

Cambridge University Press

0521828597 - Refugee and Immigrant Health: A Handbook for Health Professionals

Charles Kemp and Lance A. Rasbridge

Excerpt

[More information](#)

Part I

Issues and background

1

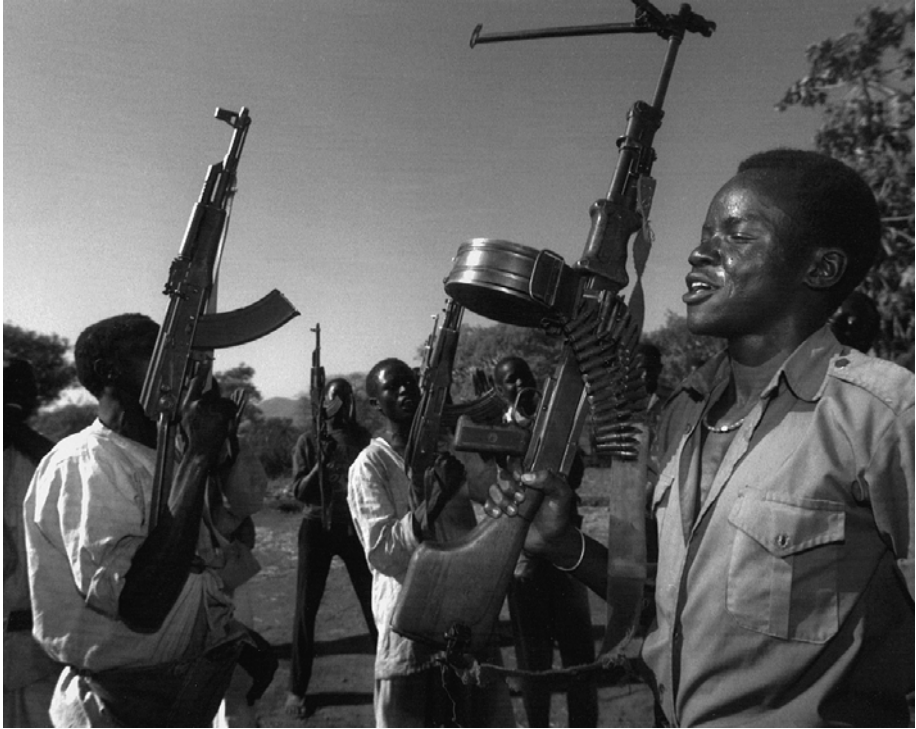
Toward a cultural understanding of refugee and immigrant health



Camp outpatient clinic. (Photograph by courtesy of Judy Walgren.)

Refugee and Immigrant Health: A Handbook for Health Professionals, Charles Kemp and Lance A. Rasbridge.
Published by Cambridge University Press. © C. Kemp and L. A. Rasbridge 2004.

4 Issues and background



Violence is always close to refugees. (Photograph by courtesy of Judy Walgren)

Introduction

The movement of peoples and populations has been a constant in the course of human evolution, and humans as a species demonstrate remarkable plasticity and resiliency in adapting to new environments. In modern times, the circumstances of why people relocate are as varied as the cultures from which they come, but one aspect of migration is universal – immigrants carry with them more than just suitcases.

From the health perspective, immigrants and refugees of all kinds bring with them diverse epidemiological profiles based on different environments and endemicities of disease in their areas of origin. Sometimes their illness picture is a direct result of the experience of emigration, especially for refugees. They also arrive with widely divergent past experiences with Western medicine. But most of all, refugees and immigrants bring with them their cultural beliefs and practices, including those involving health and illness, which frequently contrast greatly with host country norms. Apart from the epidemiology, the study of health among refugees and immigrants is really a study in culture, the domain of anthropology, because while

5 Introduction and background

illness and disease may be universal, the definition of health, the interpretation of symptoms, and remedies and treatments to promote and restore health are very much culturally defined. Sensitizing healthcare professionals to these cultural differences is the main goal of this book.

Cultural competence

Cultural competence is the ability to “perform and obtain positive clinical outcomes in cross-cultural encounters” (Lo & Fung, 2003, p. 162). Within this broad definition, there are two related sets of competencies (Dunn, 2002; Lo & Fung, 2003):

- (a) Generic cultural competence is knowledge and skills applicable to any patient or community cross-cultural encounter. This competency is gained through being involved in cross-cultural encounters on a regular basis; observing and evaluating patient, community, and provider (one’s own) responses to cross-cultural encounters; seeking and learning general knowledge and skills related to cross-cultural health care; and maintaining a basic attitude of respect for and openness to other cultures.
- (b) Specific cultural competence is knowledge and skills applicable to patients and communities from specific cultural backgrounds. This competency is gained through learning about other cultures *and* one’s own culture from “participant–observer” patient and community encounters, from other sources such as the literature, and from personal or other professional endeavors to expand the knowledge base regarding specific cultures. The capacity to communicate on a deep level with persons who speak languages other than the native language of the host country is part, but far from all of this competence. The use of interpreters is necessary, but their interactions must also be observed and understood to insure that relationships are truly therapeutic.

Although most healthcare providers think in terms of individual competency, it is important that institutions also work toward cultural competence (Shaw-Taylor, 2002).

Cultural competency in health care is of profound importance on several levels. Perhaps the most obvious, sensitivity to the customs of others to even a minor degree conveys respect, and with respect, compliance on medicines and regimens is more likely to follow. When dealing with refugees and immigrants, the communicable disease risks alone speak volumes toward the critical needs of detection, prophylaxis, and treatment. Increased rapport with patients contributes positively to this endeavor, and not taking this additional step of accommodation risks driving this vulnerable population underground, resulting in serious public health

6 Issues and background

consequences. Moreover, cultural misunderstandings can lead to misdiagnoses (see Galanti, 1997).

With cultural competence comes learning and the acceptance that different beliefs and practices are neither inferior nor more correct than one's own values: the anthropological concept of cultural relativism. Western providers have much to learn from the vast world of healing as practiced around the globe. Even the Western notion of health itself can be reevaluated in this expanded focus, notably, the idea only recently valued in the West that health encompasses spiritual, familial, and community wellness in addition to the mere absence of disease. Finally, cultural sensitivity invokes compassion and empathy, an attempt to treat the whole patient by putting his or her present health state in the context of the broader historical events, which for an immigrant or refugee runs the spectrum from cultural uprootedness to severe psychological and physical trauma.

One important caveat: the intent of this book is not to stereotype all persons from a given culture as prescribing to each and every characteristic outlined; indeed, there frequently can be more intracultural variation within an ethnic group than exists intercultural variability. The ethnic chapters are solely generalizations. Galanti informs us that generalization is the gateway from which to begin the process of patient assessment, whereby stereotyping is the endpoint, the closed door, after which no more information is sought (Galanti, 1997). The goal here is to use generalizations as a framework from which to build an understanding of the diversity in refugees and immigrants.

Of course, culture does change, and while some may argue that those refugees and immigrants who have come to the West should, indeed must, adapt to the new ways of life, these changes can take years or even generations. Furthermore, while practices may appear to change on the outside, underlying worldviews may not. For example, it is not uncommon for refugee and immigrant patients to apply traditional hot–cold humoral theory to new medicines and treatments now available to them. We in no way consider this work to be an absolute compendium of cultural characteristics but rather an introduction to the richness in cultural diversity that is particularly pronounced in the intersection of refugees and immigrants with Western health care.

Decision-making and help-seeking

Health-related decision-making and help-seeking are underlying themes in the chapters on populations. What is provided in the chapters (family structure, age and gender roles, and health beliefs and practices) is best used as part of a matrix of understanding that includes all the determinants of decision-making and help-seeking. Among the determinants of decision-making and help-seeking related to

7 Introduction and background

illness, disease prevention, and health promotion (Bruce & McKane, 2000; Kemp, 2003; Uehara, 2003) are:

- attitudes, beliefs, and personal characteristics (including socioeconomic status) of the individual;
- attitudes, beliefs, and personal characteristics of the individual's culture and social networks, especially the family;
- past and present personal and social network experience in health or illness;
- past and present experience in seeking help, especially related to health and illness;
- characteristics and competencies of healthcare systems and individuals within the systems – the “community of solution” – as they interact with individuals and populations.

Anthropologists have demonstrated that all human cultures embrace a system of beliefs relating to the maintenance of health and illness causation, and concomitant therapeutic and preventive practices relating to these beliefs. In fact, most cultures have numerous and diverse therapeutic options. In this medical plurality, which option or options chosen are determined by a complex “hierarchy of resort,” depending on such factors as cost, self-diagnosis, time, physical as well as cultural accessibility, and the like.

Clearly, the preceding is a brief summary of an extraordinarily complex and dynamic process. Yet maintaining awareness of these factors while interacting with individuals, families, and populations leads to a more complete understanding of people than simply characterization as a member of a particular culture.

Complementary and alternative medicine

As mentioned, in approaching an understanding of refugee and immigrant health, we must attempt to understand, or at least recognize, the wealth of medical systems across the globe that differ from those we experience in the West. In anthropology, this body of knowledge in the nonindustrialized world, from where many immigrants and refugees originate, is collectively known as ethnomedicine: “those beliefs and practices relating to disease which are the products of indigenous cultural development and are not explicitly derived from the conceptual framework of modern medicine” (Hughes, 1978, p. 151). Western medical researchers are beginning to refer to this body as Complementary and Alternative Medicine (CAM).

The National Center for Complementary and Alternative Medicine (NCCAM) classifies CAM therapies into five major categories (NCCAM, 2002).

Alternative medical systems

Alternative medical systems are built upon complete systems of theory and practice. Often, these systems have evolved apart from, and earlier than, the

8 Issues and background

conventional medical approach used in the USA. Examples of alternative medical systems that have developed in Western cultures include homeopathic medicine and naturopathic medicine. Alternative medical systems that have developed in non-Western cultures include traditional Chinese medicine and the (East) Indian system of *Ayurveda*.

Mind–body interventions

Mind–body medicine uses a variety of techniques designed to enhance the mind’s capacity to affect bodily function and symptoms. Some techniques that were considered CAM in the past are now mainstream Western approaches (for example, patient support groups and cognitive-behavioral therapy). Other mind–body techniques are still considered CAM, including meditation, prayer, mental healing, and therapies that use creative outlets such as art, music, or dance.

Biologically based therapies

Biologically based therapies in CAM use substances found in nature, such as herbs, foods, and vitamins. Some examples include dietary supplements, herbal products, and the use of other so-called “natural” but as yet scientifically unproven therapies (for example, using shark cartilage to treat cancer).

Manipulative and body-based methods

Manipulative and body-based methods in CAM are based on manipulation and/or movement of one or more parts of the body. Some examples include chiropractic or osteopathic manipulation, and massage.

Energy therapies

Energy therapies involve the use of what are known as “energy fields” of the body that are manipulated by the practitioner.

While embracing CAM as a means of better understanding health and illness, we are in no way endorsing the use of all CAM practices, particularly those that have not been analyzed to any degree by scientific inquiry and methodology. However, because CAM takes a different path than biomedicine, we do emphasize the many positive “complements” that CAM brings to the Western setting.

- Prevalent throughout much of traditional medicine is the emphasis on treating illness, the causes of the sickness as understood by the patient, in addition to treating disease, the etiology of the illness as defined by Western medicine. Similarly, CAM usually emphasizes addressing proximal, immediate causes of illness, such as infection, as well as the more distal causation, such as societal stressors.
- Prevention of disease is the cornerstone of much of CAM, through such avenues as nutrition, exercise, and stress reduction.

9 Introduction and background

- CAM emphasizes holism or dealing with all aspects of the patient's life, including relationships with other people, and relationships with the natural and spiritual environment, in addition to physical or emotional symptoms.
- CAM principles in general get us closer to the World Health Organization (WHO) definition of health: "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 1948).
- Practitioners and specialists of CAM, trusted individuals within their cultural group, can frequently serve as "gatekeepers" for public health interventions.

Culture-bound syndromes

The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-IV)* (American Psychiatric Association (APA), 2000) included, for the first time, a Glossary of Culture-Bound Syndromes (CBS). Based on medical anthropological and cultural psychiatric research, the term CBS "denotes recurrent, locality-specific patterns of aberrant behavior and troubling experience that may, or may not, be linked to a particular DSM-IV diagnostic category. Many of these patterns are indigenously considered to be 'illnesses,' or at least afflictions, and most have local names" (APA, 2000, p. 898).

The understanding of CBS is very much in flux. For example, depression, once considered by some as specific to technologically advanced Western cultures, is now recognized as a global health problem, whose burden by the year 2020 will be second only to ischemic heart disease (Institute of Medicine, 1997; Lee, 2002). Similarly, *amok*, once considered specific to Malaysia has now been identified in Laos, Philippines, Polynesia, Papua New Guinea, and Puerto Rico. Moreover, analysis of multiple sudden mass assault(s) by a single individual (SMASI) in the West leads to the conclusion that, in most important respects, there are so many similarities between *amok* and SMASI that neither should be considered as a CBS (Hempel *et al.*, 2000). Finally, it should be understood that there is regional variation in descriptions of some CBS (Weller *et al.*, 2002). Despite disagreements among scholars, there *are* disorders or syndromes that are identified with certain cultures and recognized by those cultures. CBS are included in the discussions of specific cultures under health practices and beliefs.

Culture and the life cycle

In this book we utilize a medical anthropological framework as a tool to embrace this diversity and approach an understanding of immigrants and refugees within the Western medical system. We not only describe, but when possible explain, medical beliefs and practices within the cultural context. Medical anthropology

10 Issues and background

draws upon both the biological and the social sciences in explaining health systems in this complex arena of cultural contact and change throughout the immigration experience. Consequently, medical anthropology offers paths to ultimately improve provider/patient rapport and medical compliance in these populations.

The life cycle course provides an excellent template from which to view health and illness cross-culturally. Anthropology focuses particularly on the social transitions that occur throughout the life cycle, including those linked to physiological changes (Helman, 2000). While culture defines the beginning and endpoints of age-grades, such as adolescence or old age, the events of childbirth, menarche, menopause and death are of course universal and are frequently surrounded by increased attention to the realm of health care. In fact, much has been said of the “medicalization” of the birth, menopause, and dying processes in Western cultures. Hence it is a useful to analyze medical beliefs and practices against the backdrop of the life cycle in order to gain insights into the medical systems of that particular culture.

Pregnancy and childbirth

Culture can have a profound effect on the health of the unborn child. For example, prescriptions and proscriptions on foods, medicine, and work can affect the size of the fetus and hence the healthful outcome of the pregnancy. Age at marriage and ultimately age at conception, in addition to access and use of birth control, are also largely cultural determinants which can impact the health of the mother and baby. Western prenatal care is largely absent from the developing world, not just because of cost, but moreover, because pregnancy is viewed as a natural physiological state. Also, time orientation is a common factor here, where more traditional societies are more focused on the daily living rather than on the future, in this case, on the outcome of the pregnancy (Galanti, 1997).

Childbirth is considered a life-affirming event, but many cultures the world over also recognize the health risks to mother and baby, entailing “a multitude of beliefs and rituals meant to help both mother and child and sometimes the entire family or community pass unharmed through this period of danger” (Jordan, 1993, pp. 3–4). These beliefs and rituals can be seen as helping to prepare the woman in her role transition from wife to mother. Most cultures have a specialized birth attendant of some sort. This specialist may assist in the prenatal and postpartum periods as well, such as providing social support for breastfeeding and a healthful diet, assistance with household tasks, and the like. Some cultures dictate rigid segregation between the sexes at all times, even more so during the peripartum stage, where it may be strictly forbidden for any male, including the husband, to have any contact with the birthing mother, for a specified period of time.

11 Introduction and background

As mentioned, childbirth in Western cultures is frequently approached as a medical event requiring medical intervention rather than a natural human process. Beyond the use of midwives, many immigrants and refugees from the third world are unaccustomed to this “medicalization” and possibly even uncomfortable with the concept of hospital-based birth. The (Western) idea of the father being present during delivery may also create discomfort.

Infancy and childhood

A common concept to many cultures from the Third World, where infant mortality is high, but with vestiges even in the Western world, is the ceremonial marking of “social birth” at some interval after biological birth, when membership in the society is formalized. For example, in many cultures a child is named only after days or weeks from birth, when there is relative certainty the newborn will survive, or perhaps even to discourage malevolent spirits from “calling” the baby during the critical early days of life. Circumcision, especially male circumcision in the West, is a similar ritual. Western providers may misinterpret cultural practices during this period of vulnerability as a lack of appropriate bonding (Galanti, 1997).

The feeding of infants is a significant concern to all cultures, but there is great variability cross-culturally in the techniques of feeding from birth. Colostrum is frequently perceived in the third world as “spoiled” or otherwise unsuitable and discarded. Breastfeeding incidence and duration has declined dramatically in most countries, especially in urban, industrialized societies or in non-Western societies undergoing modernization and urbanization (Helman, 2000). This transition from the breastfeeding norm to bottle feeding is multifactorial and well beyond the scope of this introduction, but in developing nations bottle feeding is associated with increased infection, malnutrition, and other health problems. For example, we found that recently arrived Cambodian refugee women, with no prior experience with bottle feeding, used the bottle inappropriately, as a pacifier, leading to deleterious health effects (Rasbridge and Kulig, 1995).

However, it should be noted that bottle feeding need not be inherently unhealthy, provided it is adequately explained to the inexperienced mother. All cultures have beliefs about what consists of appropriate weaning foods and when they can first be introduced. These foods are frequently simple enough, such as rice gruel, to be available in the new environments in which immigrants and refugees reside.

Care for the newborn and children in general is also culturally prescribed to a great extent. Although an extreme generalization, family size is frequently large and birth spacing short in the Third World, especially in agricultural areas, where labor needs are high. Hence childcare is sometimes entrusted to the barely older sibling, or in other cases to members of the extended family. Corporal punishment of children