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Philosophical Perspectives on Improving Chronic Disease Self-Management: Implications for Healthcare Practice in Africa

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Abstract

Periodic global surveys over the decades indicate consistent rise of chronic ailments. Chronic diseases are often viewed as a problem of the Western world. However, health research reveals that low- and middle-income societies, such as Africa, are not immune to the onslaught of deaths from these diseases. Chronic diseases are not curable, but they can be managed. While some are hereditary, most are acquired and intensified by lifestyle preferences and the environment. Hence, healthcare researchers have identified lifestyle modification as being key to stemming the tide of chronic diseases. This culminated in the philosophy of chronic disease self-management (CDSM), wherein patients and their family assume responsibility for managing the ailment, through the sustenance of healthy lifestyle and with minimal supervision of the healthcare professional. In two decades of adopting this approach in the West, research has reported the effectiveness due to its positive outcomes. Still, it is largely unpopular in Africa. Using the method of critical exposition, this paper argues that, owing to her communal way of life, Africa has a natural blueprint for successful adaptation of self-management protocol to local hospitals involved in chronic disease treatment. We explore the theoretical underpinnings of CDSM in the philosophical works of Maurice Merleau-Ponty and Sally Gadow, and determine that the core elements underlying chronic disease management are embodiment, respect, relationship, and dialectical engagement. These elements are vital in the interactions of healthcare professionals and patients, and are, therefore, central in the contextualisation of self-management support to Africa. Data for this study came from library and archival materials.

Keywords: African Communalism; Chronic Disease Self-management; Healthcare; Nursing Ethics; Philosophy; Relational Narrative

1. Introduction

Globally, the prevalence of chronic diseases is increasing (World Health Organization [WHO] 2014). Annually, chronic disease accounts for 41 million deaths with 15 million of these deaths occurring in people between the age group of 30 and 69 years (WHO 2018). A disturbing trend is that while it is widely believed that chronic disease is a problem of the Western world, an astounding number of deaths from these diseases also occurs in low and middle-income countries (LMICs), such as African countries. For example, deaths from ischaemic heart disease alone rose from about 1 million to 3.1 million in lower-middle-income countries between 2000 and 2020 (WHO 2020), indicating that Africa is not immune to the onslaught of chronic ailments. The mortality from chronic diseases is projected to rise globally and reach a value of about 52 million by 2030 if not controlled (Mathers and Loncar 2006). Chronic diseases affect all dimensions of human life and constitute a massive economic burden at both the individual and national levels. The economic impact of chronic diseases is the result of its dramatic effects on productivity, quality of life and associated high cost of treatments (Bloom et al. 2011). In addressing the challenges of chronic diseases, global strategies have focused on disease prevention and control (WHO 2013, 2014).

This paper focuses on the contextualisation of chronic disease management in Africa, a continent in which governments have primarily concentrated their efforts on prevention. Also, efforts toward effective management of chronic diseases in the region have failed due to poverty, deficit of healthcare professionals, lack of medical equipment and supplies and healthcare systems that are oriented to acute care (van Olmen *et. al.*, 2012; Maimela et al. 2015; Angwenyi et al. 2018). Another inherent clinical problem reported in Africa is non-compliance with medication and lifestyle modification recommendations among individuals with chronic diseases. The underlying cause of non-compliance is also linked to poverty, feeling of hopelessness, cultural expectations and family food preference (Dube *et. al.*, 2017). Ethical issues that arise from the inequitable distribution of the effects of chronic diseases necessitate the need to ask the fundamental question: what can be done to improve chronic disease care outcomes in Africa amidst the inherent economic challenges?

The universal paradigm for chronic disease management is oriented towards focusing on the patients. Based on this orientation, 'self-management support' has emerged as a promising approach in which individuals with chronic diseases are supported by the healthcare professionals to learn and assume responsibility for managing their health (Trappenburg et al. 2013; Grady and Gough 2018). Self-management support (SMS) is an element of the chronic care model. Chronic care model is an evidence-based guideline that seeks to improve quality and clinical outcomes of chronic disease management by concentrating on health system changes that have an impact on the patient, and on provider-related factors (Wagner et al. 2001; Barr et al., 2003; Grady and Gough 2018). The focus of SMS as conceptualised within the chronic care model is the empowerment of patients by healthcare professionals through interventions that extend beyond the didactic health education and counselling (Wagner et al. 2001). Thus, the main purpose is to equip patients with the physical, cognitive and emotional skills needed to assume responsibility for managing their diseases and health. The relationship between the patients and the healthcare professionals is such that it recognises and respects the patient as an agency capable of making decisions (Lawn, McMillan, and Pulvirenti 2011).

The success of SMS program is dependent on patients, as they are expected to perform 80 to 90 percent of the required care (Dube et al. 2017). Philosophically, humans are complex beings with multiple realities – the body and mind interact in a non-linear way (with the environment) to bring about change in behaviour (Mol and Law 2002). These realities shape the 'will' of an individual, that is, the capability of the individual for conscious choice, decision and intention. Likewise, the management of chronic disease is challenging and complex. These complexities, if not understood by healthcare professionals, could negatively affect the outcome of the SMS program. In this paper, we explore the benefits of the SMS program for Africa, using Maurice Merleau-Ponty philosophy (1945/2012). In particular, we determine how his phenomenology of perception can be applied to

facilitate the understanding and management of the complexities of patients with chronic diseases, and to promote behaviour change. Ethics plays a fundamental role in the relationship between patients and healthcare professionals. In this light, Sally Gadow's (1999) work on ethical narratives is reviewed. Then, using the insights of both philosophers, we describe SMS strategies that align with cultural traditions in Africa.

2. Self-management: History, Definition and Requirements

Historically, the concept of 'self-management' was coined by Thomas Creer in his book on the rehabilitation of chronically ill children with asthma in 1976. Based on the influence of Bandura's Self-Efficacy Theory, Creer observed that patients need to become active participants in their care, and collaborate with the healthcare professionals in order to reduce the impact of the chronic diseases on their health and wellbeing (Creer 2000; Lorig and Holman 2003; Novak, Costantini, Schneider, and Beanlands 2013). Other contributors to the development of the concept of self-management include Corbin and Strauss in 1988, and Lorig and his colleagues in the USA.

Self-management has been conceptualised and defined in a variety of ways in the ensuing literature. In line with the ecological dimension of health and illness behaviour, we adopt the definition by Richard and Shea (2011), because it furnishes a holistic perspective that integrates both the process and context necessary for successful management of chronic diseases. In this conception, self-management is defined as "the ability of the individual, in conjunction with the family, community, and healthcare professionals to manage symptoms, treatments, lifestyle changes, and psychosocial, cultural, and spiritual consequences of health conditions (particularly chronic disease)" (Richard and Shea 2011, 261). The idea that underpins this definition is the range of behaviours or strategies that the patient, supported by their family and community, may adopt to effectively manage the chronic condition (Auduly, Asplund and Norbergh 2012).

Self-management operates on a philosophy that shifts the responsibility of care to the patients (Barr *et al.* 2003). Within this paradigm, patients become active participants in the care process by performing specific self-management tasks oriented towards promoting their overall health status and quality of life. The self-management tasks identified by Corbin and Strauss (1988) include medical management, life role and emotional management. The medical management involves monitoring physical indicators; dealing with symptoms and disability; managing complex medication regimens; maintaining adequate levels of nutrition and exercise (Grady and Gough 2018). Life role involves adjusting lifestyle pattern and developing new meaningful behaviour to suit the psychosocial demands of managing chronic conditions. The third task, emotional management, involves learning and managing related emotional challenges and symptoms associated with living with chronic diseases (Lorig and Holman 2003).

The successful performance of these expected self-management tasks also requires that patients develop five behavioural self-management skills, which include problem-solving, decision making, resource utilisation, forming patient/healthcare provider partnership and taking action (Lorig and Holman 2003). The problem-solving involves actions taken to provide solutions to identified health problems. The skill of problem-solving requires a cognitive process that includes: problem definition, identification of possible solutions, implementation of identified solutions and evaluation of outcome. Decision making is an aspect of problem-solving that is informed by the individuals' understanding of the disease process and underlying treatment options. Resource utilisation is a skill that delineates the ability to find and make use of available support services or information within the community (Novak *et al.* 2013). The patient/healthcare provider partnership is necessary to enhance the collaboration pertinent to making informed treatment choices. The fifth self-management skill – taking action – involves the patient implementing the action plan made in partnership with the healthcare provider. This skill requires the patient to have confidence and belief in their ability to execute the action plan (Lorig and Holman 2003).

Central to the above self-management tasks and skills is the patients' ability and willingness to take responsibility for their health and wellbeing (Glasgow, Jeon, Kraus and Pearce-Brown 2008). Also, the healthcare professionals play a significant role by supporting the patients to achieve health goals through a complementary process that involves self-management education and support (Thille, Ward and Russell 2014). In this role, the healthcare providers function as partners, teachers, and professional supervisors to the patient through the process of knowledge dissemination, skill development and self-care efficacy (Lorig and Holman 2003).

3. Self-management Support

Having given a brief overview of SMS in the introductory section of this paper, it is crucial that we further expound on the processes underpinning the conceptualisation and outcomes of SMS. The SMS is a systematic process through which healthcare professionals provide education and other supportive interventions to increase patients' skills and confidence in managing their health problems (Institute of Medicine 2003). Technically, SMS refers to the resources and behavioural strategies used by clinicians to assist patients and families in achieving independence in the management of their health conditions (McGowan 2012). As an intervention, it comprises techniques, tools, and programs to help patients choose and maintain healthy behaviours. In the literature, SMS is used interchangeably with patient education; however, a clear difference exists between the two (Lorig and Holman 2003; McGowan 2012).

Patient education is an integral part of SMS and involves the healthcare professionals providing information and teaching the patients specific disease-related skills. For instance, in diabetes management, patient education could be tailored towards helping the patients to gain knowledge of the disease process and learn specific diabetes skills such as blood glucose monitoring and medication administration. The underlying theory in patient education assumes that disease-specific knowledge and patient's compliance with healthcare professional recommendations are necessary for behaviour change (Lorig and Holman 2003; McGowan 2012). However, evidence from literature has shown that education alone is often not effective in initiating and sustaining behaviour change (Volpp and Wohta 2018). Also, interventions that focus on improving compliance rather than empowering the patients to adopt self-management knowledge and skills to their specific context are often not successful (Lorig and Holman 2003). Hence, the philosophical and practical shift to an approach that enhances the provision of a contextualised support to patients has warranted the concept of SMS (Kawi 2012).

The SMS is patient-centred and focuses on teaching more generalisable skills that the patients can use to manage their health conditions (Kawi, 2012; Lorig and Holman 2003; McGowan 2012). This SMS adapts to the patient's context by facilitating the opportunity in which the patient directs the intervention pathway through their specific, identified problems. Based on its theoretical underpinnings, SMS aims at improving patients' self-efficacy. This is because an increase in the level of patients' confidence in making an ongoing personal adjustment to the demands of their illness yields better clinical outcomes (Lorig and Holman 2003; McGowan 2012). SMS involves using collaborative goal setting and a variety of self-efficacy strategies, including problem solving, self-monitoring, relapse prevention plans, patient education, group support and shared decision making (Johnston, Liddy, Ives and Soto 2008).

Finally, self-care and self-support do not happen in a vacuum, but within the context of persons and influences. Within that framework, family and community have been emphatically identified as playing some critical roles in producing positive outcome in chronic disease self-management. According to Grady and Gough (2018, 432):

Family is an important source of support for people with chronic conditions. Individuals with higher levels of family support have greater adherence to self-management and

better control over their conditions. This is particularly important in long-term self-management where family emphasis on self-reliance and personal achievement, family cohesion, and attentive responses to symptoms have been associated with better patient outcomes.

Families live in closest proximity to patients and their routines. So, they are uniquely qualified and positioned to be effective supporters to their chronically ill member(s). They take a natural active role in the process by providing the daily setting for self-management (Rosland and Piette 2010). Typically, this has brought about better self-management experience and outcomes (Peñarrieta *et al.* 2015). Specific roles played by different family members include providing motivation, financial assistance, and daily living assistance, such as cleaning, washing and ironing clothes, buying medicine, preparing healthy meals, and ensuring that the food and medication are appropriately taken (Siregar *et al.* 2021). Self-care is not always a burden; it can also involve 'healthy people [preventing] illness, rather than merely managing existing illness' (Grady and Gough 2018, 431).

4. Empirical evidence on self-management support

There is increasing evidence for the clinical significance of the chronic disease self-management program (McGowan 2012; Grady and Gough 2018). The establishment of SMS improves health behaviours, self-care skills and knowledge (Trappenburg *et al.* 2013; Grady and Gough 2018). Successful SMS is associated with improved clinical outcomes, increased quality of life and reduced feeling of depression (McGillion *et al.* 2008; Trappenburg *et al.* 2013; Ko, Bratzkeand Roberts 2018). Also, SMS helps to reduce the rate of hospital admission, length of hospitalisation and healthcare cost, especially where resources are scarce (Packer *et al.* 2012; Grady and Gough 2018; Ko, Bratzkeand Roberts 2018). Despite the positive results of SMS interventions, many patients are still unable to control their chronic condition due to the disparity in healthcare practices, lack of professional knowledge and skill in the management of chronic diseases, and negative attitude of the patients (McGowan 2012). Considering the above, one wonders why the disparity in the effect of SMS intervention among patients. Do nurses have a role in self-management? Moreover, how can the nurse-patient relationship be structured to improve chronic disease self-management? Aside from the patient health education program commonly used in many African countries, whose underpinning philosophy does not support long-term behaviour change, evidence on other SMS strategies for chronic disease management is limited (Angwenyi *et al.* 2018; Iregbu and Iregbu 2016).

5. Maurice Merleau-Ponty's Philosophy in CDSM Context

In *Phenomenology of Perception* (1945/2012), Merleau-Ponty traces out an existential phenomenology focusing on bodily perceptions. He projects the cardinal elements of human experience as including perception, intentionality, embodiment, relationship with others, time, morality, engagement and interdependent environment. For Merleau-Ponty, the body is not just a biological or physical unit; it is the starting point of all perceptual phenomena and experience because it structures our situation and experience within the world. The following are the four critical elements in Merleau-Ponty's approach relevant to chronic disease self-management:

5.1 Perception

According to Merleau-Ponty, the perception of a situation is shaped by bodily experience, which is a product of one's environment and culture. Perception guides every conscious human action through a process of interpreting reality. As such, all knowledge occurs within the horizons opened up by perception, and all meaning occurs through perception (Thomas 2005). Thus, to achieve specific self-management action plan, the nurse needs to invite the patients to describe the perceived meaning of the co-created self-management action plan, why the action is necessary, how their

context could affect the implementation of the action plan and how they would like to be supported by the healthcare team. Given this ontological dimension, patients are more likely to appreciate the significance of the self-management action plan, which in turn helps the patients to integrate the agreed action plan into their daily schedule.

5.2 Intentionality

For Merleau-Ponty, based on the experiential knowledge gained by withdrawing from an empirical understanding of the world, individuals develop the capacity to link their intents with their lived experiences in interpreting their contextual realities (Landes 2012). In relation to the management of chronic conditions, understanding the meaning of patients' experiences requires the description of the intentional stance of the event from the perspective of the experiencing person (Thomas 2005). Within this mutual engagement, the nurse assesses the patient's intents for behaviour change. Intentionality bears on the individual's consciousness of the reality of the nature of the chronic disease and the need to take action. This helps the nurse to determine the patient's readiness for behaviour change, which further serves as a guide for the nurse in developing a personalised care plan and utilising the appropriate SMS strategies (Goldstein, Whitlock and DePue 2004).

5.3 Embodiment

The notion of embodiment relates to the importance of the body in learning. It affords patients the ability to take action oriented towards behaviour change. The knowledge of the body enables the patients to react to the demands of chronic disease management in ways that do not require purposive thought. Through embodiment, patients learn to cope with chronic disease by listening to their body cues. Also, for SMS intervention to be successful, the healthcare professionals must draw their intentionality to the relationality within the temporal dimensions of patients' lived experiences of being with and managing chronic diseases. Ontologically, the healthcare professionals consciously immerse themselves in the patient's subjective realities and seek to align their embodied experiences with that of the patient. This allows the establishment of unity among their subjective experiences (Landes 2012), which further helps to tailor the SMS to the specific needs of the patient.

5.4 Relationship with other people

Merleau-Ponty views human beings as a 'network of relations' or a 'knot of relations'. By this, he means that relationship with others is an essential element in people's lived experience and perception of phenomena in the environment. At the heart of this network of relations is dialogue, through which a person receives recognition and affirmation. Unlike other existential philosophers who see the relation with others as an impediment in the pursuit of an authentic being, Merleau-Ponty views others as fellow travellers of the perceiving agent in life's journey (Thomas 2005, 71). In a nutshell, Merleau-Ponty believes in the intersections of the experiences of individual human beings with those of others. He avers that '... the intersection of my experiences [past and present] with those of others engage each other like gears' (cited in Landes 2012, lxxxiv). Fundamental to the interpersonal connection involved in chronic disease management is dialogue, which helps to create the pathway for the exchange of ideas. Dialogue, according to Merleau-Ponty (1945/2012, 370) provides a common ground for decision making:

In the experience of dialogue, a common ground is constituted between me and another; my thought and his form a single fabric... Here, there is a being-shared-by-two, and the other person is no longer for me a simple behaviour in my transcendental field, nor for that matter am I a simple behaviour in his. We are, for each other, collaborators in perfect reciprocity: our perspectives slip into each other, we coexist through a single world.

The core of this dialogue is mutual respect and openness to others. The prescribed characteristics presented above are very relevant for the delivery of quality self-management interventions regardless of the clinical settings. Nurses and other healthcare professionals need to respect patients' beliefs and perspectives on illness through the establishment of therapeutic communication (Lorig and Holman 2003). The relationship between the professional and the patient should be such that it encourages the patient to freely participate in decision-making.

6. Sally Gadow's Relational Narrative and CDSM

Merleau-Ponty's phenomenology enables one to appreciate the significance of relational network in the achievement of health goals. But the relationship between nurse and patient is also informed by certain ethical principles and guidelines, as underscored by Sally Gadow (1999), whose philosophy of relational ethics provides the ethical cornerstone or dialectical framework for understanding the relational process in a healthcare setting. In her approach, Gadow identifies three layers of nursing ethics that have been in operation in the history of the practice. The first is *subjective immersion* (ethical immediacy), which corresponds to pre-modern ethics and refers to where the nurse engages the patients purely on the basis of experiential knowledge of chronic disease management. The nurse, thus, discerns the appropriate solution to the patient's problem by resorting to the patient's cultural beliefs and the ethics of the nursing profession (Gadow 1996; 1999). According to Gadow (1999), the immediacy of the nurse's response to the patients' condition is possible only if the nurse is fully immersed in the practice that promotes ethical appraisal of the patients' situation or context.

In the second layer known as *objective detachment* (ethical universalism), the professional nurse applies available rational ethical principles believed to be relevant across all similar or related situations. Historically, this layer corresponds to modern ethics, with its penchant for reason, in the spirit of the Enlightenment epoch of European philosophy. One example of this principle is the belief that individuals ought to be accorded equal respect due to 'the rational autonomy' allegedly possessed by each person, for which they have to be treated 'as ends in themselves' (Gadow 1999, 61). Gadow argues that although rational ethical principles are psychologically persuasive, they lose their universality by engendering conflicting interpretations in actual clinical engagements. Blind application of rational principles strips persons of their lived realities and experiences due to the differing perspectives of those involved.

The third layer of *intersubjective engagement* (relational narrative) is 'the construction by patient and nurse of an interpretation that is their coauthored narrative describing the good they are seeking' (Gadow, 1996, 8). This layer is regarded by Gadow (1999, 57) as 'the postmodern turn in nursing ethics.' It is the idea that nursing professionals ought to engage their clients with a high degree of empathy and accompany them as active participants in the healthcare procedure, rather than as passive participants. For instance, this stage of Gadow's relational ethics can be implemented in practice by supporting the patients to direct the course and goal of clinical action. Conceptually, the patient is given a free hand to identify his/her problem, and with the empathic disposition of the nurse towards the patient, both work to develop self-tailored plans of solving the identified problems.

For chronic disease SMS program to be successful, the nurse and the patient must act as co-workers or co-authors, by entering into a mutual relationship that enables them to create a narrative or a story. This narrative embodies the true feelings and experiences of the client, with the nurse not allowing his or her specialised training and expertise overshadow what the patient feels, or has to contribute to the process (Gadow, 1999). Every clinical encounter has certain inherent peculiarities and uniqueness and is, therefore, contingent and assumes no absolutely necessary form (Gadow, 1996, 1999). For this reason, the professional works with the client to determine 'the good' of each given situation, as rote application of abstract universal ethical principles would ignore the uniqueness of the existential realities of the patients.

Gadow (1999, 58) explains that methodologically, these three layers are dialectic in nature:

‘premodern, modern, and postmodern ethics represent a dialectical relationship among different ethical approaches in which none of the three can stand alone, and only their coexistence constitutes a sound basis for practice.’ Ethics and morality play a central role in the dialectical relationship between the nurse and the patient. This implies that aside from the professional code of ethics, a nurse is also engaged in a higher level of ethical experience with a patient. The concept of *care respect* is, to all intents and purposes, the fundamental basis of Gadow’s relational narrative theory. It is the demonstration of respect for the patient by the nurse and involves an ‘attentive discernment and valuing of the individual uniqueness’ of both client and encounter (Gadow, 1999, 63). In relation to chronic disease management, respect for patients requires that the healthcare professionals take into consideration the subjective feelings and experiences of the patients at all the stages of self-management intervention – assessment, goal setting, planning, implementation and evaluation. SMS strategies aim to promote behaviour change, enhance patients’ active participation in their care, and minimise their dependence on healthcare providers for decision making. Thus, a question for consideration will be: can these approaches work in Africa given the differences in culture and context?

7. Indigenising Self-management Support through African Communalism

Culture is at the heart of every human interaction and action; naturally, it shapes the attitude, belief, definition, interpretation, decision-making and communication pattern even in health and illness (Marsiglia and Booth 2015; Dube et al. 2017; Dowie 2021). It is a well-considered fact among scholars that in the sub-Saharan African value system, one of the most notable cultural values is the communal way of life of various African peoples. To this end, the African is said to be defined in reference to his or her family and community (Mbiti 1969; Ikenga-Metuh 1981; Menkiti 1984; Gyekye 1997, 1998; Aja 1998; Ejizu n.d.). Traditionally, the communitarian way of life has been so favoured over the individualistic way of life that scholars take it for granted by viewing it as an empirical fact that is there for anyone to see for themselves. One of the strongest indications of this fact is that in many African cultures, such as the Akan of Ghana, the Yoruba and the Igbo of Nigeria, the notion of truth is derived from the communal perspective. One who speaks the truth is thought to speak the mind of all right-thinking community members, who are said to be of one voice or of ‘one mouth’ (Wiredu 1998, 176).

Traditional Africans view the family and the community as hallowed spaces populated by religious forms and symbols. In this setting, people adopt the first-person plural possessive pronouns and collective nouns in routine speech (‘our ancestors’; ‘our village/homestead’; ‘we have decided/agreed that’; ‘we have come to marry your daughter’; and the like), except where the individuality of the person concerned inheres in the communication process (Ntibagirirwa 2001). The relationship between the individual and the community, or the social nature of the African, has its roots in African ontology, epitomised by the Bantus. This communal relationship bears a moral status, and the African recognises and defines himself as a being intricately connected to other beings. That is, the African is an *ntu* (a being) in the universe of *ntu* (other beings) (Ntibagirirwa 2001; Metz 2019). The solidly planted extended family system lowers the wall between the nuclear family and the larger community in traditional African worldview. According to Metz (2019, 14-15), this communalism is given expression by various means:

Sub-Saharans often think that society should be akin to family; they tend to believe in the moral importance of greetings, even to strangers; they typically refer to people outside the nuclear family with titles such as “sister” and “mama”; they frequently believe that ritual and tradition have a certain degree of moral significance; they tend to think that there is some obligation to wed and procreate; they usually do not believe that retribution is a proper aim of criminal justice, inclining towards reconciliation; they commonly think that there is a strong duty for the rich to aid the poor; and they often

value consensus in decision-making, seeking unanimous agreement and not resting content with majority rule.

Clearly, the idea of self-management, as conceptualised and practiced across the world today, is not merely about the patient being consigned to a lonely world of individual self-responsibility. Essentially, it incorporates the idea of family support. It is not merely a concept portraying a novel system of medical care, but a fundamentally normative or moral requirement that the family participate actively in the welfare and recovery process of its ailing member. Moreover, it is also descriptive in the sense that it views family support as spontaneous, given that familial affection is a natural, biological phenomenon. In this regard, the concept of self-management even goes deeper by requiring that the patient's family, acquaintances and immediate community do more than express mere verbal concerns and sentiments by making themselves available, and rallying round the patient with different kinds of assistance within their means, and as need dictates. This support puts the sick in a good emotional state and on the path to recovery; at least, it creates the atmosphere conducive for the sick person to pass on, if the ailment cannot be reversed in spite of everything.

This facet of CDSM practice makes it relatively adaptable to the healthcare sectors of African countries. In African tradition, when someone is sick, the extended family, neighbours and the immediate community pay routine visit to register their presence, concern and goodwill, especially if it is a non-contagious disease. Even in the absence of modern channels of communication, everyone learns about the ailing person's predicament in a short time, as the news slithers through the vicinity. Those yet to visit the sick, and the few unable to visit for factors beyond their control, would, at least, assist in disseminating the information to relatives and acquaintances they come across. When they do visit, they take with them food and beverages judged to be capable of aiding the recovery process of the patient. They pray, and along with the patient while keeping track of the progress of the recovery process. This cycle of care and support continues through the illness; and when the patient eventually dies, they gather for a number of days to honour him or her with a befitting burial, during which business and work are temporarily suspended. Thus, in Africa, the family and the community do not merely care about the sick: they accompany him or her in the journey, until death and rite of passage. With this embedded ingredient of communalism in African culture, therefore, it is our considered submission that CDSM is a concept that can be adapted to healthcare systems in most of Sub-Saharan Africa with ease.

It has often been objected that contemporary Africa has lost its traditional values and identity due to the changes that necessarily accompany modernity and the different sorts of alien accretion in Africa's history. For this reason, it would not be feasible to contextualise or indigenise CDSM to Africa's healthcare. Following the beleaguered continent's encounter with factors ranging from slave trade, colonialism, and the incursions of Islam and Christianity, to neocolonialism and globalisation, it is reasonably believed that Africa has garnered some radical transformations that make it doubtful that her traditional communal value system, for example, can still be found in the pure form (Achebe 1965; Ntibatirirwa 2001; Oladipo 2009) required as basis for CDSM implementation. Contemporary Africa is beset by political patronage, dictatorship and totalitarianism, made possible by fraudulent electoral processes, and ineffectually projected to the world under the lofty banner of 'democracy' (Odozor and Akintona 2018). Most contemporary African leaders are administratively and morally bankrupt; in Ellis' (2005, 135) succinct description, they are 'lords of misrule' steeped in endemic corruption and would sooner seek medical attention abroad than fix their own country's healthcare sector (Akinfenwa 2021). In the wake of the social and political uncertainty, many Africans have migrated to the ostentatious city lifestyle in mansions built from dubious wealth, surrounded with manicured lawns and walls as high as those of a prison facility. Even while living on the continent, many Africans are literally foreigners to their culture; and their children cannot speak the native languages. This novel self-regarding attitude sometimes even fuels the stigmatisation of people living with diseases in Africa (Idemudia, Olasupo and Modibo 2018). For these reasons, it seems that African

traditional value of communalism cannot be relied upon as basis for successful implementation of the CDSM programme, because it has collapsed and, apparently been replaced by personal autonomy and individualist mindset of the Western society.

Although the above observations are true to a large extent, they are not the whole story. A number of counter-facts can be adduced in favour of the argument that there are inroads for CDSM in Africa. First, even if we granted that Africa is now irreversibly given to Western influence, or to copying ideas from the West, then we can simply expect her to automatically imbibe the Western CDSM trend at the appropriate time as well. Second, not only has Africa been exposed to Western culture and influence, she has also exerted her own influence beyond her shores. No human society is without some form of external influence and change, considering the dynamic nature of human social existence, but especially given the phenomena of globalisation and international relations (Macionis 2008). Foreign influence is part of the natural order of things in human social development and civilisation. Even the Western world is an admixture of different kinds of external influences, all the way from the Caribbean to the Far East. Third, CDSM has not always existed in the West, but was only first conceived there. So, it had a beginning in that environment, suggesting that it was a novel concept at some point, before it became a culture in medical practice. Today, it has spread to many parts of the world, including South America and Asia (Peñarrieta et al. 2015; Siregar et al. 2021). In the same way, it can become domesticated in Africa, if properly articulated and rigorously implemented. Fourth, a teeming number of medical personnel working in topmost Western hospices and healthcare facilities are Africans who could not practice in their home countries due to infrastructural deficit, poor remuneration and inconducive environment, among other incapacitating factors.

The fifth point is that not all Africans reside in cities; a great majority live in rural areas, where culture and traditions hold sway as normal way of life. Yet, even though many Africans are resident in big cities, where people are strangers to one another and violent crimes are rife due to high populations, they maintain a strong and life-long connection to their home towns to a large extent. Family and communal decisions taken back home are conveyed to all and sundry, including those in the diaspora (Ntibagiriwa 2001). This is facilitated by age-groups and other associations that serve as means of identifying with one's village community and family. Concerning stigmatisation, the sixth point is that chronic diseases are mostly non-contagious, which removes the possibility of infection (Fuller 2018). If they were contagious, CDSM would not be conceptualised let alone be implemented elsewhere in the world. Further, stigmatisation of people with diseases is not peculiar to Africa. It is ingrained in human nature, and can be controlled with enlightenment. It must, in fact, be noted that the so-called traditional African communal values are not unique or restricted to the continent, but can be found in other cultures in some degree (Metz 2015), given that familial bond and community living are biological factors of most animal species. No society exists in a vacuum, and no society is an 'island' in the radical sense of being cordoned off from the rest of the world. If people could move from place to place to interact with one another in ancient times, then it would be even much easier in the present age, owing to the escalation of technological innovations.

For successful adoption of the relevant mode of medical treatment or intervention, understanding the African conception of illness and disease is a *sine qua non* (Onongha 2015). Due to inclination to religious belief, the African conception of health and disease is routinely portrayed in literature as being shrouded in mysticism, spiritism and superstition (Onongha 2015; Asare and Danquah 2017; Ajima and Ubana 2018). For, in spite of their education, Africans view diseases and ailments as being caused by witchcraft, sometimes even after due diagnosis. Thus, they combine Western healthcare with recourse to spiritual centers and traditional healers; and they hold fast to the efficacy of prayers in the mitigation of diseases. In all, African conception of sickness and diseases and treatment is said to be holistic in the sense that body (physical), soul (psychological) and spirit (mental) are thought to be equally affected by disease and health. If this is true, then it is a factor which may hinder CDSM in Africa.

Again, these portrayals are somewhat misleading: first, not all Africans follow the traditional religions; and CDSM is typically introduced and implemented by the health personnel before being passed on to the patient and their family. Conversely, not all aspects of traditional medicine run afoul of the principles of Christianity and Islam on the one hand, or those of orthodox medicine, on the other hand. This objection tacitly assumes that African traditional medicine is necessarily bad merely for being indigenous. However, traditional medicine is not unique to Africa; it exists in some form across the world, most notably China, India, South America, and among North America's native populations, such as the Cheyenne, the Navajo and the Cherokee. This does not mean that orthodox medicine is not practiced in these places, nor that these peoples are incurably superstitious. Second, Africans take to native medicine for two main reasons: when orthodox healthcare fails, and due to poverty. This suggests that they basically do so as a last resort. That is why the Igbos of Nigeria have a common saying that: *A naghi eji anya oma aga n'uka ekpere* (meaning: 'No one consults spiritual centers under normal circumstances, except as a last resort'). A drowning man clings to a weed by the riverside, even if doing so keeps him alive for only a few fleeting seconds. Third, a gamut of media awareness and enlightenment campaigns have been sweeping across sub-Saharan Africa in the past few decades, leading people to quit attributing malarial fever and headache to spiritual attack. Through its interventions and public awareness programmes, as well as the distribution of mosquito nets, the Roll Back Malaria Initiative in Nigeria, for instance, is closing the gap of ignorance, leading many indigenous people to realise that malaria is caused by mosquito bite.

The fourth thing to note in this connection is that modern healthcare, with its expensive technological equipment, is not cheap. By contrast, traditional medicine is readily available and affordable; still, this unorthodox apparent alternative is understood as being incapable of taking the African far enough. For if Africans were truly incurably superstitious, then why do African women routinely travel to Western countries where they can access the necessary medical facilities for delivering their babies safely, so the babies can, in turn, be entitled to healthcare facilities of these foreign countries? Why do African politicians and elite embark on what amounts to compulsory medical tourism to the West and Asia? The reason is that they do recognise the value of orthodox medicine; the politicians are able to do this because they control the wealth and resources of their countries, which affords them financial edge over regular citizens. These examples suggest that even the poorest ordinary Africans would readily settle for orthodox medicine if they had the financial wherewithal.

The African family bond expressed through a communal way of life may have been somewhat eroded; but it still finds hearty expression in various ways, especially in the rural areas of southern Sahara. The vestiges of communalism in these communities continue to exert a lot of influence on African peoples across the world. Onuoha (2015, 8) expresses this sentiment as follows:

Africans ... have not 'lost' their values. I ... think [the values are] in limbo, a place of uncertainty. Unfortunately, the more it is [in] this state, the weaker it gets, and the weaker it gets the greater the chances of being supplanted. There is a place for African values in world ... discourse, but the African must wittingly cultivate and nurture these values to be seen to be relevant in the twenty-first century.

Finally, most of the social, political and health programmes in Africa today were introduced through a subtle and gradual process of public campaign and enlightenment. In healthcare, for example, some of these programmes include the Roll Back Malaria Initiative, poliomyelitis vaccination, use of condom against sexually transmitted diseases and for birth control, HIV-AIDS and Ebola virus awareness programmes, and the current COVID-19 vaccination programmes. The awareness campaigns for these projects were done through different sorts of media, including the healthcare centers themselves. On the foregoing premise, therefore, there is no reason to suppose that the same approach could not be employed with regards to CDSM awareness and education, given, as noted earlier, that the blueprint is already there in African culture and worldview in the form of the familial and communal way of life of various African peoples south of the Sahara. For if the self-management

programme is succeeding in the Western environment that emphasises individual autonomy and privacy, it will *a fortiori* be successful in Africa once the hurdles of cultural shock and novelty have been scaled (Metz 2013).

8. Conclusion

While the practice of self-care advances in the West, Africa's healthcare is steeped in situation where patients have little say in the clinical decision-making process. The rising prevalence of chronic diseases in Africa calls for a restructuring of the healthcare system to support initiatives that recognise patients' active participation in decision making. Given that the concept of self-management in contemporary healthcare delivery goes beyond the individual patient to include support from family, this paper set out to create a nexus between the concept of chronic disease self-management (CDSM) and Africa's healthcare sector through the African culture of communalism. The paper claims that Africa is naturally positioned for sustainable self-care treatment model through her extended family system and communal way of life. Despite the inherent barriers to the delivery of quality healthcare services within this region, a case can be made that a shift in clinical practice to support the identity of the patients as a subject of clinical intervention is very critical in the management of chronic disease. This proposed shift can be anchored on the core elements of Merleau-Ponty's phenomenology of perception and Sally Gadow's relational narrative, specifically relationship, embodiment, respect, and dialectical engagement. These elements motivate patients to become active participants in their own care; they also constitute the fundamental needs of all human beings irrespective of their geographical location. Since they are fundamental to human engagement, it is evident that they can be adapted to the African clinical context once the patients and the healthcare providers are willing to understand their roles in self-management decision making.

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