to reveal how the perceptual orientation of educators and learners continue to affect the educative event.

Research has found that in schools in the USA, Black and Mexican children tend to be more person than task orientated which implies that they tend to be more interested in content that has a human social focus and teaching strategies that involve them with people. They also tend to focus on the whole rather than parts and view the attributes of an object in relation to its use rather than a set of formal rules (Sleeter and Grant, 1988:45).

In America and other First World Countries, academic activities are based mainly on individual attainment and competitive participation in the classroom, both of which are rewarded. In play and on the sportsfield, co-operation and teamwork are supported. Conversely, in Black communities, the emphasis is often reversed with emphasis on co-operation in work and competition and individual excellence in play (Bennett, 1990:69). In keeping with the preferred mode of participation, group learning strategies are of significance.

Trends towards and emphasis on conformity and order in classrooms in working class neighbourhoods have been observed, while schools in middle class neighbourhoods provide less external structure and emphasise the development of self-directed learning. It follows, therefore, that students who do not acquire self-directed learning skills, experience increasing difficulty as they progress to higher levels of education (Levine and Havighurst, 1989:261). A pattern which is likely to perpetuate itself in adult education when adults, who may be completely self-directing in many aspects of their lives, hark back toward their conditioning in schools with an accompanying expectation of 'teach me' (Knowles, 1987:170).

Differences discussed under modes of communication and participation and differences between educator-learner cultural orientations reveal a few of the actual consequences of field dependency versus field independency, while research by RAMIREZ AND CASTENADA (in: Singh, 1988:357) confirms that Anglo-Americans tend to be field independent with respect to cognitive style and focus on specific data without reference to the surrounding environment.

To summarise the overall effects of cognitive, learning and communication style as a major area of potential cultural incompatibility, COHEN (in: Sleeter and Grant, 1988:45) describes the characteristics typifying approaches to learning in most classrooms. These include

"... task rather than person orientation; focus on the parts of a whole; focus on decontextualized information; linear thinking patterns; non-emotional behavior; sedentary behavior; long attention span, regardless of personal interest; use of standard English; ability to communicate without reference to context of non-verbal cues; and formal rules, schedules, preplanning and structure".

As this is the learning style fostered in most White middle class homes, SHADE (in: Sleeter and Grant, 1988:16) argues that Blacks are academically disadvantaged because their learning styles diverge from dominant teaching styles. They tend to be orientated towards co-operation, content about people, whole-to-part-learning, discussion and hands-on work. In this regard ANDERSON (1988:5), quoting Mbiti and Levy-Bruhl, states that the most characteristic feature of the African philosophical system is the focus on unity and connection in which all systems of thought and behaviour, from simple practical concerns to the more formal sciences, are interwoven into a logical and functional system in which there is no conflict between the cognitive and emotional. This world view may cause Europeans, and by implication Whites or the dominant middle classes, for whom things that are contemplated, experienced and lived are separable, to deduce that the African way of thinking is non-logical.

It is important that the research findings which have been discussed are neither regarded as absolute, nor result in further stereotyping. There are, in fact, many similarities in the world

views and cognitive, communication and interactional styles of different groups and the disparate perceptual styles and modes of thinking and acting actually fall along a continuum with certain groups seeming to cluster at one end or the other.

Whenever cultural orientations are shared there is an overarching message of rapport. The question arises concerning the potential responses of learners and educators to their situatedness in the cross cultural health education encounter.

4.3.1.3 Human, Responses to Cross Cultural Encounters

It has been revealed in the previous sections that educators, by and large, internalise and reflect prevailing social values towards cultural sub-groups within society and that these values, in turn, strongly influence the educational outcomes of learners (Frazier, 1977:13).

It has also been demonstrated that every learner, whether child or adult, brings a unique cultural identity to the classroom. Every social situation is a coming together not only of expectations concerning social roles, but also of cultural and personal identity in which notions of self-concept and self-identity play an integral role.

(a) Self-Concept and Self-Identity

Self-concept is so closely related to self-identity that according to HAMACHEK (1985:234), they are overlapping concepts with self-identity representing that part of each person of which he or she is aware: a sense of being a unique individual, distinct from others. Self-

concept refers to the cluster of ideas and attitudes each individual has of self at a particular point of time and constitutes the cognitive part of the awareness of self. Self-conceptions concern the body as a physical entity plus the person's ideas about his physical and psychological self. These ideas crystallise and are divined through involvement with the world (Vrey, 1979:45-46). The way in which people perceive themselves develops out of their interactions with others and the way others treat and perceive them. The self-image influences each person's behaviour, which, in turn, affects the way others see and treat him and the cycle, be it benevolent or vicious, is complete (Levine and Havighurst, 1989:266).

According to LAMBERT (1989:273-274), psychological comfort, to a large extent, is directly related to the perception of a threat to one's 'self': The core of who one feels one is. Self-concept acts as the centre of one's phenomenological world in terms of which all external things are measured and judged. When an individual perceives a situation as hostile or a threat to an aspect of the self-image, defenses are raised which become barriers between the self and the perceived threat. In a learning situation in which participants represent a variety of cultures, the potential for psychological discomfort is high.

Parties to the cross cultural education encounter may experience each other at different levels of their respective perceptual fields in terms of 'self'. Each is prepared, albeit in different ways and to varying degrees, to defend that perception. In multicultural societies, clearly, identifiable racial (cf 4.2.1) and ethnic (cf 4.2.2) groups as well as the lower classes (cf 4.2.3), females (cf 4.2.6) and rural populations (cf 4.2.5) have suffered varying degrees of inferior status and lack of equal social, political and/or economic opportunity. The assump-

tion can be made that all participants are aware of their status in both the health education encounter and in the wider social context. When members of groups that generally maintain a high degree of social distance meet, they will probably perceive each other as representatives of 'us-them' configurations, at least, initially (adapted from Christensen, 1985:69-71).

KATZ (*in*: Milner, 1983:184) and PETTIGREW AND PAJONAS (1973:88) reveal that Black learners display marked social inhibition and subordination to their White partners in cooperative problem-solving tasks, make fewer proposals than Whites and tend to accept the latter's contributions uncritically. Those with equal ability tend to rate Whites higher than themselves. On grounds of these and other studies, the self-enhancement theory argues that self-concept influences the level of performance.

While the above paragraph has reference to formal education, ROSSMAN ET AL., (1984:35-36) cite the fact that there are numerous examples of adult learners who have developed negative self-images characterised by a lack of confidence, low expectations and general feelings of inadequacy. In any educational milieu, a weak self-concept is linked to fear of failure which manifests as fear of being wrong, of being laughed at and of peer and teacher disapproval. Such fears culminate in restricted achievement that belie the underlying real ability of the individual and perpetuate low self-esteem.

As with research in other facets of educational outcomes and multicultural education, theories on self-concept and schooling are not adequately formulated and research findings on self-concept, race and class are conflicting and contradictory (Stone, 1981:40-41).

COOPERSMITH (*in*: Stone, 1981:45-46) and ST. JOHN (*in*: Whittle, 1982:116) maintain that recent research challenges findings that Blacks have a low self-esteem. The correlation between academic performance and self-esteem is inconclusive, displaying little uniformity across all levels of the self-esteem table, but with a tendency to be strongest at the lowest end (Bullivant, 1987:38). COOPERSMITH (*in*: Bullivant, 1987:40), on the basis of his own later research, and that of others, has arrived at the conclusion that there is little, if any, difference between the self-esteem of children from different racial or ethnic groups.

Studies related to the self-concept of children are of relevance to adults in so far as the adult's self-concept is achieved through the accumulated social activities and contacts of a lifetime. The degree of success experienced determines how people feel about themselves (Rossman *et. al.*, 1984:34). To base assumptions about self-esteem within the narrow confines of educative events, to the exclusion of the interwovenness of all other social phenomena, is limiting and liable to misinterpretation.

KITANO (1974:127) postulated that while majority group members are able to develop a single universal identity to which others have to adapt, ethnics are forced to assume multiple identities and roles as they have to adjust to the societal roles of the dominant group as well as coming to terms with their absolute ethnic (or other minority group) status. Under these circumstances, members of the majority group define the situation and are in control of the interaction. Minority groups are generally expected to be bicultural, bilingual or multilingual, bicognitive and to sustain the psychic energy to maintain their performance and measure it against a European or Western yardstick (Anderson, 1988:5). Consequently, cognitive con-

flict may become the norm rather than the exception and may generate problems relating to an identity crisis.

On the other hand, SPINDLER AND SPINDLER (1990:81-82), in reference to biculturalism, state that although minority adaptations to two cultural codes may produce good results, they are an additional strain on individuals. The greater the difference between the two codes, the greater the difficulties. Code switching through several more-or-less related codes is not so difficult.

The complexity and tenuous nature of the link between self-concept and self-identity and culture is illustrated by statements that cultures are so vast, rich and various that individuals cannot assimilate all of them equally. Each individual forges his own individual and cultural identity and almost always draws on more than one tradition (Novak, 1982:26). No single person is able to internalise the total cultural capital available to him (cf 4.4.1).

Every social situation is a coming together, not only of self-concept, self-identity and social roles, but also of shared realities: that which constitutes the intersubjective structure of consciousness.

"What is taken for granted by the native is problematic for the stranger. In a familiar world, people live through the day by responding to daily routine without question or reflection. To strangers, however, every situation is new and is therefore experienced as a crisis" (Parrillo, *in*: Gudykunst and Kim, 1984:21)".

When people meet who have been socialised within groups with different objectives, but more

particularly, subjective cultural characteristics, a cross cultural interaction occurs. The unintentional conflict that emerges as a result of a misunderstanding or the misreading of the cultural cues within the cross cultural encounter is usually experienced as some form of 'culture shock' by the participants.

(b) Culture Shock

The concept of culture shock was introduced by OBERG (1958) and has taken roots in the work of prominent researchers such as BARER-STEIN (1988:75-79), CUSHNER (1989:320), HOFSTEDE (1991:209-210) and PEDERSEN (1994:192-193).

Culture shock is the term used to describe anxiety stemming from a person losing his sense of 'how' and 'when' to do the right thing and the ensuing process of adjustment. Initially, the situation involves a non-specific state of uncertainty in which an individual does not know what others expect of him or what he can expect of others in respect of behavioural, psychological, emotional or cognitive responses. The most frequently quoted indicators of culture shock include an absence of familiar cues about how to behave; a sense of helplessness in the new setting; a reinterpretation of familiar values about what is good; an emotional disorientation ranging from anxiety to uncontrollable rage; a feeling that the discomfort will never disappear and a nostalgic idealisation of how things were. In any radically new situation, including health education in the cross cultural encounter, the cultural context is changed in unexpected ways that involve adjustments in respect of social roles and self-identity which, in turn, result in culture shock (Pedersen, 1994:192).

According to ADLER (in: Pedersen, 1994:192), the culture shock experience is classified into five stages. The first stage of initial contact has been called the 'honeymoon' stage because people are initially enraptured and intrigued by the intercultural experience. The second stage commences when people become frustrated by their inability to interpret the situation appropriately due to, 'disintegration of that which is familiar'. Difference intrudes in a manner which cannot be ignored. The person experiences loneliness, depression, withdrawal and self-blame. Highly ethnocentric reactions may emerge during this phase carrying a high probability of conflict as the third phase begins. Self blame may turn to hostility, rejection and attacks against the new setting. TRIFONOVITCH (in: Barer-Stein, 1988:77-78; in: Cushner, 1989:320) combines the second and third stages as described and aptly labels them the 'hostility phase' during which fear, dislike and distrust are commonly experienced emotions (Rothenburger, 1990:1352). This is the most volatile stage as 'reintegration of new cues' takes place. Things are getting better, but not fast enough. People begin to understand the subjective culture of those with whom they work and the way in which things are perceived and accomplished in their new environment. The fourth stage of 'developing a new identity' begins when both differences and similarities are acknowledged. The individual becomes more self-assured as he learns to function in accordance with the new conditions, accepts the strengths and weakness of his old and the new system, adopts some of the local values and becomes integrated within the new social network. This is the phase in which acculturation (cf 4.4.3.1) may be perceived to have set in. The fifth stage ideally leads toward a multi- or bicultural identity. In essence, a stable state of mind is reached ranging from a preference for what had gone before, true bicultural adaptation in which the present is on a par with the past or total conversion to the new environment (Cushner, 1989:320;

Hofstede, 1991:209:210; Pedersen, 1994:192-193).

According to PEDERSEN (1994:193), recent research on culture shock demonstrates that while the process may be painful, it is not necessarily a negative experience for it results in new insights and positive human growth. Conversely, when intergroup contact fails, it frequently results in exclusionary behaviour such as biased evaluations; denigration and disparagement of others; blaming the victim or displacing the blame for one's own actions; self-righteous comparisons that justify retaliation; dehumanising the individual; double standards and psychological distancing among others.

4.3.1.4 Résumé

Findings derived from the elucidation of differences in the frames of reference of educators and learners in the cross cultural educational milieu reveal the degree to which both are geared to react in specific ways under particular circumstances within their situatedness. Not only have the effects of negative stereotyping been highlighted, but an attempt has been made to illustrate that research, linking specific perceptual frames of reference, cognitive and learning styles and modes of communication and participation, is neither absolute nor definitive in Cartesian terms.

Hofstede's theory of cultural differentiation illustrates quite clearly how dimensions of national difference are forces to be reckoned with in respect of teacher-student expectations in the classroom and, later on, in relationships between adult workers and their bosses. This

theory also demonstrates how nationality cuts a swathe through the racial divide. These dimensions of the cross cultural encounter remain, however, only one subset of factors constituting the totality of those operating in cross cultural agogic encounters. They also exclude the previously mentioned factors of social class, regional and ethnic identity as well as existing political, economic, social and health systems.

It has been disclosed that neither learners nor educators are passive participants in the teaching-learning experience and that both conscious and unconscious forms of discrimination and inappropriate teaching strategies, on the part of educators, not only affect adult participation in adult education activities, but also have the potential to negatively influence learning outcomes. Learners are hereby denied the opportunity of realising levels of competency in essential areas of adult life.

Links between the overlapping areas of self-identity and self-concept and the concept of culture as overarching ground structure of human existence (cf 3.2.1.11) have been identified, as have the potential links between low and high self-esteem on learning outcomes. However, research on self-esteem in the learning process is not conclusive and subject to inconsistencies and contradictions.

An elucidation of the concept of culture shock reveals the degree to which the cross cultural encounter is experienced at an intense subjective inter- and intrapersonal level. The experience is the embodiment of man as an existing being in cultural terms (cf 3.2.1.2(a)) and as a being in the world in cultural terms (cf 3.2.1.3(a)) through which he is related to others

in cultural terms (cf 3.2.1.4(a)). On reflection, it may be demonstrated that the process of resolving culture shock is congruent with the ground structures of human existence in cultural terms. As beings in dependence of co-existential involvement with others, in the mutual situatedness of the encounter in cultural terms (cf 3.2.1.8(a)), dialogue ensues in which and through which the participants, as beings in openness, are capable of attributing meaning and gaining an understanding of their own world and that of others in cultural terms (cf 3.2.1.5(a)). As self-transcending, intentional beings in cultural terms (cf 3.2.1.6(a)), they are able to reflect on and question their personal relationships with their own worlds and choose (cf 3.2.1.9) to attempt to understand and accommodate to the demands of the cross cultural encounter. As beings in a state of becoming in cultural terms (cf 3.2.1.7(a)), man's conscious attempt to understand and become actively engaged with multicultural groups represents a change from that which was previously experienced. Opportunities for actualisation of personal and/or group potential, whether expressed as competency or capability, is enhanced. The choices made in both personal and cultural terms, if made responsibly (cf 3.2.1.9(a)), facilitate the realisation of objectives within the bounds of normativeness (cf 3.2.1.10(a)) as an aspect of the human capacity for autonomy (cf 3.2.1.9(b)). Failure to seek meaning and to make responsible choices in the cross cultural encounter engenders emotions of fear, dislike and distrust manifesting in responses ranging from disengagement through to overt conflict. Regression or stagnation becomes the inevitable result. In the experience of culture shock, historicity in cultural terms, (cf 3.2.1.12(a)) of which social change (cf 4.4.3) is an integral part, becomes apparent when expressed in the form of adaptation, acculturation (cf 4.4.3.1) and adjustment culminating as bi - or multiculturalism. Acculturation remains congruent with the ontic construct of man as unchangeable being in

changeability in cultural terms (cf 3.2.1.13(a)). Multiculturality is impossible outside an acknowledgement of man as being in possession of human dignity in cultural terms (cf 3.2.1.14(a)) regardless of difference, be it race or gender as aspects of bodiliness in cultural terms (cf 3.2.1.15(a)) or religion (cf 3.2.1.17(a)), language, social class or rural-urban distribution as evidenced in cultural and/or sub-cultural terms.

An attempt has been made to illustrate the social cohesiveness experienced within cultural groups or sub-groups, while at the same time acknowledging the uniqueness and individuality of the individuals comprising these groups. A finely tuned balance between the differences in and between groups and the similarities in and between individuals emerged: a balance which is susceptible to distortion due to the fact that people make judgements about others based on the behaviour they observe. In the cross cultural encounter, focus tends to be centred on that which is different rather than that which is held in common. Commonly held beliefs and practices operate at an unconscious level of human thought and action and do not infiltrate levels of consciousness. Therefore, difference is more open to analysis and research than is communality. In order that the latter be kept to the foreground of conscious thought as a concept in equivalence to that of diversity (cf 3.2.1.16), it has been decided to interpret specific phenomena underlying the communality of human experience. Equivalent consideration of diversity and communality remain fundamental in bringing issues surrounding health education in the cross cultural encounter into clearer focus and rendering more meaningful attempts to formulate guidelines towards authentic health education in the cross cultural encounter.

4.4 COMMUNALITY OF CULTURAL EXPERIENCE

Although the existence of sub-groups within specific societies has been disclosed and concepts such as core culture and social change mentioned, a study of available literature endorses the fact that certain features of these phenomena are a common denominator in the experience of all groups regardless of cultural identity. The concept of the communality of cultural experience is also in total accord with the fundamental ground structure of man as a being in a state of homogeneity in heterogeneity (cf 3.2.1.16). It is in this context that the researcher intends to approach common cultural experiences in relation to health education in the cross cultural encounter.

4.4.1 THE HETEROGENEOUS NATURE OF CULTURAL GROUPS AS UNIVERSAL CULTURAL PHENOMENON

The fact that people are encouraged to define themselves in relation to what makes them different from others, rather than those things which are shared, often results in cultural parochialism (McLeod, 1987:70), and a failure to recognise that multiculturalism is present to some degree in every human society (Goodenough, 1976:6). A view of culture that characterises societies or sub-societies as wholes and ignores minor differences between family and family and village and village which reflect in differences among individuals and different ways of doing things, is inaccurate and inappropriate. Individual people, as learners of their culture, in the context of social interaction and in pursuit of their various interests,

are involved in the necessity of making choices between conflicting goals, competing wants and long range, as against short range concerns, as they attempt to deal with the various problems of life (Goodenough, 1976:4). LEVINE (1985:46-48) endorses these findings by presenting evidence that cultural specialities and cultural alternatives exist among the Amhara in the form of cultural traits shared by certain status groups or a number of individuals within the population but not by the cultural group as a whole. He also cites the fact that individuals learn the culture of their group in different ways, resulting in cultural elements being partially or incorrectly learned or even transformed during the learning process. Furthermore, the degree of confusion about what constitutes transition should never be underestimated. Notions of uniformity, persistence and consistency of cultural elements are refuted (Levine, 1985:45).

Therefore, it may be concluded that all humans live in what for them is a multicultural world. Learning the culture or macroculture of a society is more in the nature of learning a number of different or partially different sub- or microcultural variants within the context of the individual's particular situation. Such learning includes how to discern situations in which these variants operate and are appropriate. As a result, people develop varying degrees of competency (and/or capabilities) in a number of microcultures. Contact at intersocietal level makes some people minimally competent in certain aspects of macrocultures as well (Goodenough, 1976:5).

Studies have identified the validity of speaking of sub-cultural variants within South Africa. Many show a range of deviancy within ethnic, race and other groups such as social class and

gender (Arthur, 1994:12). As the range of cultural diversity increases in complex societies, the degree to which individuals gain competencies at micro- and macrocultural levels may influence their affairs and play an important role in differential access to privilege and power. Such competencies are acquired in the context of interaction. Presented in this light, culture cannot be regarded as a transcendent entity which takes possession of individuals, but rather it emerges in the natural course of everyday learning within the context of social interaction.

Inherent in GOODENOUGH'S (1976:5) concept of the acquisition of cultural competencies in contemporary complex societies, is the necessity for individuals to become familiar with codes of conduct of other groups in order to pursue their various and competing interests and access to power. Such an approach leads inevitably to the question concerning the existence of a common cultural core in every society.

4.4.2 COMMON CULTURAL CORE AS UNIVERSAL CULTURAL PHENOMENON

The notion of a common cultural core as universal cultural phenomenon has been elucidated under the heading *Man as a Being in a State of Homogeneity in Heterogeneity in Cultural Terms* (cf 3.2.1.16(a)). The author, therefore contends that the concept of core culture and man as a bearer of his cultural capital are universal features of all, but especially complex societies.

As an extension to this line of reasoning, it becomes apparent that even in complex multi-cultural or multinational societies, survival is dependent on a common or shared reservoir of

cultural capital at macro-level, often in the form of economic, political, legal (education and health) systems, as well as major national experiences such as war and peace, depression and prosperity, great leadership and official lapses (Novak, 1982:26). Social abstractions, which none the less constitute part of the social reality, are increasingly presented as part of the common experience of all cultures in First and Third World countries. These include notions such as social change, modernisation and acculturation and the generation gap (Arthur, 1992:298).

4.4.3 SOCIAL CHANGE AS UNIVERSAL CULTURAL PHENOMENON

One of the major criticisms that may be levelled at discussions of models of society is that they represent a static view of society (Saunders, 1982:13) and, by implication, culture. This representation is in violation of the ontological-anthropological category of changeability within unchangeability. Cultural and sub-cultural groups are highly complex, diverse and changing entities (Banks, 1988:193). Culture is not static but a dynamic force which changes over time. Neither is it objective, so that any attempt to describe it must allow for the ways in which it is perceived by different people living within a particular culture (Verma, 1984:71-72). The reality is that there is constant interaction between people and between people and their environment, bringing about change in the form of accommodation (adapted from Saunders, 1982:13-14). In South Africa, according to GAGANAKIS (1986:14), the situation has been complicated by the fact that static interpretations of culture are sealed into racial categories.

Social and cultural change may, therefore, be said to be an experience common to all groups and that change always follows reciprocal interaction at individual, social and cultural levels (Marais, 1983:33). Social and cultural change is a phenomenon in which the concept of acculturation plays an important role.

4.4.3.1 Acculturation

The concept of acculturation represents the outcome of social interaction over time, not as a static event, but as an ongoing phenomenon. Acculturation is a process that is initiated when groups of people with different cultures come into continuous first hand contact with one another, with subsequent change in the original cultural patterns of either or both groups (Social Science Research Committee, *in*: Herskovitz, 1948:528) or it occurs with the introduction of an innovation into a specific culture causing immediate small changes, which then never cease (Herskovitz, 1948:504). Even if the term cultural contact is extended to include that of sub-cultural contact within a single society, the concept is not as simple as the definition would appear to indicate. MARAIS (1983:30-31) has demonstrated that words such as accommodation, assimilation, diffusion, detribalisation, westernisation, transculturation and urbanisation have been used as synonymous by various authors. Additional words which MARAIS (1983:42) found to be regarded as more or less synonymous or associated with the term are, enculturation (or socialisation), modernisation, industrialisation, innovation, adaptation (or accommodation), amalgamation or homogenisation and absorption.

The majority of the terms, whatever the source, have reference to social phenomena which

are directed toward interaction between a general evolution of adaptation to world-wide external conditions and a local condition reflecting the indigenous situation. Both internal and external systems are complex and both have changed through history (McNulty and Weinstein, 1982:71). Discoveries and inventions, occurring with ever increasing frequency and setting the scene for a process of ongoing change, laid the basis for industrialisation, urbanisation and what is referred to as contemporary, modern technological society (cf 1.3.1.4). With regard to both intra- and intercultural acculturation, individuals maintain and retain their primary cultural heritage and experience, while acquiring the knowledge and skills generated from within or from other cultures. Consequently, individuals are able to function effectively in their primary culture and other cultures (adapted from Baptiste, 1986:302). Therefore, it may be deduced that acculturation occurs over time within a specific society in which a discovery or innovation occurs and/or between cultures. Existing circumstances and cultural content will determine what is accepted or rejected (Herskovitz, 1948:539).

At this point, it appears appropriate to ponder the relationship between enculturation and acculturation and question whether enculturation is not the first step towards acculturation. BANKS AND LYNCH (1986:22-23) state that the school provides an environment where acculturation should take place, where teachers and students should assimilate some of the views, perceptions and ethos of each other as they interact with one another. BANKS, (1979:248; 1988:129) states that America experienced and is still experiencing multiple acculturation. In fact, learning itself implies change.

Reflection reveals a linkage between the concepts modernising, industrialisation, urbanisation

and the West but McNULTY AND WEINSTEIN (1982:74) indicate that Westernisation and modernisation are not synonymous, for other non-Western countries such as Japan, the former Soviet Union and Eastern Block countries have also contributed to its evolution. Neither is modernisation a phenomenon from which African and other developing or Third World countries are excluded.

4.4.3.2 Modernisation

In the contemporary world, it may be claimed that modernisation is a universal cultural phenomenon. The question for most developing countries, is no longer whether they should modernise, because as ADAMS (1982:117) puts it, the choice not to be modern is "... to choose social suicide or at best backwardness". Modernisation in this sense implies desired socio-economic change that may be viewed as a specific form of social change associated with technology.

Modernisation may be seen as a process or series of processes with a common core, generating common or similar problems in every society. These problems include phenomena such as growing differentiation, social mobilisation and breakdown or weakening of traditionality. Each society is confronted with difficulties in regulating and continuously developing changing structural and cultural parameters within a common institutional framework. Institutional structures capable of absorbing more change to deal with continuously new and changing problems beyond its own initial premises are required (Eisenstadt, 1972:7).

It is important to recognise that the traditional and the modern are not polar opposites, but rather intertwined processes with several mutually reinforcing elements (Lutz and El-Shakhs, 1982:2), and that the modern-local dimension is only one of the several axes along which change is occurring. The modern does not merely replace the local-traditional (McNulty and Weinstein, 1982:74; 77), because all social groups tend to organise themselves in new modern settings in effective ways (Singer and Rudolph, *in*: Eisenstadt, 1972:3) as each individual attributes personal meaning to his world under the guiding influence of cultural norms. Possibilities may be acted upon within the context of man's own social situation, thereby contributing to further social change, acculturation and modernisation. "Man, in terms of his own creativity, becomes the initiator of changes" (Arthur, 1992:306).

In presenting arguments for the recognition of communalities that exist between cultural groups, the notion of difference continually comes to the fore. By the same token in discussing diversity, the reality of communality cannot be ignored. This symbiosis, revealed as homogeneity in heterogeneity, must be taken into account if authentic health education is to be achieved in the cross cultural encounter.

4.4.4 RÉSUMÉ

In seeking that which is universal in the culturality of human beings, what has emerged is the clear reminder that culture is imperfectly shared and that learning remains an individual matter (Wolcott, 1987:48). Findings remain congruent with man as culturality, but negate the somewhat static view of culture implicit in many views of multicultural education, where

sets of more or less immutable characteristics are attributed to different groups of people, producing stereotypes.

By demonstrating the realities of the existence of core cultures as well as man as a bearer of a portion of his cultural capital, the universal experience of heterogeneity within groups and social change, Goodenough's (cf 4.4.1) concept of cultural competencies which everybody in contemporary complex societies must acquire, becomes meaningful. Possibilities for individuals to distance themselves from their own culture or sub-cultures, become familiar with codes of conduct of other groups and penetrate these groups, is increased. Contemporary terminology for Goodenough's notion of competency is that of capability or capacity expressed, in educational terms, as capability or capacity building.

In societies undergoing rapid social change and modernisation, the twin concepts of enculturation and acculturation are both features of the (formal and informal) educational system for there can be little doubt that a basic acculturation for all children (and adults), is an essential key to full participation in society. Acculturation greatly enhances life chances, provides access to opportunities and, for the individual, may be a necessary source of identity in the alienating conditions of complex industrial societies (Craft, 1989:144).

It may be stated that the dynamics of social change, in all its manifestations, provide the individual with a wide diversity of possible activities in respect of his own cultural or sub-cultural capital and that of others. It may also be said that the path which is followed is determined by human decision making. Nowhere, in the opinion of the researcher, is the

result of human choice more easily and clearly discerned in the education system than in adult education, where the programmes followed are the direct outcome of individual choice. These choices are based on the relevancy and appropriateness of course content and education strategy and the availability, accessibility and affordability of health education programmes for the client. In the health sphere, the existence of core values is readily demonstrated. However, the adoption of alternative values and practices that enhance levels of health, thereby impacting positively on the quality of life, does not preclude remaining within the culture of origin.

Intrinsic to the dynamics of cultural change, modernisation and acculturation are different possibilities for action that are open to the individual with respect to his own cultural capital as well as those of others (Adapted from Marais, 1983:54). Possibilities may be acted upon within the context of man's own social setting. The dilemma for education (both formal and informal), according to LYNCH (1984:148-149) is to achieve an astute, sensitive balance of both alternative and core cultures and to provide for the cultural transmission of both core and alternative norms and values in a functional way: in full recognition that the participants in the programmes are adults.

4.5 CONCLUSIONS AND FURTHER PROGRAMME

The researcher, in an endeavour to arrive at a deeper understanding of the overlapping human realities of health and education, examined human activities and human relationships in the context of the group or cultural life of individuals and the position of individuals as unique

human beings capable of exercising choice, within the context of their cultural group.

What has been revealed is a mosaic of complex mutually interactive factors that separately and in combination influence the effective delivery of health services to different sectors within multicultural societies. Disparities have been revealed between the levels of health and quality of life experienced by the dominant and minority groupings respectively. Within the formal and informal education systems, these same factors also serve to negatively influence the learning outcomes of clearly identifiable sectors of society in respect of both participation and performance.

It has been demonstrated, at the objective perceptual level, that factors such as race, ethnicity, social class, gender and urban-rural distribution are inextricably interwoven entities linked with the social realities of status, privilege and power or the lack thereof. When the notion of subjective culture, as acquired through socialisation within a particular group, is added to the equation, the significance of difference has been shown to become more complicated still. Components of the subjective culture discussed include, but may not be limited to, the way in which people categorise and perceive the world around them, their cognitive and learning styles and their modes of communication and interpersonal and group participation.

At the same time, it has been revealed that there is a danger in talking about people in an undifferentiated way. Levels of education and income, as reflected in social class, are more important than race or ethnicity when it comes to participation in adult education programmes and to the general levels of health experienced. Poverty, too, cuts across racial and ethnic

groupings while middle class status enables minority groups to live a life-style that makes them appear 'less ethnic' hereby giving credence to Gordon's (cf 4.2.4) concept of ethclass. At this point, it becomes evident that difference is mediated by the uniqueness of specific individuals and/or groups within the circumstances of their particular situation.

The study clearly reveals that any notion of absolute difference is illusionary. On grounds of deductions that certain aspects of culture constitute universal experiences within all groups and the ontological anthropological fact that all people share a common humanness, any perspective which views all cultures as basically discrete, incompatible entities should be broadened to encompass an approach which acknowledges the feasibility and the reality of people achieving competency in aspects of local and national cultures. An acceptance of this point of view ultimately makes provision for questions relative to the means whereby cultural idioms and meanings are acquired in cross-cultural interactions and to their effects on cultural identity (Hoffman, 1988:164).

In arriving at this conclusion, it would be naïve to ignore the difficulties that operate at the formal and less formal levels of culture which are not always clearly defined but are none the less significantly functional in agogic events (Warren, 1987:120). The evidence accumulated thus far highlights the fact that any learning activity in adults constitutes a complex interaction between external factors such as public roles, social networks and the internal psychological factors of attitude, prejudice and a tending toward social conformity which carries a degree of permanence in adults (Northmore, 1986:182). In addition, those factors that DODD (1987:49) refers to as the cognitive pathways of thought all combine to make up the barriers

to learning so commonly encountered in the cross cultural health education milieu: barriers that not only contribute toward resistance to change but also manifest as culture shock.

Conversely, if the communalities of human experience are stressed and if multiculturalism is seen to be present in all human groups, then cross cultural education as authentic health education can be realised. Implicit in this paradoxical assumption, is an understanding that failure to take cultural dimensions into account will not permit of actualisation within the educative event because human beings as individuality and culturality retain, as ontic fact, the essences of homogeneity in heterogeneity and cohesion in diversity. By the same token, it is as individuality and as self-directed independent being, that each person, through an act of the *agein*, can be accompanied towards acts of discovery and responsible choice in the realisation of his capabilities and by so doing gain a measure of control of the circumstances of his life. As self transcending intentional being (cf 3.2.1.6), he is open (cf 3.2.1.5) to opportunity and acculturation and as being in a state of becoming (cf 3.2.1.7), he is capable of accommodating to the impact of culture shock as he attributes meaning to a world (cf 3.2.1.5) that is increasingly perceived as being characterised by multiculturalism.

In the final chapter it is, therefore, the intention of the researcher to seek a clarification of the theoretical basis of the practice of health and community education as foundation for the realisation of authentic education in cross cultural health education encounters. This elucidation is to be followed by suggested guidelines to enable health educators to transcend potential and existing barriers imposed by cultural difference within the health education situation.

CHAPTER FIVE

TOWARDS AUTHENTIC HEALTH EDUCATION IN CROSS CULTURAL ENCOUNTERS

5.1 INTRODUCTION

The initial thrust of this research has been to investigate the most relevant social, health and educational research knowledge bases and the issues relative to health education in cross cultural encounters. The first major section includes an exploration of differences inherent in allopathic versus traditional health care systems while, at the same time, including notions of social change, the concept of communality in diversity, the co-existence of multiple realities and the fact that

"The history of health care is inseparable from the total history of communal organization and of the economy" (Feierman, 1985:73).

An understanding of the common denominators across all human and group experience emerged and, with it, insight into the problems that arise when universalistic conceptions of human behaviour "... are married to communicentric or cultrocentric hegemony" (Gordon, et al., 1990:16).

The second section places major emphasis on concepts of race, ethnicity, social class and gender as predictors of health and educational status. Incorporated into the predictive frame-

work of cultural and sub-cultural variables that affect health knowledge and learning activities are those embedded in cognitive and learning styles as well as communication patterns. The conclusion has been drawn

"... that variables may have different characteristics, different meanings, and different impacts for persons whose life experiences are different, and whose attributions may be idiosyncratic to their position in life (Gordon, et al., 1990:16).

Concurrently, realisation has emerged that cultural and sub-cultural factors are

"... increasingly understood to influence the mechanisms by which behaviors are developed and consequently the theories by which they are explained" (Gordon, et al., 1990:16).

The ground structure linking these two sections is the ontic reality of culture as the overarching structure of human existence (cf 3.2.1.11(a)). The purpose of this investigation is to reconcile and weave the insights concerning human behaviour that have been acquired from many disciplines and subdisciplines into a comprehensive, but manageable, and verified set of guidelines for the implementation of health enhancement strategies in cross cultural encounters.

"Health education and health promotion (as an aspect of PHC) have come of age" (Breckon, et al., 1994: xiii) and, in symbiosis, emerged as a fully constituted subdiscipline with its own professionally trained practitioners who possess educational credentials up to, and including, doctoral level. In addition, allied health specialists are increasingly undergoing training in

order to change the health related behaviour of individuals and communities (Breckon, *et al.*, 1994:xiii). Sophisticated research designs in health education have been published over the past decade. Ambitious and well-controlled research protocols are becoming increasingly prevalent and many theories have been developed, including those on adult participation behaviour, for the field of health education shares problems with other branches of adult education in this respect. Too often, however, the targeted health activities and/or health problems are only superficially conceptualised. It would also appear that many theoretical frameworks have been developed without empirical grounding, (inadequate cross-referencing of findings from other disciplines) and too great an acceptance of theoretical models that profess to explain adult participation and learning behaviour with only a few psycho-social variables. Health and learning activities should be seen as interfacing with all other parts of the primary biological, psycho-social, environmental and cognitive life of people. These are the areas that constitute built in barriers to social exchange which, in turn, culminate in resistance to change and become the basic challenge underlying the work of the health educator. While health education as a field of study combines an eclectic constellation of a diversity of disciplines into its theoretical foundations, it appears that health educators have not been as inclined to incorporate the principles of research evaluation and have displayed a basic disregard for the inherent complexity of human behaviour (Duryea, *et al.*, 1988:6-10; Garrison, 1987:212).

An extensive review of standard health education texts has led the author to the conclusion that the majority of works concentrate on the scope and practice of health education, organisational structures, professional skills, procedural aspects such as planning, implementation

and evaluation of programmes, health care settings and ethical concerns. In addition, many studies have been carried out in local settings world wide where the concept of culture has been stressed, but mainly in either socio-medical or anthropological terms. The former having reference to age, gender, educational standard, employment, religion, income and housing in relation to the aetiology of disease, while the latter is concerned more with world view as described in Chapter Two of this work. In many instances, descriptions and assumptions, drawn from social science investigations are based on "... inaccurate cross-cultural generalizations" (Singer, *in*: Gort, 1987:50).

Undoubtedly, both socio-medical and anthropological sources of information are necessary. However, the data featuring in much health education literature has reference to the objective or tangible aspects of a particular group: factors such as what they eat, how they live, specific health practices and socio-political and family structures. The more potent subjective, less visible and tangible elements of culture into which people are socialised are more difficult to study, inspect and analyse and, hence, largely overlooked. These are the areas from which cultural and communication barriers derive as these are the elements carried around in the minds of men: elements such as unique value systems, norms of behaviour, modes of interaction, learning and cognitive styles and linguistic patterns. It is at the level of people's subjective culture that most intercultural misunderstanding and communication problems lie (Cushner and Trifonovich 1989:318-319) and the level at which culture shock is most likely to be experienced.

It is within the context of a broader interpretation of the conceptualisation of culture and an

ongoing process of socio-cultural explication of the patterned relationships between elements in a social system, that relationships may be described from different perspectives (Schensul, 1985:66) and answers sought to crucial problems experienced by health educators in cross cultural encounters.

Culture is not an inanimate thing to be added to or restructured, but has a life that permeates all its parts so that advancement of knowledge and competency building can be furthered only through involvement of the whole (Bibeau, 1985:937). LEININGER (1988:152) identified culture, as a holistic concept, as the missing link between nursing knowledge and practice. The author projects this notion into the field of health education with the addendum that man as ethnicity in culturality (cf 4.2.2) is the missing link between health education theory and practice. This concept appears more appropriate in a multicultural society such as South Africa and is readily subsumed under the ground structure of culture as overarching ground structure of human existence. The feasibility of competency being achieved in more than one culture or sub-system is hereby postulated (cf 4.4.1).

This research has demonstrated that communities are exceedingly complex and diverse in inter- and intraethnic composition, the distribution of resources, the manner in which educators and learners relate and adapt to one another and the fact that linguistic and cultural difference is often accompanied by class and power differentials both inside and outside the health and education systems. Therefore, it becomes appropriate to examine the more widespread theoretical models that have evolved to bridge 'cultural gaps' in aspects of the agogical phenomenon with special reference to health and community education.

5.2 THEORETICAL BASIS OF THE PRACTICE OF HEALTH AND COMMUNITY EDUCATION

A growing recognition of the need to develop a more broadly based approach to health and community education incorporating the variables which affect learning outcomes has led to the emergence of a wide range of theoretical models drawn from the research findings of many disciplines. No one theory encompasses all variables, there is much overlapping and all reflect the orientation of the author. Certain of the models were not developed with health education in mind, while others were extended or emerged to meet criticisms about their predecessors (Tones and Tilford, 1994:89).

Because models are derived from theory and seek to provide an explanation of features of the human world, they do not provide detailed replicas of reality, but offer simplified and partial representation of whatever is of interest to the practitioner. The process of simplification is important as it concentrates on priorities. A good model includes all the key elements and the interrelationships of the various components which are essential to human decision making. A better model facilitates predictions about the likelihood of an individual or community adopting and sustaining a particular course of action under particular circumstances (Tones and Tilford, 1994:87).

It is not the intention of the researcher to analyse the conceptual approaches described or to favour one model over another. The distinctions are drawn with a view to enhancing an understanding of the field of study, facilitating appropriate choices for education in cross

cultural encounters and providing a theoretical and practical point of reference against which the proposed guidelines may be applied. The theories presented should not be viewed as exclusive of other models or of models which may be developed in the future. Ideally guidelines for authentic education should make provision for universal application.

5.2.1 SOCIAL LEARNING THEORY

Social learning theories are derived from an emphasis on the role of the subjective expectation's individuals hold concerning the subjective probability that a particular action will achieve a particular outcome. These expectations are based on vicarious and symbolic psychological processes mediated by social experience, and are linked to perceived incentives (Fincham, 1992:240; Rosenstock, *et al.*, 1988:176).

For heuristic purposes, expectancies may be divided into three types. Firstly, those that relate to environmental cues or beliefs about how events are connected in terms of cause and effect. Secondly, expectations concerning the consequences of personal action relating to perceptions about how behaviour is likely to influence outcome: termed outcome expectation or belief. Finally efficiency expectations or beliefs people hold concerning their ability to perform the activities required to influence outcomes (Fincham, 1992:240; Rosenstock, *et al.*, 1988:176). The concept of self-efficiency has close ties with that of self-esteem (cf 4.3.1.3(a)) and plays a critical role as mediator between what is known and what is applied (Freimuth, *et al.*, 1993:512). Incentive as the value component of a particular object or outcome is an important determinant of behaviour in so far as human action is influenced by

its consequences, but only in so far as "... *those consequences are interpreted and understood by the individual*" (Rosenstock, et al., 1988:176).

BANDURA (1986:xi) states of social learning theory (which he recently relabelled social cognitive theory (Rosenstock, et al., 1988:176))

"People are not only knowers and performers. They are also self-reactors with a capacity for self-direction. The self-regulation of motivation and action operate partly through initial standards and evaluation reactions to one's own performance. The capability of forethought adds another dimension to the process of self-regulation".

An underlying assumption of social learning theory is that human activity is dynamic and dependent on personal and environmental constructs which simultaneously influence each other. The environment provides the social and physical situation within which the individual functions, thereby providing both incentives and disincentives or expectancies for action. An individual has the behavioural capability to act and the potential for self-control over his actions. Action may be the result of the characteristics of a particular person or environment. Conversely action may be taken and activities used to change existing variables (Perry, et al., 1990:165-167).

Application of the model includes attempts to interest and motivate people toward changing specific behaviours, skills training enabling people to acquire new competencies, the development of support networks to maintain new behaviour through reinforcement and dissemination of the innovation to all levels of the family and community (Fincham, 1992:240). An

innovation in this context is "... any idea, practice or device that is perceived by people to be new" (Bandura, 1986:142).

Social cognitive theory distinguishes between two identifiable activities, namely, the acquisition of knowledge or learning and the adoption of the innovation in practice. Each phase is affected by different determinants (Bandura, 1986:144). Both activities have been incorporated into a number of theories which are either directly or indirectly linked to health education.

The health belief model stems directly from social learning theory.

5.2.1.1 The Health Belief Model

The hypothesis underlying the health belief model is that health related activities depend upon the simultaneous occurrence of a number of factors. These include environmental cues in which persons perceive themselves to be susceptible to a condition which is potentially serious, an expectation that the proposed action will be beneficial and outweigh any perceived costs or barriers to action and a motivational state in which a reduction of the perceived threat constitutes the incentive (Dignan and Carr, 1987:6-7; Rosenstock, *et al.*, 1988:177; Tones and Tilford, 1994:88).

5.2.1.2 The Theory of Reasoned Action

The theory of reasoned action of AJZEN AND FISBEIN (in: Fincham, 1988:240; Carter, 1990:68-69; Tones and Tilford, 1994:89) suggests that behavioural volition governs behaviour and that all other factors of influence are mediated through intention. Two major factors determining behavioural intent are a personal attitudinal factor and a social normative factor. Attitudes (cf 4.3.1) are a function of beliefs, the perceived consequences of that behaviour and the person's evaluation of the outcome. The social normative factor is determined by that salient referent which individuals or groups think ought to be done and the influence of 'significant others' on the individual's 'intention to act'.

The theory is essentially based on attitudes, as predictors of social change, in which the frequently substantial gap between intention and practice is acknowledged (Fincham, 1988:240; Tones and Tilford, 1994:89). The model typically generates long lists of different beliefs about specific health actions, attitudes surrounding these beliefs, beliefs about the likely responses of significant others to proposed behaviours, people's motivation to comply with the perceived wishes of significant others, strength of behavioural intent and actual behavioural outcomes. Information is obtained by means of questionnaires and open ended interviews (Fincham, 1988:240; Carter, 1990:69; Tones and Tilford, 1994:89).

The major limitation of this theory is the focus on volitional control to the exclusion of environmental constraints and psychological and cognitive factors. A model stemming from these shortcomings is the health action model.

5.2.1.3 The Health Action Model

The model was developed to provide a comprehensive framework encompassing the major variables influencing health choices and actions. The model includes two sections. The first has reference to behavioural intent and comprises an interactive cognitive, affective and normative system. Central to the cognitive dimension is a belief system which interacts with the processing of information. Included are a number of intellectual skills required to handle incoming information and to interpret environmental events in a meaningful way. The affective dimension is reciprocally related to the belief system and is concerned with the motivational state of the individual. The normative system has close links with motivation and signals the importance of social pressure on any intention to act by the individual. The second section is concerned with all those factors that determine whether intention is translated into practice in addition to those which sustain newly acquired activities or lead to a rejection or relapse of a previously made decision (Tones and Tilford, 1994:90-91).

The theories and models described thus far do not take in depth cognisance of those determinants which play a role in social change and stem directly from the social organisation of the community.

5.2.2 COMMUNITY ORGANISATION APPROACHES

Adoption of new patterns of behaviour is partly governed by self-evaluation reactions to personal behaviour, but does not occur in isolation from pressures of social influence

(Bandura, 1986:150). In order to introduce and support positive behavioural change, reinforcement of change through the mobilisation and extension of community structures and resources is required. Innovation-diffusion theory is a key component of community organisation and social change and is of great relevance to community based programmes (Fincham, 1988:241).

5.2.2.1 Innovation-Diffusion Theory

ROGERS' (1983) theory of diffusion and social change is one that focuses on the wide gap between what is known and what is used. People are classified on the basis of their innovativeness as early adopters, early majority, late majority or late adopters. The role of communication, as a common factor, is highlighted and a conceptualisation of the innovation making process depicted (Rogers, 1983:1, 5, 164-189).

Diffusion represents a form of social change in that it constitutes the means whereby "... alteration occurs in the structure or function of a social system" (Rogers, 1983:6). Diffusion is also the means by which

"... an innovation is communicated through certain channels over time among the members of a social system with certain effects" (Rogers, 1983:5).

The act of communication is thought of as a two-way process of convergence or divergence in which participants create and share information with one another in order to move toward

or away from each other in respect of the meanings they ascribe to particular events. Diffusion is a special type of communication in which messages are concerned with a new idea, the newness of which involves some degree of uncertainty. Doubts arise in respect of the relative advantages of the innovation as perceived by the individual or group, its compatibility with prevailing norms and values and its complexity. The degree to which the new idea may be experimented with on a limited basis or be observed by others in terms of 'trialability' and 'observability' are two further areas of concern. These are the factors which play an important role in the decision making process of adopting or rejecting change (Rogers, 1983:5-6; 15).

According to ROGERS (1983:20-21, 164-165), the innovation-decision process comprises five phases. During the first phase, **knowledge** of the existence and functioning of an innovation is gained. This is followed by the **persuasion** phase involving the formation of favourable or unfavourable attitudes toward the new idea. As a result of decision making activities, a **decision** is then made to adopt or reject the trait. In the event of a positive response, **implementation** or reinvention in the form of modification of the element occurs which then culminates in **confirmation** of the decision, or perhaps reversal, in the face of conflicting messages and uncertainty.

The antecedent and knowledge variables considered by ROGERS (1983:165) are held in common with the previous theories. These include previous practices, needs and problems, norms and values and the degree of innovativeness within the group. Attention is paid to socio-economic characteristics, personality variables and patterns of communication. During

the persuasion and decision phases, individuals increasingly seek evaluative information concerning the potential consequences of change. Interpersonal networks with peers are particularly important as a source of such information. All the information gained, from whatever source, will influence decisions taken during the decision, implementation and confirmation phases (Rogers, 1983:21).

Rogers' theories have evolved into a number of comparative decision making models based on research on community decision making (Albert 1981:179-182).

5.2.2.2 Community Development Models of Adult Education

Conceptual models of community development ranging from the simple to the complex are emerging in an attempt to identify both process and outcome for community developers. Because health education and community development are integrated concepts these models are of relevance to health educators.

(a) The Collective Innovation Decision-Making Process

The collective innovation decision-making process is usually conceived of as five or more phases commencing with the original recognition of a need for a new idea to its implementation in the social system. The initial stage is that of **Stimulation** of an interest in the need for the new idea, followed by an **Initiation** of the new idea into the social system. Both these stages are introduced by the agent of change. The next stage is **Legitimation** of the

idea by the power-holders within the group followed by a **Decision** to act by members of the social system which then culminates in *Action* or the implementation of the new idea (Albert, 1981:179). Linkages with the previous model are clearcut.

(b) A Community Development Model

A more comprehensive model involving the community development specialist, core groups of citizens, the local community, its extended boundaries, special interest groups and the resources required has been developed by DEAN AND DOWLING (1987:80-87). Here, too, the model is developed sequentially, commencing with an **Initiating Phase** during which an issue that is important to a community, a core group within the community or a community specialist is investigated. This is followed by an **Organisation Development Phase** in which an organisational structure is developed by the core group and/or the community developer. Arrangements are made for training the group members, leadership skills are developed and goals begin to emerge that coalesce with the values of the group. The combined values and goals serve to shape and guide the group during the next phase of **Community Action**. Action is generated and maintained through ongoing training of the members of the core group, increased contact with interest groups and the initiation of community programmes. An inner core group continues to function, but membership increases and boundaries between this group and the community become more fluid. As interaction between the two groups becomes consolidated, the core group becomes better established and, at best, synonymous with community interests. The group gains **Increased Independence** and autonomy with a decrease in involvement by community developers. Three possible **Outcomes** feature in

the final phase. Firstly, the core group may disband after solving the original problem. Secondly, the group may divide into smaller groups each interested in special issues and lastly, the group may maintain its identity by taking on new challenges. Successful implementation of the model results in identifiable improvements in conditions within the community, personal growth of community members, enhancement of personal problem solving strategies and interpersonal relationships.

In order to overcome limitations in single model approaches, a number of attempts have been made to develop integrated models for community development of which the following is an example.

(c) *An Integrated Practice Model for Community Development*

JONES AND SILVA (1991:3-8) integrate the three community development processes of:

- * **problem solving** comprising the sequential phases of exploration, assessment, goalsetting, planning, implementation and evaluation;
- * **community building** with its identified stages of entering a community, discovering a community and developing community relationships, building an organisation, enhancing community capacity and phasing out or exiting; and
- * **systems interaction** reflected in terms of change agent system, client system,

action system, target system and return to change agent system.

Jones and Silva demonstrate that, when pursued simultaneously, each of the three processes contribute an essential ingredient to community development. In short, problem solving generates action, community building accords broad ownership of the action to the community and systems interaction lends direction to the action by the agent of change.

In practice, the three components of the model are interwoven as opposed to discrete systems of interaction undertaken by the community developer. During the first phase, community building is initiated by the community developer, as agent of change, by means of simultaneously entering the community and exploring the issues. During the second phase, the practitioner determines the exact nature of the client system, makes an assessment of the problem to be addressed and discovers the circumstances, resources, abilities and potential for change of that community. Developing a relationship with the community is an integral part of this phase. As an organisational structure begins to emerge in the third phase, goal setting settles into more concrete action planning. From there, a target system is identified and the process moves on to implementation where the critical work of enhancing capacity occurs. People learn to work together in building an effective organisation that takes action, meets with success or failure and grows in stature. In the fifth phase an evaluation should, but does not necessarily take place. If all is progressing well, the community developer can start phasing out his inputs into the programme.

Due to the sequential nature of these approaches, each can and has been presented in the form

of a flow chart that functions as a map to guide the activities of the health educator/ community developer. Variables pertaining to the psycho-social milieu of the educator as well as the client are not included in the models as presented thus far. According to field psychology, a branch of phenomenological theory (Christensen, 1985:65), differences within the perceptual field of educator and client may culminate in a 'them-us' syndrome, as integral part of the cross cultural counselling encounter. A perceptual approach to cross cultural counselling is presented as having relevance to the proposed guidelines that are to follow.

5.2.3 A PERCEPTUAL APPROACH TO CROSS CULTURAL COUNSELLING

The approach is based on concepts of perception drawn from psychology. The perceptual field comprises the whole universe as experienced by a person at a given moment. It is the reality according to which the person lives, although the experience may not correspond to any given reality and may change over time. All systems within the perceptual field are interrelated so that change in one area affects all parts of the system. The perceptual field is characterised by stability and flexibility as well as direction or need satisfaction. The fundamental need toward which the individual strives is adequacy expressed as self-actualisation. At any moment, the field consists of perceptions at varying levels of awareness ranging from those toward which action is directed to those that are vague and undifferentiated.

Central to the perceptual field is the notion of self-concept (cf 4.3.1.3(a)). People from

different cultural backgrounds share fewer common life experiences and are, therefore, more likely to have dissimilarities in their perceptual fields (Rogers, *in*: Christensen, 1985:65).

CHRISTENSEN (1985:67-76) presents a multidimensional approach to cross cultural counselling that is structured in concentric circles and encompasses individual, socio-political and ethnocultural factors. Equal weight is given to the perceptions of client and counsellor. The approach emphasizes the fact that, at any moment, the perceptual field is organised around the concept of self and related levels of self awareness. It also gives credence to the fact that many actions and reactions taking place in a cross cultural encounter are embedded in a reality structure outside the immediate situation and the qualities of the persons involved. It is from family members and personal social networks that both counsellor and client learn the implicit and explicit rules governing social interaction. The influences of significant others are integral components of each life encounter and, hence, a reality within the context of the cross cultural encounter.

Carrying the concept of concentric circles of influence further, at a more extended level, people participate in a society representing a particular world view (cf 1.3.1.1) that focuses on the individual's place in society, ideological and philosophical points of view and time orientation. The reality of world view merges imperceptibly into a universal dimension. Assumptions about man's place in the world are inherent in all theories or models, whether in terms of health, education or capacity building. Difference at each level may manifest in misunderstanding, stereotyping and opposing assumptions concerning therapy, educational content, goals or strategy.

While Christensen's approach makes room for inclusion of the perceptual fields of both client and counsellor in the cross cultural encounter, Barer-Stein has developed a theory that incorporates notions of culture adaptation and culture shock as aspects of a process of learning.

5.2.4 EXPERIENCING THE UNFAMILIAR: CULTURE ADAPTATION AS AN ASPECT OF THE PROCESS OF LEARNING

BARER-STEIN (1987(a); 1987(b); 1988), in seeking a deeper understanding of the concept of culture, was confronted by insights into the process of how people learn. Based on the truism that people do not learn what is already known, but learn in varying degrees what is not known, she arrived at the previously mentioned conclusion that learning is an ongoing "*... sequential process of experiencing that which is different or unfamiliar*" (Barer-Stein, 1987(a):89). Further to the previously demonstrated link between enculturation, as an outcome of learning, and acculturation (cf 4.4.3.1), BARER-STEIN (1988:72-74), following a slightly different course of radical reflection, poses the question as to whether a relationship exists between learning, adaptation to culture difference and culture shock. If culture represents the many ways in which people group together, constitute, understand and live their daily lives while at the same time transmitting their way of life to others, then cultural adaptation in cross cultural encounters must involve some sequence of modification or adjustment to a different mode of daily living. A connection between learning and attainment of cultural understanding is hereby established. Culture shock, in these terms, may be viewed "*... as a synonym for coming face to face with the unfamiliar*" (Barer-Stein,

1988:88).

In developing a model of the process of experiencing the unfamiliar, BARER-STEIN (1987(a):91-92, 94) draws on her conceptualisation of 'Surface' and 'Submerged Knowledge' (cf 1.4.2.1). The former represents knowledge of which a person is fully aware and the latter, the more obscure levels of knowledge requiring effort to recapture. Intrinsic to the approach is an acknowledgement of human consciousness, however fleeting, of being faced with that which is unfamiliar or different. The experience is accompanied by a deliberate effort to exhume, analyse and interpret or reflect on the event.

The phenomenologically based model comprises five phases, each of which is associated with essential themes that permeate the entire process with varying degrees of intensity. At each level, reflective pause occurs during which a decision is made whether to move forward towards further understanding or not. At least three sets of interpretive cognitive activities are involved, namely, a collecting of information, a questioning of that which is collected and a comparison with previous knowledge. The themes are experienced throughout, either cyclically or on a sequentially regressive or progressive basis. Each phase is entered into voluntarily as a matter of individual choice. The possibility of remaining in a phase or essential theme exists (Barer-Stein, 1987(a):94; 1987(b):29-30; 1988:81-82).

The initial phase of **Being Aware** denotes access to the unfamiliar. The individual must "... be aware of something in order to distinguish it from anything else" (Barer-Stein, 1987(a): 95; 1987(b):30). The three themes within this phase represent *an awareness of the interest*

itself, *curiosity* in the sense of a desire or need to know and *seduction* in the form of inducement or incentive. The second phase of **Observing** suggests an attentiveness to that which is observed. Brevity and superficiality are characteristics of the reflective pause at this stage. There is no real focus, commitment or responsibility as is indicated by the theme of *spectator* which progresses into that of *sightseer* when attentiveness intensifies and focuses on a specific interest (Barer-Stein, 1987(a):95-96, 102; 1987(b):30-31; 1988:81).

The third phase of **Acting**, more appropriately called **Acting in the Scene**, depicts movement closer to the object of interest, from audience to participant. The associated theme of *witness-appraiser* indicates an intensification of reflective pause as the individual repeatedly delves deeper into his accumulated and increasing knowledge of the event and of self. Activity melts into that of *cultural-missionary* characterised by a perception that the world is divided into those who have certain collections of knowledge and those who do not. The perception embodies a conviction that one's own culture is correct and a zeal to do something for those perceived as less fortunate in the form of sharing (perhaps imposing) the benefits of one's own culture on them. The dichotomy between cultures becomes so complete that individual differentiations blur as other people are viewed as homogenous groupings. The "... judgemental sweeping up of other individuals ... into one indistinguishable mass..." (Barer-Stein, 1987(a):97; 1987(b):32) has been labelled *cluster-judgement* and depicts the 'we-they' dichotomy. Since neither group in this dichotomy is able to comprehend the complexity or reality of each other's culture, cluster-judgement becomes apparent on both sides. *Living the life of* is the last essential theme of this phase and represents an ultimate expression of professed familiarity with an unfamiliar situation. It involves an over simplifi-

cation of the ease with which an individual is able to fit into the life-style of another group (Barer-Stein, 1987(a):96-98; 1987(b):31-33; 1988:81).

Confronting, or the fourth phase, is commonly taken to imply impending conflict, but takes on the essential meaning of coming face to face with something. A shift in behaviour occurs as the unfamiliar within the familiar is disclosed, either as an aspect of daily life or from within the self. Security is undermined when the familiar ceases to yield to meaning when reflective pause is applied. The perception that familiar practices no longer work solidifies. As always, the individual has a choice. He may choose to be *passive* and ignore the confrontation and allow it to pass in a way that denies the capacity for transcending (cf 3.2.1.6) what is learned, thereby inhibiting forward movement. Alternatively, he may choose to engage in *conflict* utilising the various mechanisms for conflict resolution to disprove the differing reality or withdraw into himself or his past familiar world to escape the source of his anxiety. The possibility of a continued **Awareness of Interest** always exists, in which case the individual transcends his immediate situation and expands his present reality (Barer-Stein, 1987(a):98-99; 1987(b):35-38; 1988:82-83).

The final phase is that of **Involvement**. It represents the reality of experiencing the unfamiliar in such a way that the object or subject that was different now finds an integral place of importance together with all the other personally relevant meanings constituting the daily life of the individual. BARER-STEIN (1987(a):100-101; 1987(b):38-40; 1988:83-84, 91) uses the term *Sh'ma* to describe the process through which 'Submerged Knowledge' may be disclosed in order that the discovery of personally relevant meaning is made possible. The

term is derived from the Hebrew word *schema* meaning 'to hear', but implying 'to hear' and 'to heed'. The *Sh'ma* is not a method to be memorised nor a body of knowledge to be learned. It embodies a broad grasp of reflective thinking that centres on a fourfold central theme comprising hearing-listening and reflecting-heeding. Inherent in the final phase of **Involving** is a movement towards the **Paradox of Involvement**. This phenomenon occurs when a particular interest becomes so deeply entrenched that it becomes internalised and an inextricable part of the self. It becomes one with the daily life of the individual.

5.2.5 RÉSUMÉ

It has been demonstrated that health education, in terms of its eclectic nature, can only be strengthened by being inclusive rather than exclusive (cf 1.4.2.2). The field has demonstrated both a need and an ability to synthesize what has been done in other disciplines in order to build a conceptually sound research basis and field of application (Glanz, *et al.*, 1990:xxi). However, the discipline, as a whole, appears not to have taken cognisance of the fact that almost every health education situation entails a cross cultural encounter. Fundamental findings from the fields of multicultural education and communication science, more specifically those relating to cross cultural encounters in global business enterprises, appear not to have been incorporated to any great degree in the body of knowledge, application or research of health education as science.

Models based on social cognitive theory and community organisation approaches are well documented in health education literature and extensively utilised in the implementation of both

health education and community development programmes. Collectively, social cognitive theories either include the socio-cultural, economic and political factors addressed in previous chapters or may be readily modified in order to do so. For example, social cognitive theory does not include costs or barriers to action, the health belief model excludes the concept of self-efficacy and the theory of reasoned action adds an additional dimension to the role of attitudes in human behaviour. A serious deficit in models based on social cognitive theory lies in the fact that they do not include important variables relating to decision making activities or those stemming directly from community organisation. The community health education approaches address these factors in a systematic manner with special emphasis on capacity building and community participation in decision making activities. The feasibility of integrating models has also been demonstrated.

The potential exists to develop community health education models and their related variables in ever clearer operational terms in order to measure the growth and progress of local community enterprises (Dean and Dowling, 1987:88). However, fundamental problems underlie this approach. Thus far, while it is universally recognised that community health education encompasses more than functional stages and associated variables, the models are clearly derived from Western scientific constructs (cf 2.2.2) and cognitive processes (cf 4.3.1.2(b)). Conceptualisations are translated into flowcharts that are presented sequentially and orientated toward problem solving which, in turn, is generally task orientated. Emphasis is placed mainly on behavioural data as apposed to how the learner experiences the material. The very assumption that educational models are developed to measure progress in quantitative, as apposed to qualitative, terms is indicative of a dominant concern with accuracy, repetition and

personal detachment generally associated with physical observation as opposed to attempts to explore the depths of human experience and feeling. Such an approach precludes a key phenomenological assumption that

"...perceptions of the social environment are more meaningful than external observations in that *perceptions* of what is true ultimately govern behaviour" (Darkenwald, 1987:128).

Guidelines for action dictated by 'stand alone flowcharts' are subject to the risk that programmes will be undertaken with only a superficial understanding of the variables involved on the part of health educators, a concomitant lack of appropriate direction and a greater probability of failure. Stand alone guidelines may be used in response to demands for quick action by those in power to address specific socio-political issues as opposed to the more cumbersome workings of broadly based participative groupings. It has been suggested that quick action, problem solving and non-participatory approaches typically represent male (and Western) as opposed to female (and other culturally) orientated approaches where attention tends to be focused on dialogue and relationship building (Jones and Silva, 1991:18). This line of reasoning may be extended to differences inherent in Hofstede's (cf 4.3.1.2(d)) concept of masculine versus feminine societies.

Action generally appears to be initiated by a health care provider or other specifically designated agent of change. Frequently, these specialists have been socialised into the culture of their specific profession so that, as they become more knowledgeable, they move further from their previous belief system and from the communities they are called upon to serve (Spector,

1991:59). The sub-cultural base of these professional groupings and the personal world view of individual practitioners are ignored as integral part of the educating-learning experience. The fact that the community health education environment is a dynamic social system that includes not only educator behaviour and educator-learner interaction but also student interaction is frequently ignored (Darkenwald, 1987:128).

The perceptual approach to cross cultural counselling appears not to have made inroads into the field of psychiatric counselling or that of health education in the sense of the health care provider examining 'self' on the same levels of analysis generally applied to the client or community (Christensen, 1985:79). Barer-Stein (cf 5.2.4), using an existential phenomenological approach, explores the relationship between culture adaptation and learning in an attempt to understand the place and meaning of culture shock in cross cultural education encounters. The focus of all teaching is deemed to be the guidance of learning and the necessity of understanding how learning takes place. In the context of cross cultural education, it is hypothesized that it may be less important for educators to be familiar with countless details of custom, values, language, behaviour *et cetera*, than for educators to understand their own learning as a process (Barer-Stein, 1988:89). Both these approaches tend to place emphasis on individual experience as opposed to culture *per se* or group relationships.

Despite the fact that the importance of cultural factors has been formally recognised as intrinsic to sound health education practice, the reality of cross cultural health education has yet to emerge. It appears that the practice of health education continues to be unilateral in approach and representative of the Western health care system (adapted from Dobson,

1989:100) while at the same time failing to acknowledge the ontic fact of communality in diversity (cf 3.2.1.16) within a single community. It appears that models developed by academics have, all too frequently, missed existential human cues and hereby fostered misunderstanding.

As man strives to constitute a world of meaning for himself and his group, he possesses only a vague consciousness of the reality of culture, is indebted to contrasts between his culture and that of others for this awareness (Fitouri, 1986:130) and is, therefore, more likely to conclude that the individuality of human beings is subordinate to that of cultural identity. Such a line of reasoning is in opposition to the ontological-anthropological ground structure of homogeneity in heterogeneity or communality in diversity. It serves to highlight the reality of the 'we-them' syndrome which culminates in judgements conducive to prejudice, stereotyping and the imposition of alien value systems and practices.

Because difference is obvious and observable and communality taken for granted, an identification of man as ethnicity in culturality, as the missing link between health education and practice, could be construed as reinforcing the one-sided notion of unity within diverse groups. Such a conclusion is andragogically irresponsible and unjustifiable. It does not permit of authentic education, for man is not only ethnicity in culturality as an aspect of culturality (cf 3.2.1.11), he is biological exception (cf 3.2.1.1) and enjoys a personal mode of existence. As an existing being (cf 3.2.1.2), he is not only situated (cf 3.2.1.2) in the world, but is involved and encountered (cf 3.2.1.3): exploring, questioning, discovering (cf 3.2.1.6) and making decisions (cf 3.2.1.9) as he strives towards an understanding of (cf 3.5.1.4(b)),

and attribution of meaning to his human world (cf 3.2.1.5) and the realisation of his personal potential (cf 3.2.1.7(b)). As an initiator of action in his relatedness with his world (cf 3.2.1.4) and in terms of his needs, interests and circumstances, he makes choices (cf 3.2.1.9). By so doing he displays intentionality (cf 3.2.1.6). He is an active participant in the actualisation of his own potential (cf 3.2.1.7). Although bound by the situatedness of his normativeness (cf 3.2.1.10), his culturality (cf 3.2.1.11), his religion (cf 3.2.1.17) and his language, he remains free to choose (cf 3.2.1.9), with whom, and to what degree, he will function in mutual concern and involvement (cf 3.2.1.8). The choices the individual makes are influenced not only by his cultural situatedness, but by the degree to which he is acknowledged as a bearer of human dignity (cf 3.2.1.14) and the variety of options open to him in the community where he lives. Not only is culture itself dynamic and subject to change but man himself is an open being (cf 3.2.1.5) wanting to become that which he is capable of becoming (cf 3.2.1.7) (Arthur, 1992:288).

These phenomenological conceptualisations reveal that it is the personal or the 'I' within the notion of man that renders any one-sided notion of man as ethnicity in culturality invalid. The place of the individual as pivotal figure in the learning of culture should be acknowledged. As learners of cultural content, the question of individual choice and personal interests are congruent with the anthropological ground structures and andragogical categories discussed in Chapter Three.

In an attempt to avoid the tendency toward one-sidedness inherent in the original assumption concerning the missing link between the theory and practice of health education and to avoid

attempts to accommodate educators and learners within a preconceived mould that is in violation of their essential dignity and humanness, it is proposed that man as unique individual in culturality, understood as unique individual in ethnicity and in culturality, remains central to any attempt to formulate guidelines for the realisation of authentic education in cross cultural encounters.

5.3 GUIDELINES FOR AUTHENTIC HEALTH EDUCATION IN CROSS CULTURAL ENCOUNTERS

Throughout the study, an attempt has been made to draw tentative conclusions concerning problems surrounding realisation of authentic education in cross cultural encounters as measured against research findings and the ontological-anthropological ground structures of human existence. Arguments appear to have centred around questions concerning the multidimensional aspects of man as culturality in which culturality, representing difference and perceived as homogeneity, readily constitutes a perceptual filter blinding health professionals and educators to the fact that man shares a common humanity in addition to attributing personal meaning to his culture as an individual. The ontic fact of unity in diversity and homogeneity in heterogeneity in and between social groups prevails. Failure to bear this in mind becomes a denial of the human reality which gives expression to the humanness of man. To resolve differences between individuals and sub-groups in socio-cultural context requires determined and protracted effort to inform, understand and remove misunderstandings and prejudice (Hulmes, 1989:2).

Questions arise concerning health education approaches and evaluation criteria on which a system of health education in cross cultural encounters is to be based. All the evidence points to the fact that approaches and criteria need to be founded on the concept of education, more pertinently health education, and that which is of permanent and central importance to human beings (Wilson, 1986:3). Such an approach is not in accord with health education models and strategies in isolation from the subjective world of feelings, perspectives and relationships of educators and learners alike nor with evaluation systems that only record the external results and observable activities of participants in the educative event. An approach is required that is geared toward the experiential phenomenon of human learning.

In focusing on the existential phenomenological aspects of education, it should be noted that the researcher is not dismissing the core propositions of the scientific method which represent major advances in the pursuit of knowledge and understanding, but rejects the narrow range of perspectives and investigative techniques that consolidate and empower a Western scientific communicentric bias in knowledge production. This bias has frequently led to negative consequences in the life experiences of those who possess a different world view. In the final analysis, knowledge is relative to the context in which it is generated and experienced. Learning, knowing and understanding are extensions of the individual's own world or existential self. Individually and collectively man perceives and eventually conceives of the world and its happenings in terms of whether they fit or can be accommodated within that which is known (Gordon, *et al.*, 1990:15).

For these reasons and the fact that existing theories and models, singly or in combination,

cover the major areas of clearly identified and, to some extent, measurable areas of concern in cross cultural encounters, the researcher has decided not to develop a more comprehensive model on which to base health education practice. Instead, an attempt will be made to formulate guidelines that focus on the personal existential experience of the relationship between knowledge and behaviour and the links between learning and the attribution of meaning: guidelines which should find universal application to all models in so far as they relate to individuality in culturality as opposed to the group as culturality. Further justification for this stance is expressed in the following points of view:

- * When the concept of health education and the approaches and criteria used have little to do with learning and personal security, a mismatch occurs (Wilson, 1986:14). Health education has intrinsic value, is worthwhile in itself and not because it leads to something else which is of no value (adapted from Lynch, 1983:55).

- * The values inherent in health education demand that health care and related services be potent enough to override external investments and agendas of both educators and learners in order to develop understanding and relevant skills rather than ideological commitment (adapted from Wilson, 1986:11). The argument to integrate and be open, in other words to play along with social ideology, is logically inconsistent with the aims of health education. The educator, to a greater or lesser extent, withdraws learners from the world in order to reflect on it and themselves, to pursue knowledge and understanding

and to develop powers of judgement, thereby empowering them to view the world differently and more clearly (Wilson, 1986:12). Opportunities for the acquisition of desired skills are an integral part of this approach. In this sense ideology goes beyond that which is relevant to health education and may be referred to as opportunistic indoctrination.

- * An issue, in cross cultural health education encounters, is the principle of cultural and structural adaptation specific to ethnic-cultural groups and not the specific details of any one particular programme (Bullivant, 1984:x) or way of life. The role of health education cannot be expected to reinforce the specific values, beliefs and cultural identity each learner brings to the situation (Department of Education and Science, 1985:321) for learning itself implies change. This statement is of particular relevance in so far as human beings make choices within the context of their personal and social identification and way of life.

- * The ideology of the preservation of culture, especially in relation to health education where existing practices are detrimental to health, may be regarded as self-defeating for all cultures in the sense that all cultures are dynamic, continuously changing and being changed. There are no discontinuities within cultural origins and histories, but continued shifts and evolution in which aspects of what is established are discarded and aspects, both foreign and new, are assimilated (Jeffcoate, 1984:129).

* SIZER (1976:34-35) states that in the light of all the current trends in education, it is increasingly clear that persistent reassertions of the one best system will simply no longer do. New approaches towards education are required that take account of group needs and identities within a larger South African society and relate health education, in particular, with other aspects of life in thoughtfully constructed and carefully combined ways. Credence is given to the fact that education and training alone cannot redress all the socio-economical and health problems within society for any health education system is structurally and functionally entwined with all the other social systems in South Africa.

* Education is a means to an end in both the private and public domain. It is instrumental in that it inevitably reflects a consensus view about society. From time to time, it may be instrumental in bringing about radical change as consensus shifts, but principally it strengthens the culture it serves and nurtures the dominant culture of which it is part (Hulmes, 1989:18). Although this premise may appear to negate a number of principles elucidated, it cannot be denied that knowledge is a social construction reflecting the perspectives, experiences and values of the peoples and cultures that construct it. That these constructs are changing, dynamic and debated among both creators and users (Banks, 1991/92:34) is clearly evident as is the fact that Western allopathic medicine enjoys dominance in the formal institutionalised health systems of both First and Third World societies. In addition, little attention has been paid

to the fact that the cross cultural education movement emerged out of Western democratic ideals of freedom, equality and justice and a condemnation of societal practices contradicting these ideals (Banks, 1991/92:32). As the RDP is implemented, demands will be placed on educators and learners to develop abilities to think, perceive, communicate and act in completely different and new ways. Adaptation and accommodation to the ways of others and a perception that they have equally valid ways of attributing meaning and interacting in the world become critical features (Cushner, 1988:160) of cross cultural health education encounters. In these terms adaptation may be said to involve reciprocal enculturation or even acculturation.

- * Education and learning are viewed as congruent processes grounded in human behaviour, not in the sense of imparting and learning things, but in the sense of arriving at an understanding of the meaning, of things (Barer-Stein, 1987(b):45). 'Submerged Knowledge' becomes 'Surface Knowledge' through an act of reflection (Barer-Stein, 1987(a):91-92).

Against the background of the accumulated insights provided through the use of the analytical, historical and phenomenological methods, a conceptual framework has been provided for the researcher to observe, analyse and think about what occurs in cross cultural education encounters and gain a greater understanding of the issues involved. Feasible explanations for educator and learner behaviour have emerged and possible causes and consequences of actions identified, thereby providing a more secure knowledge base from which guidelines for

authentic health education may be developed.

The researcher will attempt to offer practically based recommendations for the realisation of authentic health education in cross cultural encounters in accordance with the andragogically grounded criteria as revealed in Chapter Three of this study. The guidelines which follow are by no means prescriptive or all encompassing. Neither is it the purpose of the study to offer solutions, but rather to present a general framework and provide fundamental andragogical support for suggested policies and practices within organisations where difference is acknowledged as a problem area in the realisation of successful learning outcomes.

Because an absence of any clear-cut (health) education policy, resulting from and concerning changes in society, helps confuse issues, reinforces stereotyping and fosters racism (Watson, 1984:389), the first recommendation concerns the necessity for governing bodies of organisations concerned with community health education to issue a mandate for action based on their philosophy of cross cultural education (adapted from Baker, 1983:30).

5.3.1 ORGANISATIONAL PHILOSOPHY OF CROSS CULTURAL HEALTH EDUCATION

Health care providers and educators are affected and constrained by the chosen mode of development of their country. In terms of the RDP, health authorities and health professionals have an obligation to deal educatively with socially and politically acknowledged problem areas thereby enabling South Africans to realise their potential in respect of physical,

emotional and social health. Health education planning and decision making are part of, and interact with, wider complex socio-political processes and are, therefore, inevitably concerned with competing values, interests and power. It has previously been demonstrated that education planning and decision making are not neutral, but are themselves indications of value and ideological positions to alternative modes and strategies of development that affect the lives of all people, particularly those described as 'disadvantaged' or 'minority' groups. This self-evident statement is frequently ignored in attempts to implement progressive, egalitarian incremental health and social reform through education or community development. It is also indicative of the high levels of responsibility health educators have in assessing the socio-cultural and personality constraints associated with health education in cross cultural encounters as they attempt to develop realistic and appropriate strategies to benefit specific communities (Alexander, 1987:138-139). While health educators do have a degree of autonomy, the foundations for effective cross cultural education rest on organisational commitment and should be contained in a statement of the organisation's mission. Not only must the organisation's philosophy be clear and unequivocal, but it must also be reflected at the operational level (James, 1978:17). The policy must incorporate a definition and the intended impact of the policy on the organisation as a whole (Baker, 1983:30). Although the essences of the pedagogic event, outlined by Landman, *et al.*, (1982:37; Scheme, F), have reference to a Christian philosophy of life, it appears that they have equal relevance to the microcosmic philosophy of cross cultural education, and, therefore, andragogics in the cross cultural encounter. In this respect, the call for a statement of commitment in the organisation's mission complies with the demands of an acknowledgement of propriety in terms of cross cultural education, taking a position and being called upon to

act in accordance with the norms of cross cultural education. A clear policy concerning health education in cross cultural encounters reflects an acceptance of a commitment to that which constitutes the particularity of South Africa today and is answerable to the demands of pure humanness which transcend all barriers of race, gender, culture, language, creed and class.

At operational level, organisational commitment should become evident in policies relating to the in-service training of health educators, community participation, capacity building within the community and to sectional relationships with all agencies that, either directly or indirectly, may have an impact on the health status of communities. The policies which are to be implemented, either directly or indirectly, must be congruent with the goals of cross cultural health education as stated in the mission (adapted from James, 1978:18) and the aims of the educative events. Such policies contribute to the educator's fundamental knowledge of the educational reality in a particular organisation and are in compliance with the essences of constancy and durability while managing meaningful change in the conviction that people, in communality and in diversity, can realise their potential through the attainment of relevant understanding and acquisition of appropriate skills.

In order to prevent a backlash resulting from confused goals and ambiguity, with authorities pressing for one set of goals and educators another, and because the educator is the major and most important single factor in realising the reality of education in the cross cultural context (Frazier, 1977:13), the next set of suggested guidelines are related to the fact that

"Clarification of one's own cultural identity and feelings toward other cultures should be an integral part of any professional preparation effort" (Santos, 1986:22).

5.3.2 IN-SERVICE TRAINING OF HEALTH EDUCATORS

The principles as highlighted have relevance for both professional and in-service training although the elucidation is directed more specifically to the field of application.

The most well-intentioned educator, who plans and organises instruction from a monocultural, unilinear perspective, is likely to encounter antagonism, indifference and outright hostility (James, 1978:16). Provision of in-service experiences for all educators is contributive to the quality of health education in cross cultural encounters. This proposal is of great significance for health care in South Africa in the light of the recent history of separatism and the strong English, Afrikaans and First World cultural bias in both the education and health systems.

If successful learning outcomes are to be achieved in cross cultural encounters, the changing of educator's attitudes becomes absolutely critical (Watson, 1984:398) and promises to be a most difficult task (Banks and Grambs, *in*: Frazier, 1977:15) for educators have been brought up with ethnocentric views which have been reinforced during their years at school, college and university. Ideas once formed are not easily changed (Watson, 1984:391). According to MUKHERJEE (1981:120), in the Western World, the 'cult' of reason has more or less destroyed the world of feeling, with the result that while the concept of cross- or multiculturalism has been grasped intellectually, it has not been incorporated into the world

of feeling. The 'White' intellect is, therefore, capable, willing and free to accept the concept, but is unable to activate the subjective world of feelings to participate effectively in cross cultural activities.

The starting point of any training must of necessity be situated in the reality of the educative event which, in turn, is a human reality. In the every day life-world of educator and learner, the education phenomenon finds its clearest representation in the education relation (Van Vuuren, 1990:70). The reality within cross cultural encounters brings this dictum into sharp relief. Successful outcomes among and between diverse peoples ultimately depend upon the degree to which positive, functional perspectives and interrelationships emerge (Cushner, 1989:318).

Educators and learners have constituted a world of meaning for themselves in terms of which knowledge, attitudes, values, skills and expectations become manifest. Educational strategies are selected, implemented and responded to, engendering a cycle of understanding, acceptance and actualisation or defeatist and aggressive counterproductive behaviour which may result in culturally based self-fulfilling expectations on the part of both learners and educators.

The question concerning the format and content of health educator training programmes is complex and the suggestion that educators should know the cultures of all their students is, in the opinion of the author, impractical. The fact is that educators cannot know everything about ethnic groupings (Garcia, 1982:15; Rothenburger, 1990:1363). However, the fact is that educators can come to 'know' and 'understand' the communities with which they work

(cf 2.5.1.1). The real issue becomes one of gaining a clear sense of cultural dynamics as they effect health education and of developing strategies which ensure that each learner is enabled to realise his potential as an aspect of capacity building. Resolution of this issue may be seen as basic to meeting the criterion of respect for human dignity (cf 5.3.2.4) and laying the foundation for acceptance and mutual trust in the andragogic encounter. Learners, in mutual accompaniment with the educator, may then be enabled to experience their world meaningfully, to become interested in and motivated toward self-directed behaviour and responsible choices, as they strive towards becoming that which they are capable of becoming in the actualisation of potential. Competencies are acquired as part of the process of capacity building and the facts pertaining to culturality in cross cultural encounters are kept to the forefront of conscious thought.

Formulation of the issues concerned is, however, insufficient. HUNTER (1974:36) proposes certain considerations which are basic to any teacher training programme for multi- and cross cultural education.

5.3.2.1 Basic Considerations for In-Service Training Programmes

A need exists to develop and apply cross cultural theory to the training of health educators. The dual bind of cultural meanings experienced by health educators in responding to their multicultural communities is as complicated as the choices they must make in developing programmes for or with these groups (Mitchell, 1991:15). A basic consideration is the establishment of a knowledge base in which educators explore and learn about culture, the

effect it has on their own individual life-style and personality and their personal contribution towards the development and maintenance of their own particular culture. This knowledge can be expanded by exploring and learning about other cultures (Hunter, 1974:36). Such a knowledge base meets criteria implicit in the understanding and experiencing of difference, interpretation, actualisation and appreciation of possibilities and experience of the future (Landman, 1977:63; Landman, *et al.*, 1982: Scheme B) (cf 5.2.4). The dual meaning of cultural appreciation is to accept human diversity while calling forth man's common humanity (Mitchell, 1991:18).

Culture specific knowledge and fundamental anthropological perspectives are necessary for the realisation of informed policies and guidelines. However, knowledge is not behaviour. Acquisition of knowledge concerning cultural boundaries is not the same as increasing the educator's abilities to interact effectively with people of different cultures (Pedersen, 1981:21). Learners, irrespective of gender, social class, and other specific ethno-cultural affiliations will, in future, almost certainly expect that their cultural beliefs, values and life style be respected and acted upon by health personnel (Leininger, 1989:42).

Reinforcement of the organisation's supportive philosophy, as adjunct to the knowledge base, is necessary as it determines attitudes and perceptions individual educators may have about the concept of diversity (Hunter, 1974:36). Such an approach is in keeping with the educative aims of ennobling and improving and placing the interests of the learner first. Regard for the dignity of the student as human being is taken into account in order to give him the opportunity to acquire freedom and assume responsibility. Mutual confidence and

acceptance as a condition of education becomes possible (Griessel, 1985:19). It is proposed that the concept of ennobling be substituted by that of empowering or competency building as being more appropriate to the aims of health education.

The design and implementation of learning experiences involving strategies, techniques, methods and evaluation procedures that include multicultural perspectives (cf 5.3.2.9) are further considerations to ensure credibility, probity and cultural sensitivity (Leininger, 1989:42). Failure to plan for the cross cultural educative encounter may mitigate against realisation of authentic education due to misunderstandings, non-acceptance and lack of trust. The great difficulty in culture is making explicit that which "... is already familiar, implicit and assumed to be universal" (Barer-Stein, 1990:164).

The criterion of understanding runs like a thread throughout all the structures within the educative event, making the conceptualisation of essential understandings compiled by HILLIARD (*in*: Hunter, 1974:44-47) of particular relevance to this study and the problem areas outlined in Chapters Two and Four.

5.3.2.2 Essential Understandings in Multicultural Context

Understandings in the cross cultural context constitute a conceptualisation of the educator's role and provide a base for programme development for the training of health educators. The following elements are included for consideration.

- * All educative events always constitute a cross cultural encounter in which learners and educators are representatives of a particular configuration of sub-cultures. Furthermore, by definition, the educator, as a professional, has learned ways of acting and thinking which have not yet been acquired by learners (Erickson, 1986:117) and which, in turn, certain individuals have little desire to acquire. For too long, educators, have attempted to integrate people into modes of living alien to them. "People are neither objects to be formed nor cases of ignorance to be treated" (Fuglesang, 1982:24).

- * The personality, values and social background of the educator are critical cultural inputs in that the educator is not only the primary professional or trained lay person in the learning event, but, as a human being, is unique.

- * All educational methods and approaches are culture bound and currently favour white middle class male learners.

- * The classroom is not a benign context but a potent matrix, in that the real world of the learning situation includes the so-called invisible activities or transactions between educator and learner which are embedded in a reality structure outside the immediate situation. Aspects of this reality include social pressures, judgements, labelling, rewards and sanctions, control of time and space, presentation of material and inclusion or exclusion of activities.

- * Educators must understand how students may be victims of oppressive social and economic conditions, either directly or indirectly, and how learning is related to a sense of power over some of the forces which impinge on people's lives. Motivation is low when powerlessness is experienced. Mismanagement within education can be avoided by making power and cultural conflicts "... a source of creative action within broader educational purposes..." (Mitchell, 1991:16). Educators must understand that all minds are equally complex, that the thought processes of all people are functionally equivalent (Fuglesang, 1982:23), and that ethnic and racial minorities and the poor can, and have been able to learn at the same level as others when proper support is provided. Expectations of the educators are determining factors in building a climate for actualisation of learner potential.

Careful reflection of Hilliard's understandings reveals that they are fundamental to the educator's ability to offer authentic andragogic support to those who are in existential need of a guide on whom they can depend for guidance and support and who can be trusted to provide safety and security thereby enabling them to progress in confidence toward an unknown and uncertain future. In the absence of authentic support, andragogic intervention and activities will fail (adapted from Gunter, 1969:118).

The essential understandings, as described, appear limited in the absence of an understanding of authority and freedom as human phenomena in the andragogic relationship (cf 3.2.1.9).

5.3.2.3 Authority and Freedom

If the purpose of health education is accepted as assisting individuals, families and communities to move toward health (adapted from Watts, 1990:39), it may be stated that health educators represent demands of propriety and educative authority. There is a distinction between being *an* authority and being *in* authority (Morrow, 1988:92). Therefore, authoritativeness does not indicate that the educator is authoritarian as in dominance or obstinacy, but rather as one who possesses specialised knowledge and skills that may be measured against criteria of expertise, reliability and credibility. Credibility, in turn, refers to the degree of believability vested in the educator and encompasses essences of trust, co-operation, dynamism and authority (as in leadership). In these terms the concept of expert authority may be regarded as universal.

If health is viewed as a dynamic internal process achieved through an expansion of consciousness that occurs as a result of personal choice and involvement, it follows that decisions must be made by people themselves (Watts, 1990:40) as an act of autonomy. Based on the ontological criteria that human beings, as existence in need, are not only goal directed but also free to make their own choices, they are, in turn, free to accept or reject andragogical intervention.

Democracy and education are inextricably linked in that the values of one are transferred and reflected in the other (Lawson, 1979:25). An inherent tension exists between the rights of the individual and those of the group. Values of freedom and equality accorded to persons

in a democratic society are poised in equivalence with concomitant responsibilities that are linked to the common good. These include the notions of justice, fairness, responsibility, negotiation or reconciliation, identification with those who are different or powerless and participation (Lawson, 1989:14; Watts, 1990:39). In this regard, a normative (cf 3.2.1.10) ethical framework (cf 5.4.6) is viewed as a necessary aspect of social control rather than as an undesirable imposition. Public as distinct from personal verifiable and guaranteed forms of knowledge are presupposed (Lawson, 1989:14).

Authority neither implies tyranny nor excludes freedom. Authority interacts with the freedom of individuals to make choices which, in turn, is based on responsibility and autonomy (Van Zyl and Duminy, 1980:44-48). If autonomy means freedom and freedom implies responsibility, it may be stated that personal freedom is the quintessence of adulthood (Gunter, 1969:130). The educative relationship demands the essences of elevated dialogue, equality in negotiation, acknowledgement of expert authority in inequality and dependence in independence. Learners are guided to levels of accountability and freedom in responsibility with respect to the choices they make concerning capacity building. Such choices are both ethically and value-laden (Hiller, 1987:101).

The above observations apply equally to the notion of authority as vested in the functioning of any organisation in terms of health education. The symbiotic human realities of authority and freedom may be held in balance through negotiated partnerships between health services and the communities served. The responsibility to initiate such action lies with the health authority.

Implicit to a more complete understanding of the situatedness of the education encounter is an acknowledgement of the essential uniqueness and human dignity (cf 3.2.1.14) of all persons.

5.3.2.4 Respect for Human Dignity

It is a moral imperative for man to become what he is capable of becoming. This notion embodies the essence of man as a being for whom acceptance and honouring of his personal human dignity by others is essential. The moral values man strives for should also include respect for the human dignity of all other human beings (Reeler, 1985:160-161).

Deep down at the root of human existence lies man's craving to be acknowledged and recognised by a fellow being, to be respected, accompanied, motivated and enabled to live a worthy human life (Oberholzer, 1979:15-16). As criterion, respect for human dignity is not a denial of inequality, as an aspect of expert authority, but an affirmation of equivalence of all persons as human beings. It is through inequality but in equivalence as human beings that the agogic receives significance and meaning (Oberholzer, 1979:13).

Implicit in this criterion are acceptance of and high expectations for all learners, and an absence of bias and prejudice in programme planning, learning content and activities. The criterion includes an affective dimension which means a recognition of alternative frameworks of human meaning so that all gain maximum benefit from a learning situation in which educators accept the responsibility of enabling students to learn (Lynch, 1989:109).

Inequality in equality does not imply a *laissez-faire* philosophy, but one which imposes the highest standards of social and ethical conduct on all. It implies openness in professional and lay judgements and decision-making, a willingness to discuss positional strengths and weaknesses frankly and in confidence and a readiness to negotiate situational realities rather than impose them (adapted from Lynch, 1989:109). It entails "... eliciting a sense of ethical responsibility" (Hiller, 1987:101).

Problems generating ethical conflict cannot always be resolved by reaching a single conclusion. Differences in choice should be tolerated. Educators need to engage in ethical discourse (cf 5.4.6) in an attempt to extract points of difference, to examine the reasoning of others and to resist false evaluations and distinctions with the aim of resolving conflict (Hiller, 1987:101-102). Ongoing clarification of opposing values is integral to demonstrating respect for human dignity.

Closely related to the successful establishment of cross cultural community partnerships is the concept of transcultural reciprocity.

5.3.2.5 Transcultural Reciprocity

The term 'trans' means 'across' or 'between' while that of reciprocity has reference to

"... a state or a relationship in which there is mutual action, influence, giving and taking, or a correspondence between, two parties or things" (Dobson, 1989:97).

While transcultural reciprocity has been presented as a core concept for the practice of transcultural nursing and health visiting (Dobson, 1989:97-101), it has equivalent relevance to health education. Health educators and learners enter into a reciprocal relationship in which educators have special knowledge and skills that can enable learners to set and realise goals. Learners, in turn, have knowledge and perceptions about themselves and their problems. Past experiences, present needs, expectations and perceived goals or incentives influence how educators and learners react to one another. Relationships are interactional and dynamic. The encounter embodies the notion of a genuine supportive human relationship based on a sense of mutual reciprocity rather than unidirectional assistance. A relationship based on reciprocity is dependent on a two-way sharing of information, ideas, concerns, feelings and ultimately of 'self', during which essences of interdependence, sharing and trust evolve. Reciprocal relationships reflect characteristics of collaboration, negotiation, reciprocal influence and exchange as participants are called upon to unfold the meaning of the world in which they find themselves. Through acts of intent, educators are called upon to transcend themselves in order to perceive the uniqueness of others and to establish rapport with those different from themselves.

Transcultural reciprocity involves an ongoing, intentional bridging of cultural disparities that may exist between practitioners and learners as clients and a firm commitment by the service to provide culturally sensitive programmes as a central rather than peripheral concern. Transcultural reciprocity may be seen as a process in which practitioners and clients participate on equal terms but, likewise, one in which understanding and trust may be slow to evolve over time. The concept of learners as clients in this paragraph reflects a significant semantic

paradigm shift that reinforces the idea of interdependence as opposed to that of dominance or dependence: a notion so often implied in the terms 'educator' and 'learner'.

A concept which may be subsumed under that of transcultural reciprocity and one which is described as an essence of man as a related being (cf 3.2.1.4(b)) is that of empathy. As concept, the traditional definition of the term is rooted in Western frames of reference, but in the context of this study will, more appropriately, be discussed under the heading of relational empathy.

5.3.2.6 Relational Empathy

ROGERS (1959:210) described empathy as an ability to perceive the internal frame of reference of another person with accuracy and identify with the associated emotional components and meanings as if one were that person, but without losing the 'as if' condition. He later depicted empathy as

"... entering the private perceptual world of the other and becoming thoroughly at home in it" (Rogers, 1980:142).

According to BROOME (1991:236-240), these definitions of empathy are inappropriate in respect of intercultural interactions for the following reasons:

- * Emphasis on accuracy diminishes the usefulness of empathy in intercultural encounters because of differences in cultural perspectives, thought processes,

and the individual socio-cultural and developmental characteristics of both communicator and client as well as risks associated with stereotyping, ethnocentrism and projection of personal circumstances onto those of other individuals. No one person can have "... *direct* knowledge about the mental experience of another person" (Broome, 1991:237).

- * Focus on affective identification with the emotions of another has led to an assumption that it is possible for the affective state of one person to duplicate that of another. On the contrary, empathy can only be grounded in the process of arriving at integrated understandings of the perceptual field of others by means of affective, cognitive and conative adaptation to the values, symbols, meanings and intentions of others, in the sense that these aspects of behaviour are inseparable and complementary.

- * The improper portrayal of empathy as a skill or ability based on characteristics which may be learned and applied by the communicator in a manner reflecting a unidirectional view of the process fails to take into account cultural differences as to how empathy is expressed. Little attention is paid to the fact that many skills leading to understanding in one culture may communicate disrespect and bring about rejection in other cultures (cf 5.4.5).

While the communicator always falls short of grasping the totality of the experience of another person, it is possible to develop relations in and through which interpretations of the

world by others assume meaning. In this sense, empathy becomes relational, emphasizing a productive rather than a reproductive approach to understanding so that shared meaning emerges during the interpersonal encounter (cf 5.3.2.8). Human understanding remains understanding in openness and is, therefore, subject to growth. Cognitive and affective constructs should be continually adjusted during any interaction by means of feedback. Such feedback, whether verbal or non-verbal, conscious or unconscious, enables individuals to determine how well they have construed the perspectives of others. In these terms, empathy may be defined as part of a corrective, on-going dynamic and cyclical process reflecting the transactional nature of the interaction and the interdependence of the participants. Relational empathy allows two or more people to move toward varying degrees of understanding (Broome, 1991:240-241). Such understanding may be characterised by the emergence of unique norms and values which may not have existed prior to the interaction to constitute what interculturalists often refer to as a 'third culture' (Broome, 1991:143) or "... *a shift into a different behavior than was previously experienced*" (Barer-Stein, 1988:81).

A relational approach to empathy does not rely only on the skills or characteristics of the educator, but is influenced to a great extent by the context of the encounter and the variables operating in the communication process. It also makes possible the bridging of difference as apposed to resting on the assumption of similarity.

In order to move toward realisation of a 'third culture' to achieve the aims of health education, the concepts of critical reflection and perspective transformation are of significance.

5.3.2.7 Critical Reflection

Reflection, as an observing of the mind and its operations, includes the object reflected upon and the act of reflecting itself. It has reference to that of which the individual is conscious as an intentional object singled out for cognitive attention (Collins, 1984:185, 187).

An act of reflection may constitute a simple awareness of a specific perception that a person has of seeing, thinking or acting which embodies elements of affect, discrimination (in the sense of discernment) and judgement. Critical awareness or consciousness, on the other hand, is an act of critical reflection, in which the individual becomes aware of his awareness and critiques it. The levels of critical consciousness include conceptual reflectivity as an act of self reflection, psychic reflectivity resulting in a recognition of habits of making precipient judgements on the basis of limited information and theoretical reflectivity, encompassing an awareness that the reasons for habits of precipient judgement lie in sets of taken-for-granted psychological and cultural assumptions (Mezirow, 1981:12-13).

Meaning is given to ongoing or future projects through anticipative reflection. Projects are carried through to completion by reflecting on past experience and future anticipation (Collins, 1984:187). This is a premise, excluding the critical dimension, on which social learning rests (cf 5.2.1). Emphasis on critical reflection, as an ongoing evaluative dimension of adult learning, introduces a new perspective to programme planning. By means of critical reflection, individuals are made aware of how the original meaning of a project may be modified by subsequent acts or be differently interpreted by those from different socio-cultural

backgrounds. The idea that a project can be circumscribed by definitive behavioural statements prior to involvement by participants is hereby pre-empted. Anticipative critical reflection permits deliberate cognitive experimentation with future projects, evaluation of the consequences of potential activities and referral back to relevant areas of past, and present, personal and cultural experience. From this perspective, activities are planned by people themselves rather than determined by external forces (Collins, 1984:187-188).

The conceptualisation of reflection as integral to emancipatory learning (cf 2.4.1) runs a parallel course with BARER-STEIN'S (cf 5.2.4) framework of experiencing the unfamiliar in respect of cross cultural adaptation - both being grounded in the philosophy of existential phenomenology. She (1987(a):101-104) makes reference to collective reflections on grounds that it is not possible to limit or contain the possibilities inherent in the act of learning (cf 3.2.1.5). A reflective response by any individual has the potential to bring into "Awareness that 'seed' in yet another person with differing experiences, needs and cultural matrix" (Barer-Stein, 1987(a): 101). Meaning is hereby expanded and enriched. The phases of **Being Aware**, **Observing** and **Acting** may be said to correspond with an act of reflection *per se* as they are characterised by superficiality, passivity, a brief reflective pause and the maintenance of distance from the intentional object of awareness. Movement from the phase of **Acting** to those of **Confronting** and **Involving** requires an act of critical reflection. It involves a potential shift from the familiar to the unknown and a choice regarding the possibility of change: a position which may be clouded with anxiety or fear. In this regard the role of the educator is one of facilitation and the role of the learner, one of choice.

Critical reflection is a process central to that of perspective transformation.

5.3.2.8 Perspective Transformation

The notion of perspective transformation is rooted in the phenomenon of understanding conceived of as an apprehension of meaning requiring a readiness to suspend taken-for-granted norms in favour of a critical stance towards everyday experiences (Collins, 1984: 180-181). It is a process that lies at the core of emancipatory learning (Habermas), social renewal (Van Gent) and conscientization (Freire). According to MEZIROU (1984:124), encounters posed by the existential challenges of adulthood involve a process of negotiating irregular successions of transformations of 'meaning perspectives' as the adult strives to meet the demands of the world by which he is confronted. In these terms, perspective transformation has reference to

"... the structure of psycho-cultural assumptions within which new experience is assimilated and transformed by one's past experience" (Mezirow, 1984:124).

The content and timing of such past experience has a decisive influence on the handling of daily activities and is determined, in turn, by the individual's stock of knowledge. Man's stock of knowledge is formed as new elements of knowledge or cognitions and their implications become integrated within layers of previously acquired knowledge. Existing knowledge influences the very way in which new knowledge is integrated. Man's ability to make critical judgements is a dimension of his stock of knowledge, accounts for his motivational traits and the way in which the world is experienced (Collins, 1984:181).

The psycho-cultural assumptions relevant to this study and referred to in the previous quotation are discussed in sections 4.1 to 4.3.

In educational terms, perceptual transformation is a learning process in which people become critically aware of why and how the structure of psycho-cultural assumptions come to constrain the way they see themselves. It permits of a more inclusive and discriminating integration of experience which enables educators and learners to reconstitute assumption structures and to act upon new understandings (Mezirow, 1984:124).

Perceptual approaches to cross cultural counselling (cf 5.2.3), and by implication education, position the notion of self as central to the perceptual field, while CHRISTENSEN (1985:67-76) makes room for the perceptual fields of both client and counsellor/educator. However, these approaches appear to fall short in so far as they do not offer the means for closing the gap between theory and application. According to BARER-STEIN (1987(a):106), as long as learning as an aspect of meaning dwells in any place outside of the self, it may not be called education or even culture, for learning becomes uniquely that of the self only when used in some way through an act of involvement (cf 3.2.1.9).

Perceptual transformation, as an educational approach, places emphasis on enabling learners to identify real problems within the situatedness of their life-world by using a technique of problem posing. Facilitation of understanding takes place by means of self examination and critical assessment of personal internalised role assumptions. The shared as apposed to the personal nature of the experience of problems is acknowledged.

Having gained understanding, learners are given access to alternative meaning perspectives by exploring new ways of acting, building competencies related to these options and developing self-confidence in implementing the new roles. Planning a course of action as an aspect of involvement and intentionability (cf 3.2.1.6), in the sense of a "... *purposive experiencing of objects and events in which individuals bestow meaning on their activities*" (Collins, 1984:186), is an integral part of perspective transformation and the educative event. So, too, are processes relating to the acquisition of knowledge and skills for the implementation of a plan and provisional efforts to try out and evaluate new roles by means of feedback (Mezirow, 1984:125).

The approach is congruent with innovation-diffusion theory (cf 5.2.2.1) and the community development models of adult education (cf 5.2.2.2), but adds the dimension of ensuring that individuals and communities are active participants (cf 5.4.2) in the process from beginning to end. Neither does it preclude learning goals pertaining to realisation of learning needs relating to the technical and practical domains of cognitive interest (cf 2.4.1). Because meaning transformation involves a redefinition of an identified problem, learning occurs in ascending spirals as opposed to a linear direction "... one goes back in order to go forward" (Mezirow, 1985:26).

Because the life world perspectives of health educators are not value free and their selection of educational strategies and alternative meaning perspectives reflect their own professional philosophy and cultural values, the actuality of learner participation in the educational event remains of central importance (Mezirow, 1984:136) in the ontic fact of multiple life-world

realities.

5.3.2.9 Multiple Life-World Realities

Man and his life-world constitute a fundamental human reality, but paradoxically no two people experience the same situation in exactly the same way. The greater the difference in cultural background, the greater the differences in world view. In addition, experiences that are readily accessible, or within the potential reach of some, lie outside the range of others.

Adult educators who question their own life world perspectives reduce the likelihood that they will impose preconceived, inappropriate personal cognitions onto the meaning structures of the different orders of reality experienced by learners (Collins, 1984:184). At the same time recognition of areas of communality between cultures becomes possible, reducing the propensity toward stereotyping and laying the foundation for designing adaptations from one culture to another (Mitchell, 1991:18).

During in-service training (cf 5.3.2), health educators can be brought to move beyond a preoccupation with self to understand and confront how their personal prejudices and prior understandings influence the outcomes of any cross cultural encounter. They can be taught to focus on building mutual understanding rather than focusing on specific areas of overt cultural difference (Broome, 1991:245-246). Man as being in dependence of co-existential involvement, represents a world that each individual shares with others and, in the educative

encounter, one in which man assumes co-responsibility for his fellow man (cf 3.2.1.8).

By anchoring cross cultural communication within the *context* in which cross cultural interactions take place, educators and learners are able to explore the conditions that constitute the structure of their respective life-worlds and, by so doing, understand the variables by which their worlds are affected in order to plan for and take purposeful action to bring about desired change. Adoption of a set of 'dialogic attitudes' can also be promoted whereby educators, as learners, can perceive that 'truth' as 'reality' exists in the encounter itself and not in the reality of culture *per se*. In order to develop cross cultural understanding, educators must be motivated to put the necessary effort into working through differences, demonstrate sufficient commitment to the encounter to overcome potential areas of breakdown, be willing and able to explore and negotiate alternative meanings for ideas and situations and be willing to participate in mutually creative exploration in a search for the development of a 'third culture' (Broome, 1991:246-247). In exploring options for change, the cognitive map of educators can be extended and limitations in the vision of learners can be reversed (Mitchell, 1991:19) in order to realise the aims of health education (cf 2.4.2).

At this point, it should be noted that cross cultural communication is not always successful. Success may come to those who attempt it, but will not come to those who never try to bridge intercultural gaps (Dodd, 1987:32).

5.3.2.10 Communication Competence

Most of the literature reveals that conceptualisations of cross cultural communication competence are similar to those relating to intracultural communication (cf 1.3.6.1). The only difference lies in the fact that cross cultural communication competence is conceived of as effective and appropriate interaction between people as well as between people from different socio-cultural backgrounds (Chen, 1990:247). Communication competence may, therefore, be defined as an

"... ability to effectively and appropriately execute communication behaviors to elicit a desired response in a specific environment" (Chen, 1990:247).

The definition may be interpreted as a "*... demonstrated ability to negotiate mutual meanings, rules and positive outcomes*" (Collier and Thomas, 1988:108) or a

"... knowledge of appropriate communication patterns in a given situation and an ability to use the knowledge" (Cooley and Roach, 1984:25).

Implicit in these notions are processes of 'cultural negotiation' and 'cultural brokerage' which may be considered as acts of cross cultural translations of meaning in which messages and belief systems are explored, linked and interpreted by educators and learners. Despite subtle differences between the two concepts, both give attention to facilitating an expression of views held by individuals and communities. Conflict is acknowledged and clarified. Through acceptance of the view of clients as learners, the health educator is more likely to achieve

rapport with the community (Tripp-Reimer, 1989:614). These concepts are congruent with those discussed in the previous section.

Systems of meaning are integral components of communication competence which not only reflect differences in the manner in which reality is perceived, recognised, interpreted and believed (Kincaid, 1988:285), but also takes place under circumstances in which community patterns of verbal encoding and decoding are significantly different (Kim and Reuben, 1988:305). It may further be deduced that any referent, whether word, concept, object or situation, to which meaning is attached together with its associated meaning values is essentially a function of the cognitive domain of individuals (Kreitler and Kreitler, 1988:726, 729).

If culture and cognition are interdependent (Forgas, 1988:192), two properties of human communication are of significance, namely, those of intersubjectivity and impact. Intersubjectivity constitutes the means whereby shared meaning is generated and established by the stock of knowledge shared by communities based on their common experiences (Fitzpatrick, *et al.*, 1992:3-4). The criterion of mutuality or communality is basic to this concept and one which determines the effectivity or otherwise of the impact of a message.

Central to the creation of intersubjectivity, as shared experience, is what ROLOFF AND KELLERMAN (1984:191-192) refer to as interpersonal awareness or the degree to which the communicator, as educator, focuses attention on and adapts communication to the variety of stimuli inherent in the interaction. An interpersonally aware educator cannot be simul-

taneously focused on self and the environment, but focuses in rapid frequent attentional shifts from personal behaviour to that of others. Continual cognitive activity in matching interactive behaviour reduces the incidence of mismatched interpretations. Ongoing interactive scanning permits of conscious adaptive actions across different contexts. By so doing, the educator complies with the human demands of involvement, openness in attribution of meaning, respect for the human dignity of the other and the criteria of awareness, attentiveness, self-evaluation and guidance of those in need in reciprocal interaction or dialogue.

Intercultural sensitivity is reflected in understanding situational constraints that influence the behaviour and attribution of meaning within the communicative event. These include experiences such as anxiety, situational ambiguity, sense of belonging, unrealised expectations, prejudice and ethnocentrism, all of which engage the emotions. Knowledge about, and insight into, specific areas of cross cultural difference as reflected in group versus individual activity (cf 4.3.1.2(e)), value systems (cf 3.2.1.10(a)), spatial and time orientation (cf 4.3.1.2(c)) roles and role expectation (cf 4.3.1.2(d)), class and status hierarchies (cf 2.3.5; 4.2.3) and language usage (cf 1.3.6.2; 4.3.1.2(c)), also play a role. Cultural difference relating to how people think about and evaluate information, in terms of categorization of information (cf 4.3.1.2(a)), formation of in- and out-groups (cf 4.2), learning style (cf 4.3.1.2(b)), differentiation and attribution formation are fundamental issues relating to the impact of communication in cross cultural encounters (Cushner, 1989:126-127).

The notion of communicative competence is embedded in the concept of cultural competence as part of the total set of knowledge and skills that communicators bring into a situation.

Cross cultural communication requires the perception, selection and interpretation of the salient features encoded in actual communicative situations and an integration of these features with other cultural knowledge and skills in order to implement appropriate strategies for achieving the aims of health education (adapted from Saville - Troike, 1990:23-24).

Guidelines underlying the andragogic practice of health education based on an application of the knowledge base and essential understandings in cross cultural educational encounters may now be developed. It is, therefore, the intention of the researcher to identify andragogically accountable principles for andragogic practice which will serve to "... guide opinion, value and action in a multicultural society" (Lynch, 1983:14).

5.4 ANDRAGOGIC PRACTICE

Offering guidelines to the complex question of andragogic practice in cross cultural encounters carries the inherent danger of seeking easy solutions and a subsequent presentation of simple generalisations and specifications. Such an approach could lead to the assumption of a mechanistic relationship between application of the what and how of multicultural education and an absence of any overall conceptual framework of multicultural education and its essential and irreducible core components (Lynch, 1983:47). Therefore, the integrated, multidimensional nature of the proposed guidelines and the necessity of viewing them from a holistic perspective are stressed.

The mechanisms and procedural activities relating to community health education are well

documented in the literature (cf 5.1) and will not be reflected in this study. The guidelines to professional practice as presented emerge from progressive insights gained from radical reflection on the recorded combination of factors which are integral to the cross cultural educative event. The researcher has reached the conclusion that compliance with the demands of pure humanness, either wittingly or unwittingly as measured against andragogical criteria, lie at the core of the success, or otherwise, of cross cultural health education encounters. Pending the outcome of further research, it is proposed that the inclusion or omission of the following andragogical practices are central to the contradictory research findings concerning the relevance of health education to an improvement in the health status of individuals and communities (cf 1.2.2).

A reorientation of health education professional practice is required in line with the connotation of health education as dialogue between educators and community in the sense of educators and community members who wish to share experiences and identify feasible solutions to common problems (Feuerstein, 1982:28). As the educator-learner transaction referred to is one that is multifaceted and complex, it seems appropriate to commence with an elucidation of learner centredness.

5.4.1 LEARNER CENTREDNESS

WOLCOTT (1987:26, 30) records a scepticism toward educators and social scientists who regard teaching and learning as one and the same thing and ponders the effect it might have if learning was taken as a central theme, not only with respect to their students but

themselves as well. Wolcott's misgivings are confirmed in the light of the fact that the individual attributes meaning to his world and designs a life-world for himself. He assumes increasing responsibility for constituting his world meaningfully. As intentionality, he stands in a dynamic relationship to the world in his becoming (Landman, *et al.*, 1975:19-20). Learner centredness, as an aspect of multiple life-world realities appears totally relevant to cross cultural health education. Central to the notion of learner centredness is that of participative learning.

5.4.2 PARTICIPATIVE LEARNING

Health professionals are not in a position to make the most important decisions concerning health and disease. At local level, networks of people care for their health within their home communities (and environments) and make decisions as to whether to effect social and behavioural change or not (Feierman, 1985:130) (cf 2.2.3.3). For this reason, guidelines for effective cross cultural education must address educator and client variables equally and deal with the pertinent perceptions of both, namely, those relating to socio-economic class, ethnicity, race, culture (Christenensen, 1985:77-78), gender, rural-urban-distribution and above all health related beliefs and practices in conjunction with educational expectations.

Regardless of the theoretical model on which practice is based, from awareness to adoption, knowledge to confirmation or assessment to evaluation, an injunction to 'know the community' is a recurrent theme in health education literature. It is frequently taken as axiomatic that the responsibility for such assessment lies in the hands of health educators alone (cf

5.2.5). A simple unilinear collation of facts may well produce well founded objective analyses of demographic variables and community structures as well as observable health practices, family support systems and interactions with health professionals. Situational variables affecting health status are also identified with relative ease. What is not readily apparent is the subjective experience of these factors by individuals not to mention the group. Discovery of objective truths has been increasingly revealed to be a chimera (Webster, 1989:60). A further problem in respect of both educator and client lies in differences inherent in the gap between, 'culture as idealised' and 'culture as reality': a reality that is further complicated by rapid social change and modernisation.

For these reasons, as well as ethical acceptability (cf 5.4.6) and effectiveness, client-community participation is essential (French, 1990:9) at all levels (Kussrow, 1990:21-22) and in all practices having application to teaching-learning transactions, curriculum development and instructional design activities plus plans and actions that support the learning encounter (Brookfield, 1988:100). Furthermore, DOVEY AND MJINGWANA (1985:82) recommend that individuals should not be treated in isolation from their reference groups. Although referring specifically to psychological problems, the statement has equal relevance for other circumstances of life, for it is a truism to state that psychological, social and physical problems are usually 'group' and seldom 'individual' problems (cf 3.2.1.8).

Essences of effective participatory learning include the following principles.

5.4.2.1 Spirit of Collaboration

The existence of a collaborative spirit (cf 3.2.1.8(b)) is fundamental to participatory learning (Brookfield, 1988:100, 101). Adults have a wide range of quantitative and qualitative experience. They bring a rich reservoir of learning material into any learning experience to which new meanings and skills can be attached by themselves and others. LINDEMAN (in: Warren, 1989:212) states that "the resource of highest value in adult education is the *learner's experience*" - in respect of family, community, work and recreation (Knowles, 1978:10). This reservoir of knowledge and experience constitutes the conceptual framework and perceptual field in and through which the multidimensional and complex cognitive, affective, conative and behavioural constructs, of both clients and educators, are integrated.

The task of the health educator is to facilitate learning in cooperation with the community and in openness (cf 3.2.1.5(b)) in order to assess needs, identify objectives, determine methods of learning and evaluation procedures. During the process educational roles alternate so that different members of the group assume responsibility for posing questions, identifying issues and resources, suggesting priorities and organising activities. Collaboration is constant in that competing claims are explored, discussed and negotiated (Brookfield, 1988:100; 101-102).

The statement by WILSON ET AL. (1991:373) that health workers should stop trying to get communities to participate in what they are doing, but rather to participate in what the community is doing, is indicative of the fact that realisation of participative education is neither automatic nor easy. Creation of a climate for learning in which clients can feel comfortable

to challenge and be challenged by one another is an essential task of the health educator. It is a task in which demands for respect of the human dignity of each individual (cf 3.2.1.14(b)) as normative (cf 3.2.1.10(b)), religious (cf 3.2.1.17(b)) and cultural (cf 3.2.1.11(b)) being, as well as being in bodiliness (cf 3.2.1.15(b)) are integral essences of the educative event. Compliance with the demands of man as biological exception as adragological category (cf 3.2.1.1(b)) enhances the possibility of community participation in health education projects.

5.4.2.2 Voluntary Participation

According to FRENCH (1990:9), voluntary participation is a principle on which health education programmes should be built as a guard against propaganda. In addition, "adults engage in learning as a result of their own volition" (Brookfield, 1988:100), although promptings to do so may be due to external as well as internal influences (Brookfield, 1988:100).

The voluntary nature of participatory learning means that participation can be withdrawn if learners feel that the activity does not meet their needs, make sense or is incomprehensible. The same holds true if learners perceive themselves to be treated with disrespect (Brookfield, 1988:100). Any infringement of the adult's need to be self-directing in the form of 'being told' or 'directed' frequently meets with defensiveness, resentment and resistance (Knowles, 1987:171). The adult is entitled to frame his life and conduct his personal affairs as he sees fit, provided only that his obligations to others are met and that he does not injure the legitimate interests of others or infringe upon their spheres of liberty. As autonomous

being, the adult is capable of responsible choice (cf 3.2.1.9(b)) and is free to choose what, how, when and from whom learning will take place (Brookfield, 1983:27-29; Paterson 1984:144-145).

For these reasons, curricula themes and topics should be grounded in the experience of the group and explicit connections drawn between that which is unfamiliar or unknown and the past experiences or current preoccupations of the community itself. The practice of guiding learners from the known to the unknown, the simple to the complex and concrete to the abstract is rooted in the andragogical categories of man as self-transcending intentional being (cf 3.2.1.6(b)), existing (cf 3.2.1.2(b)) in a world of meaning (cf 3.2.1.3(b)).

Participatory learning embodies the essence of the andragogical category of man as related being (cf 3.2.1.4(b)), permits of activities that are congruent with the categories of unchangeable being in changeability (cf 3.2.1.13(b)), as educators strive towards enabling people to become the persons they are more fully capable of becoming (cf 3.2.1.7(b)), in a historical epoch (cf 3.2.1.12(b)) of accelerating social change. Participation implies open discourse in which both diversity and communality (cf 3.2.1.16(b)) are acknowledged and attention paid to the needs and interests of the community.

5.4.3 LEARNING NEEDS AND COMMUNITY INTERESTS

Decision-making concerning educational needs and allocation of education and training resources are not value-free to be resolved by technical and empirical ordering of priorities.

Needs are not unproblematically present in people's lives, but proceed from their interests and goals which, in turn, are based on value judgements (Alexander, 1987:137) that evolve from differing socio-economic, cultural and political contexts. The health needs of a community as perceived by health professionals may not coincide with those of the community itself. The situation becomes compounded in cross cultural encounters. It may also be assumed that any group coming together for health education has an unwritten agenda about what they wish to know (Strehlow, 1983:41).

For these reasons and the fact that motivation lies at the core of decision making and action, the notion of meeting client and community needs has become an issue in health education practice: a notion to which the conceptualisations of felt-needs and the adult as self-directed learner have become linked.

5.4.3.1 Felt-Needs

The felt-need rationale is equated with the practice of satisfying the educational wants in the manner expressed by learners themselves (Brookfield, 1989:204). Two fundamentally incorrect assumptions are embedded in this rationale. Firstly, adults are not always fully aware of the nature of their situation, their statements may not be consistent with their actions and their interests, frequently individualised and unique, may be distorted or limited by existing physical, psychological and social factors. Needs expressed as need statements are norm related and hence norm statements (Hamm, 1989:78-79, 83; Mezirow, 1985:27). Secondly, health educators possess knowledge and skills not available to the community and

a responsibility to encourage learners to explore alternative ways of thinking and learning (Brookfield, 1989:204) and develop capacities that are geared toward realising the aims of health education (cf 2.4.2). An educator is ideally an authority in expertise and in accompaniment, but not in dominance.

That learning experience should build on an examination and assessment of the existing perceptions and goals of clients, as an aspect of leading from the known to the unknown, is not in question. What is an issue, is how the educator facilitates the aim of self-directed empowered adults.

5.4.3.2 Self-Directed Learning

According to BROOKFIELD (1988:100), the task of the health educator is to nurture the development of self-directed empowered adults who will view themselves as initiating pro-active individuals engaged in a continuous re-creation of their personal relationships, social circumstances and working worlds, rather than as reactive individuals buffeted by forces over which they have no control. Choices made today can make the difference between a preferable as opposed to a problematic future. In the words of TOFFLER (1974:XXV-XXVI):

"Learning for tomorrow includes learning to know one's own mind, to understand one's own values clearly enough to make consistent and effective choices".

The premise of self-directed learning is based on the assumption that adults have a need to be self-directing as their self-concept moves from being a dependent personality toward that

a responsibility to encourage learners to explore alternative ways of thinking and learning (Brookfield, 1989:204) and develop capacities that are geared toward realising the aims of health education (cf 2.4.2). An educator is ideally an authority in expertise and in accompaniment, but not in dominance.

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The premise of self-directed learning is based on the assumption that adults have a need to be self-directing as their self-concept moves from being a dependent personality toward that

of self-directed human being. Adults have a psychological need to be seen by others as being in charge of their own lives and judged competent to take responsibility for themselves (Knowles, 1987:170-173; *in*: Van Gent, 1991:204) or their position in the group. Conversely, while adults may be self-directing in other areas of their lives, they may tend to revert to conditioning from their schooldays and abrogate their decision-making attributes to the educator (Knowles, 1987:170). In addition differences regarding educational expectations as described by Hofstede (cf 4.3.1.2(d)) are a human reality.

While the capacity of adults for self-directed learning should not be under- or estimated over, there is a need to bridge any gaps that may lie between dependency and self-directional activities. Such bridging is likely to be ineffective if placed within pre-structured processes as specified by the educator (Tennant, 1986:114-115) whose background is generally orientated toward the middle classes and Western health systems.

It should also be borne in mind that adults operate within self and culturally imposed limits and to this extent are trapped within their own history. They assimilate and integrate values, ideas and behaviours from others until they become so internalised that the concept of self is defined in these terms. As a result, people are comfortable with established practices. Therefore, it is difficult to conceive that they will or are able to shift paradigms if they are not helped to realize that there are alternative states of being (Brookfield, 1985:10; 1988:103).

In order to assist adults to learn in a manner enabling them to function as self-directed

learners, the following guidelines are presented within the context of the discourse thus far and contributions by PERRY ET AL. (1990:167) and MEZIROW (1984:137-138).

- * Learners should be assisted to define their learning needs in relation to their current problems and levels of understanding of the forces influencing their perception of their needs. In the cross cultural encounter, it is useful to change the focus of perceived realities *per se* and to focus instead on interactions between these realities (Webster, 1989:62). Such an approach makes provision for reciprocal corrections between the perceptual fields of educator and clients. In these terms "... education is viewed as a consumer oriented activity" (Ballantyne, 1989:6).

- * A self-corrective reflective approach to learning should be encouraged to correct misconceptions, integrate experience and to develop criteria against which the self and programmes can be monitored. During adulthood the individual comes to acquire a 'theoretical self-consciousness' that is capable of recognising paradigmatic assumptions within the thinking process. It is an intellectual competence which enables individuals to express and communicate a systematic justification for the felt necessities of their ideas and to theorise about alternative paradigms or sets of assumptions. This approach should significantly influence the group's selection of data and interpretation of evidence (Mezirow, 1981:11) within the framework of culturality as overarching ground structure of human existence (cf 3.2.1.11(a)).

- * Learners should be assisted to assume increasing responsibility for defining their learning objectives, planning the learning programmes and monitoring progress. Such activities include guiding learners towards optimal utilisation of learning resources including those of the educator and social support systems. "Programme implementation would follow in a manner most meaningful to participants" (Ballantyne, 1989:7).

- * Problem posing, problem solving and decision making are skills that should be fostered amongst learners. Related activities include the selection of learning activities that expand the range of available options, acknowledgement of alternative perspectives of understanding and an examination of problems associated with the implementation of proposed courses of action. Adults equate what they learn with their life experience and use these experiences in making decisions (Rossman, *et al.*, 1984:23).

- * Decision making abilities are enhanced by reinforcing the self-esteem of learners by providing opportunities for progressive mastery of skills and acquisition of insights. Action includes planning for change on the basis of manageable, specified, attainable stages, supportive feedback that encourages provisional efforts to change and take risks, avoidance of judgemental attitudes and appropriate use of supportive groups and agencies. With an increase in feelings of self-worth, come feelings of confidence and a readiness to engage in additional capacity building activities.

- * Inclusion of credible role models and appropriate choice of instructional methods, including strategies for experiential, participative and projective learning that are based on learning needs and anticipated learning outcomes, are fundamental requirements of any health education programme.

5.4.4 EDUCATIONAL TECHNIQUES

"Health education is an essentially practical activity rooted within educational practice" (French, 1990:9). The guidelines thus far should be viewed as integral to the actual practice of health education in full recognition that a dialectical and dynamic relationship exists between education and attitudinal and behavioural change.

Health education in the cross cultural context involves not only what is taught and how it is taught but the climate in which the encounter takes place. From the preceding discourse, it may be accepted that any educational technique must position the course content within the current concrete existential situation of the people concerned and reflect their aspirations. The problems posed, or elicited, should be of interest to the group and challenging to them. Ultimately any health education activity requires a response at the level of action and not only one at the intellectual level (Lovett, *et al.*, 1983:73).

If health education is to be successful, educators will need to be guided by principles founded on considerations of differences in the cultural orientation of educators and clients in respect of perceptual frames of reference (cf 4.3.1.2(a)), modes of communication (cf 4.3.1.2(c)),

modes of participation (cf 4.3.1.2(e)), Hofstede's theory of cognitive differentiation and associated role expectations (cf 4.3.1.2(d)) and cognitive and learning styles (cf 4.3.1.2(b)), as well as those individual differences such as intellectual abilities, physical attributes, personality, cultural and familial backgrounds, interests and values that make each person unique. The consequences of neglecting these differences are potentially destructive to the establishment of an educational milieu in which participative learning becomes possible.

At the same time, in order to fulfil the responsibility of guide to the adult learner in the self-empowering process of capacity building and meeting the demands of a challenging world in respect of improved health status, the health educator must observe all those factors described in Chapter Three which express the essence of human reality. Such an approach reflects an understanding of culture as overarching ground structure of human experience and the communalness of human experience as well as similarities and differences between people.

When seemingly intractable differences emerge concerning the appropriateness as to how educators and learners define the course content, learning approaches or potential solutions to problems, it is the responsibility of the health educator to make use of reflective pause to confront his own position in relation to cultural adaptation (cf 5.2.4). A cross cultural educational programme cannot be implemented successfully using traditional methods of teaching in which aspects of knowledge are transmitted, via a specific communication process, from a person who knows to one who does not know (Yebio, 1982: n.p). On the basis of findings presented in this research, health educators should:

- * Question the traditional Western, linear, compartmentalised, objective modes of presenting material;
- * Seek and experiment with strategies in which learners can participate actively in the learning experience and where material may be treated holistically within the contextual experiential framework of the learners themselves. In other words, incorporate more affective and experiential data into the learning experience, use a meaningful whole as starting point and break it down into its component parts in an attempt to guide learners toward responsible choice and self-directed learning;
- * Identify educational strategies whereby the decision making abilities, problem solving and participation skills of learners are developed. Inherent in this guideline is an acceptance of responsibility to prepare learners to make critical assessments and decisions, to modify and change information where necessary, to move from the concrete to the abstract and back and to anticipate problems in the face of an information explosion and an increasing acceleration of technological innovation and development. Such activities are directed toward the future. Learners, as intentional consciousness, are guided toward self-directed independence, self-assurance and an ability to choose responsibly and develop their human capabilities;
- * Develop a variety of educational techniques that take into account and are

relevant to the domains of human cognition and interest as developed by Habermas, (cf 2.4.1) in addition to taking into account differences in learning and teaching style, modes of communication and participation, person versus task orientation and active versus passive involvement. An andragogic encounter in which these guidelines are realised permits of co-existence and co-operation, experience of meaning, meaningful and dynamic participation and risk taking which, in turn, is conducive to enthusiasm and interest, and the formation of meaningful relationships; and

- * Create an emotionally nurturant environment in which all members of the group are involved in mutual inquiry, feel accepted, supported and respected and one in which the educator's expression of trust, self trust and openness engenders reciprocal responses in learners (Rossman, *et al.*, 1984:36-38).

Evaluation as a systematic means of determining the degree to which educational goals and objectives are realised by learners (Gronlund, 1985:5, 18) is an integral part of health education programmes and provides answers regarding the validity of a large number of educational decisions. Radical change in teaching strategies must of necessity be accompanied by major change in evaluation strategy. In addition to the general guideline of identification, selection and implementation of viable and reliable evaluation techniques to each phase of any health education programme, the health educator should:

- * Recognise that evaluation is an integral part of participative and self-directed

learning; and

- * Provide opportunities for ongoing reciprocal feedback between educator and learners to foster interest, maintain motivation and assess the outcome of any designated course of action on an ongoing basis.

It has become evident that the complex diversity of learners in cross cultural milieus necessitates a greater flexibility in educational approaches by health educators. They need to recognise that the way in which health education is structured provides the potential path through which learning may take place. However, it is the reality of existing social and psychological factors that is likely to determine the fate of the learning experience (Bandura, 1986:152).

Because the education process closely parallels the communication process, effective education depends, in part, on interpersonal communication (Potter and Perry, 1993:353).

5.4.5 COMMUNICATION

While it is a self-evident truth that improved communication occurs if the educator is proficient in the language of the group, it must be borne in mind that communication remains a human interaction rather than a language process (Westwood and Borgen, 1988:116-117).

The most significant variables in successful health education outcomes remain the educators: their levels of cultural sensitivity, attitudes, understanding of the environment of the clientele,

insight into role related behaviour patterns, quality of education and facilitation skills, professional ethos and their ability to be supportive and respectful and to offer constant assurance that individuals and communities are capable of making responsible choices and developing capacities to control those areas of their lives which affect their health status.

The list of communication competencies about which educators should be aware can be overwhelming (Hurt, 1984:161) and are to be found in standard health education literature. Therefore, these points will not be covered in this study. The guidelines which follow should not be viewed as a different process from cross cultural competency, are by no means exhaustive and represent only a few of the findings emerging from the relatively new discipline of intercultural communication.

According to ERICKSON (1986:122), cultural difference in communication style may be of more significance than cognitive style differences in education. Language comprises not only vocabulary, rules of grammar and a sound system, but also appropriate facial and body gestures, the use of varying levels of formality in appropriate contexts, correct styles of conversation and an ability to express abstract concepts (Ovando, 1989:224). The common assumption that once individuals have acquired a basic competence in a language, they have learned it, fails to recognise that members of subordinate classes, cultural and ethnic groups frequently signal solidarity with their group by selective in-group language, vocabulary, dialect or accent (Gallois, *et al.*, 1988:165). A further dimension is added when the cognitive complexity of the task, or the amount of information which must be processed and related to the previous knowledge and experience of the individual, is considered (Kerr and Desforges,

1988:39). Furthermore, each language does not necessarily possess the reciprocal word for the translation of every concept (Gollnick and Chinn, 1986:142) and where language acquisition in the mother tongue has already occurred, there is the additional tendency to transfer meanings and patterns from the first into the second language which is frequently inappropriate (Kerr and Desforjes, 1988:43).

The health educator generally comes to the cross cultural encounter as the stranger: the person who has to adapt and manage the dynamics of a group characterised by communality and diversity. In this regard, KREITLER AND KREITLER (1988:740) suggest that the dynamics of intercultural communication are not radically different from those of intracultural communication. They have found that major and dominant meaning values are tied up with meanings across most cultures, hereby implying the existence of a cross culturally shared framework of meanings referred to as 'semantic universals'. The findings are underpinned by the theory of value orientation (Gudykunst and Kim, 1984:42) that people of all cultures must find solutions to a limited number of common human problems, that available solutions are not unlimited but vary within a range of potential solutions and that, while one solution may be preferred by members of a given culture, all the potential solutions will be found across all cultures. The point of view is further endorsed in respect of the theory of limited options presented under section 2.2.2.2. KREITLER AND KREITLER (1988:740) point to the fact that it is the (submerged or) 'subsidiary meaning values' which create problems because of their unexpected and insidious impact and state that these are at their most potent when communicators are misled through the sharing of 'dominant meaning values'.

A communication theory linking closely with Hofstede's theory of cultural differentiation (cf 4.3.1.2(d)) is that of uncertainty reduction. The notion rests on the fact that lack of security constitutes the psychological end result of being in a new situation. Attempts to adapt to ambiguities and uncertainties may manifest in anxiety in which cyclical patterns of tension-reducing and information seeking behaviours emerge. Uncertainty and anxiety, as independent dimensions of intergroup communication, are not only affected by the socio-cultural context of the interchange but by the personalities of the educators themselves (Gudykunst, 1988:126).

CHEN (1990:248-258) presents a comprehensive overview of characteristics operating within the educator that contribute toward effective cross cultural communication. These characteristics reflect findings expressed in CHAFFEE (in: Gudykunst and Kim, 1984:196-197); GALLOIS, ET AL. (1988:162); GUDYKUNST (1988:136-137) AND WESTWOOD AND BORGEN (1988:122). The following attributes contribute towards more effective cross cultural communication:

- * Educators with a positive self concept are more likely to feel positively toward members of out-groups than those with a low self-esteem. In the uncertainty reduction process, people with a high self-esteem tend to display a greater willingness to openly and appropriately reveal information about themselves in an act of self-disclosure.

- * Ongoing introspection, characterised by self-monitoring skills, in respect of

appropriateness of presentation and sensitivity to social cues enable the educator to tailor his expressive behaviour to a particular situation.

- * Communication skills that not only address factors such as fluency in the host language and congruency between verbal and non-verbal behaviour, but include the educator's interpretive competency or understanding of the significance of message skills are vital components of communication. Message skills include the ability to use descriptive and supportive messages during the interaction. The former have reference to the use of specific and concrete feedback and an acceptance and tolerance of difference, while the latter is associated with affiliative behaviour or communication cues such as eye contact, head nods, facial expression, physical proximity, choice of speech in respect of complexity, pace, pitch and familiarity.

- * Behavioural flexibility or the ability to select appropriate behaviour in various situations and contexts and the complexity of the cognitive systems of educators are negatively associated with perceived uncertainty. Educators with higher behavioural flexibility and more complex cognitive systems demonstrate more accurate perceptions in the midst of difference and display tolerance of ambiguity and adaptability in attending to information. Consequently, they are able to carry out different strategies to realise the goals of communication and education.

- * Interaction management and interaction involvement are two further components of effective communication. Interaction management deals with the ability to handle procedures for structuring and maintaining the interaction including the provision of opportunities for all participants to contribute toward the discussion. Other features include permitting only one speaker at a time, full focus of attention on the speaker and intolerance of interruptions. Interaction involvement has reference to the degree to which individuals perceive the situation as involving their conceptualisation of self and perceived incentives. It encompasses the educator's empathic orientated abilities, affective displays, verbal responses indicating understanding and a capacity for active listening. Criteria of responsiveness, perceptiveness and attentiveness are of relevance.

- * Educators possessing social skills such as empathy (cf 5.3.2.6) and identity maintenance display higher levels of intercultural competency than those without these abilities. Identity maintenance has reference to the degree to which educators not only understand themselves in the interaction, but permit the participants to know who they are as an act of acceptance, respect and understanding.

- * Effective communicators use a 'third culture' perspective that functions as a psychological link between their cultural perspective and that of others. They

have an ability to adapt psychologically to a new culture (cf 5.2.4) which is linked to their potential for coping with stress, frustration, ambiguity and alienation. Further characteristics include open-mindedness toward new ideas and experiences, accurate perceptions of similarities and differences between their own and other cultures, a tendency toward describing what is not understood rather than evaluating it as bad or meaningless and relatively astute non-critical observations of their own behaviour and that of others.

Training in communication competence can develop effective communication skills and create opportunities for educators to develop the personality characteristics which should enhance the success of health education in cross cultural encounters.

Guidelines for any form of andragogical practice that rest on an affective and experiential foundation must be tempered with ethical considerations in order to ensure that programmes are developed to realise the aims of health education and not for any other purpose.

5.4.6 ETHICS IN HEALTH EDUCATION PRACTICE

Ethical theory has reference to the

"... activity of articulating and defending theories of the ultimate grounds on which moral judgements are made or should be based" (Haydon, 1986:97).

Ethical issues are built into educational theory in order to ensure that decisions and activities

are justified. Normative ethics focus on concrete issues to address difficult questions of conduct and practice. Ethics act as a guide to practitioners wrestling with difficult questions. Ethics have to do with what ought to be done and not what is done (Hiller, 1987:91). Ethics, in this context, focuses on the role of the health educator.

5.4.6.1 Ethical Universals

RYDER AND CAMPBELL (1988:13) endorse the notion of ethical universals such as keeping promises, refraining from harm, enabling people to recognise moral choices and their own criteria for deciding them. To these may be added criteria extrapolated from section 3.2 such as integrity, credibility, professional expertise and accountability. There is an ongoing need for health educators to evaluate the degree to which they comply with these criteria.

5.4.6.2 Ethical Theory

An understanding and application of fundamental ethical principles and theories to complex problems provides a strategy and the means to promote professional responsibility and increase individual capacity for making reasoned judgements (Hiller, 1984:101)

Health educators must recognise that each decision carries implications for others. Questions arise concerning how far intervention in changing life-style is justified, to what extent conflicting priorities can be balanced, how personal values can be reconciled with or influence

those of other groups, to what extent should people be free to choose if their action is damaging to their own health or others, in whose interest is the dialogue operating to name but a few (Hiller, 1987:88, 101; Lupton, 1994:55; Hubley, 1993:16)?

Health educators should develop analytical skills and recognise value laden issues. They must understand major ethical theories and apply them to the problems they confront in a coherent and consistent manner. They need to appraise their immediate responses to a situation and be in a position to be challenged and defend chosen actions and their potential or actual consequences on ethical grounds. As an act of ethical responsibility, personal and professional conduct should be ethical and freedom for clients to make moral choices should always be ensured (Hiller, 1987:101).

In the cross cultural encounter, ethical issues may be characterised by resistance, disagreement and ambiguity. Practitioners need to be able to engage in ethical discourse with those holding opposing views. Honesty, reason and tolerance are required and a recognition that ethical conflict is not always resolved by reaching a single conclusion (Hiller, 1987:101-102).

The suggested guidelines for educational practice cannot be realised by educators in isolation. In addition to in-service training, a need for cross cultural research and resource centres becomes apparent.

5.4.7 RESEARCH AND RESOURCE CENTRES

In the face of the rapid change which is taking place in South Africa's health system and the additional demands which are placed on health professionals in respect of health education, there exists a need for the formulation of educational strategies providing the criteria for and means of cross cultural health education. In the opinion of the researcher, this can only be achieved by:

- * Involvement and co-operation, on national and international level, in action, philosophical and participative research concerning the reality of cross cultural health education today;
- * The development of cross cultural health education programmes that translate insights into the phenomenon into effective practice;
- * Development of resource centres from which information and appropriate audio- and printed material can be disseminated, through which seminars and conferences can be co-ordinated and a listing of resource people, research findings and resource facilities be made available (Morrison, 1981:187-188).
- * Research into the much neglected area pertaining to ethical issues inherent in the interaction between educators and clients in cross cultural encounters.

5.4.8 RÉSUMÉ

The researcher has endeavoured to judge the validity and describe the andragogical-ontological acceptability of the theory and practice of health education, on the basis of which guidelines for authentic education in cross cultural health education encounters have been formulated. In microcosm, the proposals are believed to be in accord with attempts to give consideration to human life and reality that is and as an aspect of futurity. The guidelines link up with, and begin from, an attempt to do justice to learners and educators in the particularity of their situatedness, taking into account that educators are not socially, emotionally, connotatively or cognitively uninvolved participants in attempts to realise the goals of health education, any more than are their clients.

In the attempt to create a firm and relevant basis for the practice of successful health education in cross cultural settings, the researcher has deviated from reiterating guidelines relating to procedural activities and technical mechanistic skills. Instead, answers have been sought in human activities and relationships that enable people to translate knowledge into practice that is relevant to everyday life and to support them in exploring and making choices that can contribute towards improved levels of health. Co-existential involvement holds the key to avoiding academic, one-sided ethnocentric approaches toward problems and the associated tendency of victim-blaming.

It has been concluded that successful health education outcomes are grounded in the experiential life world of educators and learners alike. Health educators, however, are

the pivotal force in cross cultural encounters. Their personality traits, interpersonal relationships, intra- and intercultural communication skills play a role in determining the results of the educational occurrence as does their commitment to empowering people to gain a measure of control over their lives. Further factors include their compliance with the agogical criteria derived from the andragogical ground structures of human existence and an acknowledgement that competency in cross cultural health education can be realised through ongoing education and a preparedness to take risks based on andragogically responsible choices.

While emphasis has been placed on critical reflection, perspective transformation and participatory learning as mutually reinforcing functions of consciousness raising and capacity building on the part of both educator and clients, there has been no intention of suggesting a *laissez-faire* attitude toward education or that the agogic relationship is not one of equality in inequality in respect of health and andragogical expertise. The moment educators begin any dialogue, they know a great deal in terms of their expertise and what they wish to do with it in order to realise certain objectives. Mutual inquiry and critical reflection makes for a more vigorous understanding of reality (Shor and Freire, 1987:17-20). At the same time, the educator cannot but give certain leads, make available certain facts and encourage certain perceptions which give direction to decision making with no guarantee that social conditions will be changed (Tones and Tilford, 1994:21).

A careful reflection of the suggested guidelines reveals that they are not exclusive to health education in cross cultural encounters, but are universally valid for all educative and many

communication occurrences. This observation poses both a question and a warning. Does this mean that multi- or cross cultural education is merely another theory to become absolutised or serve as a basis for research, a platform for rhetoric or a vehicle for the attainment of societal as opposed to educational goals? The author is of the opinion that health education in multi- or cross cultural situations should not become an issue, but rather an ethic out of which certain kinds of decisions about education may flow (Lynch, 1983:19), at which point the guidelines return full circle to the responsibility of the organisation in determining health education policy.

5.5 CONCLUSION

At the onset of this study, it was the intention of the author to examine the major cultural factors affecting every aspect of health education in cross cultural encounters with a view to offering specific guidelines that could be readily and universally applied to the South African situation.

By means of formal analysis and radical reflection based on the phenomenological method, it became clear that this intent was rooted in the Western medical tendency (cf 2.2.2.1) toward standardisation, specialisation and the creation of scientifically validated routines for professional practice. Initially, the approach paid dividends in respect of an analysis and assessment of the intimate connection between health, education, communication and culture in historical time. Intimacy in the sense that a health education system is at once an expression of culture, as well as a means of reinforcement, transmission of and induction

into a way of life (Charlesworth, *in*: Palmer, 1986:1) with the world view of the dominant culture prevailing in official health and education systems.

An awareness developed that the theories and models on which health education practice rest emerged from the cumulative insights, field of interest, subject speciality and perceptual framework of the designers of the respective strategies as they collated and applied selected data extrapolated from a variety of disciplines. While clearly delineated tenets relating to health education practice provide professionals with a sense of confidence and emotional security, consequences of this approach include a disregard for variations falling outside designated frameworks for action, codification and ritualisation of existing norms, expectations and established educational techniques as well as an exclusion of the subjective feelings of educators and learners alike. The stage is hereby set for closedness in the sense of a conceptualisation of culture as a tightly structured, unitary and immutable system as opposed to openness in the light of cultures being more open to diversity and change than is frequently believed and openness in the sense of attribution of new meanings to a human world in which educators and learners are existent in normativity. Openness as an aspect of intentionality and freedom in responsibility to make choices regarding the world by which man is encountered may also be ignored. It also became apparent that artificial barriers and limitations have been created in respect of learning opportunities for educators and learners to transcend the circumstances of their lives in co-existence with others, because theories and models, by their very nature, tend to be exclusive rather than inclusive.

Gradually, in response to further radical reflection concerning conflicting and, sometimes,

damaging reports concerning the success rates of health education programmes, it became evident that a gap exists between the habitual tasks undertaken by health educators and the everyday experiences of all people. Educational tasks generally focus more specifically on analyses of the circumstances of people's lives, needs assessments, planning of projects and choices regarding educational materials, strategies and evaluation techniques within the framework of the designated theoretical model and not on that which is personally relevant and meaningful to individuals.

If it is accepted that education is "... the art of guiding learning..." (Dewey, in: Barer-Stein, 1987(b):26), it may be deduced that educators need to

- * develop an understanding of the unspoken value assumptions behind issues and topics and the taken for granted communication patterns inherent in cross cultural encounters (adapted from Rash, 1988:212), and
- * become involved in the reality of experiencing the unfamiliar in a manner that permits of integration into and adaptation to a new situation: integration and adaptation as an aspect of a refinement of awareness so that educational choices increasingly reflect the situation of the moment (Rash, 1988:217-218).

The conceptualisations of understanding and involvement are not presented in the sense of overlooking difference for the sake of conformity but in the sense of uncovering shared meaning as starting point in the search for personally meaningful solutions to problems

experienced during the course of daily life. In an attempt to find a balance between the differences in and between groups and the similarities in and between individuals it should be acknowledged that "... 'facts' and 'rightness' are filtered through people's cultural biases ..." (Rash, 1988:221). Therefore, there can be no single solution to any problem and no one way to think or act in cross cultural situations. What is required is a sensitivity toward culturally appropriate ways of behaviour which rests on foundations of shared experiential meaning and humanness. Under these circumstances the possibility of authentic dialogue becomes a reality: dialogue in which all participants are free to engage in an active exploration of ideas and practices that offer meaningful solutions to problems concerning health.

The guidelines for health education practice in cross cultural encounters, as presented, are an attempt by the author to offer solutions to the gap that exists between the factual procedural aspects of education and the human experience of learning. The guidelines embody the notion that the role of the health educator in the cross cultural encounter is one of facilitating meaningful, appropriate and informed choices on the part of learners in a situation where opportunities exist for an ongoing realisation of potential for all involved in the encounter.

The guidelines do not offer the possibility of a 'quick fix' or a course of action in which success is guaranteed through upholding dogma and ritual or following a set course of action. Any act of learning requires active involvement and sustained cognitive, affective, conative, social and physical effort, in varying combinations and degrees, on a continuous basis.

Success in health education is no exception to the rule. The successful health educator expends considerable energy and ongoing motivation in exploring the unfamiliar, in displaying a willingness to take risks, to be flexible and open to change in addition to showing

"... a more intensified hearing, a more open listening, a broader display of possibilities within reflecting, and a more vigilant and conscious heeding ..."
(Barer-Stein, 1987(b):47).

The proposed guidelines embody an affirmation that man, as creator, is able to transform circumstances into opportunities, so that he can take an active part in promoting societal and personal welfare (Du Plooy and Kilian, 1990:58) without denying individuals or groups their freedom of choice. Awareness of social change, the concept of a common cultural core and multiculturalism as universal normal human experience, has the potential to lead health education in cross cultural milieus away from divisive dichotomies, toward a greater appreciation of the range of cultural competencies open to all men (Gibson, 1984:113) and the means whereby successful learning outcomes may be achieved.

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