

CHAPTER

1

APPLIED MEDICAL ANTHROPOLOGY AND HEALTH CARE

In improving patient satisfaction . . . administrators' attention is being directed to the impact of culture—of organization, roles, and values—upon overall quality of care and outcomes

—PRESS, 1997, p. 6

LEARNING OBJECTIVES

- Introduce how culture affects health
- Illustrate how anthropological perspectives can facilitate effective health care
- Introduce the nature of cultural competence in health care
- Illustrate medical anthropology's major applications in addressing cultures' impacts on health
- Illustrate the broad range of concerns people have with respect to their health
- Introduce the biopsychosocial framework for understanding diverse effects on health
- Present a cultural systems model for addressing factors that affect health
- Illustrate principal mechanisms of culture's effects on health

CULTURE AND HEALTH

Have you ever felt when you went to the doctor that your problem wasn't understood or that your treatment was not relevant to your health problem? Cultural differences between physicians and their diverse clients make cross-cultural misunderstandings inevitable. Culture affects patients' and providers' perceptions of health conditions and appropriate treatments. Culture also affects behaviors that expose us to disease and the reasons prompting us to seek care, how we describe our symptoms, and our compliance with treatments. This makes culture central to diagnosis and an important issue for all of the health professions.

Patients and providers need knowledge of the relationships of culture to health because culture is the foundation of everyone's health concerns and practices. Improving health care requires attention to cultural influences on health concerns, conditions, beliefs, and practices. People's health occurs within cultural systems that are concerned with broader issues of well-being than addressed by physicians' concerns with disease and injury; we are also concerned with psychological, social, emotional, mental, and spiritual well-being. As biomedicine turns from a disease-focused approach to concepts with health and well-being, cultural perspectives and cultural competency emerge as central frameworks for improving care.

Medical anthropology is the primary discipline addressing the interfaces of medicine, culture, and **health behavior** and incorporating cultural perspectives into clinical settings and public health programs. Health professionals need knowledge of culture and cross-cultural relationship skills because health services are more effective when responsive to cultural needs. Cross-cultural skills also are important in relationships among providers of different cultures when, for example, African American and Filipino nurses interact with each other or with Anglo, Hispanic, or Hindu physicians. A knowledge of culture is also necessary for work in community settings, such as collaborating with diverse groups and organizations to develop culturally relevant public health programs. Health care providers and patients are more effective in managing their health and care with cultural awareness and the ability to manage the numerous factors that affect well-being.

What do health professionals—providers, researchers, social service personnel, educators, and other “helping professionals”—need to know about the effects of culture on health? They all need systematic ways of studying cultural effects on health and developing cultural competence. Cultural responsiveness is necessary for providers, researchers, and educators if they are to be effective in relating to others across the barriers of cultural differences. The cultural perspectives of medical anthropology are essential for providing competent care, effective community health programs, and patient education. For biomedicine to be effective, providers need to know whether a patient views the physician as believable and trustworthy, the diagnosis as acceptable, the symptoms as problematic, and the treatment as accessible and effective.

The concept of culture is fundamental to understanding health and medicine because personal health behaviors and professional practices of medicine are deeply influenced

by culture. **Culture** involves the learned patterns of shared group behavior. These learned shared behaviors are the framework for understanding and explaining all human behavior. This includes health behaviors, particularly intergroup differences in health behaviors and beliefs. Culture is a principal determinant of health conditions, particularly in exposing us to or protecting us from diseases through structuring our interactions with the physical and social environments: for example, through producing environmental contamination, work activities, contact with animals, sexual practices, diet, clothing, hygienic practices, and others. Culture also defines the kinds of health problems that exist and the resources for responding to health concerns, defining our perceptions, and producing the resources for responding to them.

Cultural knowledge is also essential for addressing public health mandates to assess communities' health needs, develop appropriate health policies and programs, and ensure adequate and culturally competent health services. The health needs of communities vary widely, requiring an understanding of each community's perceptions of health and illness to develop appropriate services. Public health initiatives require knowledge of culture to change the behaviors and lifestyles associated with an increased incidence of disease. Addressing the effects of culture on health is an important issue for everyone, not just physicians, because disease in any group impacts society as a whole. According to Durch, Bailey, and Stoto (1997), "Improving health is a shared responsibility of health care providers, public health officials, and a variety of other actors in the community." This requires people with an ability to engage communities in a culturally appropriate manner and understanding of their cultural systems, health beliefs, and practices.

Perspectives for addressing culture and health relations are provided by medical anthropology and the **cultural systems models** used within nursing, public health, and medicine to understand systemic ecological and social effects on health. The foci on principal factors affecting health reflect the major traditions of medical anthropology:

- Medical ecology, which examines culture's mediation of health through the physical, biological, and material relationships with the environment
- Political economy and critical approaches that address how health is affected by economic resources, power, and social activities that produce risks and distribute resources
- Symbolic approaches that examine how cultural meanings create the socially legitimated healing processes and link beliefs to physiological processes

This book helps you understand how cultural effects occur across a wide range of health concerns, ranging from clinical care to prevention programs and the funding priorities of health care. Hundreds of factors can have effects on our health, ranging from social conditions producing or reducing exposures to germs and noxious agents to the cultural, economic, and political factors that enable a person's access to quality care.

CASE STUDY

Cultural Conflicts in Health Care

The potentially tragic consequences of conflicts between biomedical culture and the culture of patients became more widely known to providers and the general public through the accounts provided by Anne Fadiman (1997) in *The Spirit Catches You and You Fall Down*. Numerous factors produced a disastrous outcome in infant Lia Lee's interaction with her doctors, factors that derived as much from the Hmong culture as from that of biomedicine and its efforts to control the Hmong and ignore their beliefs. The result was a brain-dead child; physicians blamed the parents and their failure to adhere to the prescribed medications.

In trying to explain why Hmong patients did not accept the physician's point of view, Fadiman recounts the Hmong history of resistance to the Chinese and other outside invaders and authorities: fighting rather than surrendering and standing up to intimidation. Fadiman suggests that their history of resistance is the root of their opposition to the doctor's orders. But the Hmong are not some static culture caught in the past; rather, they have continually adapted and changed in the face of many dominant cultural groups that have attempted to control, tax, assimilate, militarize, and profit from them. The Hmong have changed in many ways, adopting influences from other cultures that have served them well. This is manifested in their Christianization, U.S. military service, education, and acculturation.

Lia's family had undergone acculturation and accepted the value of biomedicine, taking her repeatedly to emergency departments and doctors' appointments. Nevertheless, they often resisted visiting hospitals, which they believed were haunted by spirits of the dead. And they resisted treatments imposed by physicians, viewing them as coercion rather than gifts of healing. The Hmong view of health was a mixture of religion, economics, lost souls, and spirits, a balance of virtually all aspects of life. To the Hmong, many basic aspects of medicine were taboo or horrifying—blood specimens for tests, autopsies to study diseased organs, and invasive procedures including spinal taps, surgery, and vaginal exams. Their doctor's orders for the constant drawing of blood, sometimes as often as three times a week for Lia, increased her parents' concern about the vital fluids being taken from their child. Experimental procedures and treatments unrelated to her complaints reinforced many of the Hmong's worst fears: that doctors would eat the liver, kidneys, and brains of their patients. They had seen the doctor's offices with body pieces cut up and stored in jars, preserved like food.

Lia's parents often resisted her treatment, not understanding why she was restrained to her bed in the hospital, why boards were attached to her arms to hold intravenous lines in place, or why the doctors changed her medicine so frequently. The frequent changes in Lia's prescriptions made it impossible for her nonliterate parents to medicate their daughter effectively. This contributed to her seizures and the repeated visits to the emergency department that evoked frustration and anger in Lia's physicians. So exasperated were the physicians in their relations with the Hmong that a standard joke among them was that the preferred method of treating the Hmong was "high-velocity transcortical lead therapy"—a bullet to the head.

CULTURE, ETHNOMEDICINES, AND BIOMEDICINE

Culture is at the foundation of all medicine, the **biomedicine** of physicians (M.D.s) as well as all other **ethnomedicines**, the health care practices of a culture. Medical systems are intimately intertwined with a culture's economic, social, political, and philosophical systems; this is illustrated in the United States in biomedicine's control of governmental resources, its successful lobbying in Congress, and its powerful economic position in society, including government.

Culture affects health behavior in many ways:

- Conceptualizing health maladies (disease, illness, and sickness) and their significance
- Affecting the distribution of causes of disease and illness
- Creating risk behaviors and disease exposure
- Informing symptom recognition and care-seeking behavior
- Creating health providers' and their institutions' responses to health care needs
- Shaping utilization of the popular, folk, and professional sectors of health care
- Producing social, economic, and political impacts on health and health care
- Creating emotional and psychodynamic influences on health and well-being
- Providing psychodynamic, symbolic, and social mechanisms of healing relationships

Culture mediates our responses to health maladies through ethnomedicines, cultural practices for addressing health problems. The term ethnomedicine typically distinguishes other cultures' health practices from biomedicine, the dominant ethnomedical system of the United States, which is also referred to as Western medicine, scientific medicine, and allopathic medicine. Biomedicine is also an ethnomedicine, reflecting the culture where it is practiced (see Chapter Five).

Ethnomedical studies (see Bannerman, Burton, and Wen-Chieh, 1983) reveal that health problems and treatments are conceptualized within cultural frameworks. Culture directly affects the manifestations of conditions, their assessment and social implications, and processes of treatment. Ethnomedical analyses show the importance of understanding healing from the cultural perspective of the group, their social dynamics, the social roles of healers, and the conceptual and cosmological systems (Rubel and Hass, 1990).

Many contemporary U.S. health issues illustrate underlying cultural dynamics:

- Death due to lifestyle (e.g., poor diet and alcohol and cigarette use)
- Political decisions that leave major segments of the population without health services
- The spread of infectious diseases through immigration and lifestyles
- Pharmaceutical companies and physicians' groups lobbying Congress for legislation to deny U.S. citizens access to foreign medicines

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Health concerns often feature prominently in the most important institutions of the culture from birth to death. In the United States, virtually all social institutions interface with biomedical practices that regulate our lives at all stages:

- With preconception management of birth through prescriptions for contraceptives
- In birthing processes, with legally mandated neonatal treatments and birth certificates
- In required school immunizations and health exams
- Through required marriage screening (e.g., blood type, Rh factor, and AIDS tests)
- Via validation of work absences and workers' compensation
- In the management of terminal illness and issuance of death certificates

Most Americans probably think of biomedicine as the normal resources for health problems. Health choices in the United States are strongly influenced by biomedicine, but people around the world, including many in this country, also use other ethnomedical systems. These include numerous forms of self-care and medication, ethnic healing traditions, and other professionals (e.g., chiropractors, homeopaths, naturopaths, herbalists). Personal expenditures in the United States for “unconventional” medicine—complementary and alternative medicine—are at twice the level of out-of-pocket expenses for biomedical care (Eisenberg, Kessler, Foster, Norlock, Calkins, and Delbanco, 1993). These resources are also used by many patients who also see physicians. This constitutes a medical pluralism that illustrates the need for biomedical providers to understand the ethnomedical resources used by patients.

Biomedicine characterizes its approach as scientific, contrasting itself with other ethnomedical systems that it accuses of being religions, superstitions, quackery, or fraud. Other ethnomedical practices are not, however, lacking in empirical content and have often provided agents for modern medicine, such as biomedicine's use of derivatives from the plant *digitalis* for the treatment of cardiac conditions. Although ethnomedical practices involve religious rituals, these activities may have social, psychological, and even physiological effects (see Chapter Nine). Rituals such as white coats and rigidly scheduled temperature and blood pressure measurements are also widespread in biomedicine, which has many practices not substantiated by scientific methods. These *cultural* traditions of biomedicine have led to a recent emphasis on developing criteria to reveal “evidence-based practice.”

Cultural perspectives are essential for understanding the nature of biomedicine (Sargent and Johnson, 1996). Cross-cultural perspectives clarify the nature of biomedicine: one of many sources of knowledge about health treatments but not an exclusive, exhaustive, or infallible source. Effective techniques for health are not exclusive to any one ethnomedical system. The relevance of ethnomedicine to scientific medicine was recognized in the World Health Organization's programs of *Health for All by the Year 2000* and the continuing emphasis for the future. These programs emphasize that ethnomedical traditions are essential for the health care of most of the world because of the prohibitive cost of

pharmaceuticals. Consequently, if scientific medicine is to be widely available, it requires establishing the scientific basis for traditional ethnomedical practices.

Cultural approaches help explain why other ethnomedical practices persist. The greater use of alternative therapies in the United States among those with higher economic and educational status reflects reasoned considerations, rather than desperate efforts of those lacking access to biomedicine. Ethnomedical traditions engage cultural and symbolic healing processes that involve influences of mental, psychological, and social levels on the physical body (e.g., the experiences of physiological stress when thinking about a problem). The biological effects of social and mental factors constitute a fundamental revision of the biomedical paradigm, as seen in fields such as **psychoneuro-immunology**, which reconceptualizes healing as the causal effects of symbolic processes on physiological responses.

Different health systems can be compared using some key distinctions provided by anthropology. These include **emic** (the definitions of the world that are particular to a specific culture) and **etic** (universal models of human behavior applicable to all cultures). For instance, some cultures' beliefs (emic) consider that the failure to do rituals for one's ancestors can cause nightmares and death (see "Nightmare Deaths" in Chapter Six). Biomedical approaches consider a universal etic sleep paralysis response to be responsible for these and similar cases found around the world. Biocultural approaches ask questions about how emic beliefs elicit etic physiological responses, how our expectations may influence the biological responses of our bodies.

Anthropology illustrates the importance of emic perspectives for health, how a particular culture views health concerns and shapes people's health behaviors. Anthropology also contributes to establishing an etic system that recognizes the mechanisms of efficacy found in other groups' practices as well. Anthropology shows the limitations of biomedicine's claims as a universally applicable etic framework in illustrating cultural differences in health needs. Physicians have often presumed that they alone have scientific and legitimate healing procedures and that these are equally applicable for everybody. Anthropological studies show important cross-cultural differences in concepts of health and effective treatment.

Ethnomedicines as Subcultures

The concept of culture is important for understanding biomedicine because its practices are shaped by cultural systems. All healing occurs within a cultural system, but health providers also have different subcultures (e.g., doctors versus nurses; see Chapter Five). Biomedicine shares with all ethnomedicines three major interrelated cultural functions (Kleinman, 1973b):

- Providing meaning and efficacy: the construction and organization of the illness experience
- Creating cognitive categories for naming, classifying, ordering, and explaining illness
- Performing acts of healing

Kleinman (1973b, 1980) characterizes all ethnomedicines as systems that are “social and cultural in origin, structure, function and significance . . . [and can be analyzed] . . . in the same way that political systems, religious systems, kinship systems, language and other symbolic systems” are analyzed (1980, pp. 27, 33). The social realities of medical systems are created through culturally ascribed relationships and meanings. For instance, biomedicine has the power to determine which medicines you can have access to or, in their capacity as public health officials, to have a person quarantined because of contagious disease.

Beliefs about the causes of maladies and appropriate treatments are related to social power and political ideologies, such as when the Congress passes legislation (e.g., Americans with Disabilities Act) that explicitly excludes people with addictions as disabled. Instead, it heightens their difficulties with legislation, increasing the penalties for their biological addictions (e.g., the highly punitive crack cocaine versus powder cocaine laws that were only recently given some relief through judicial review).

Religious beliefs also affect care: for instance, when providers express their disapproval of patients who have sexually transmitted diseases (STDs) caused by promiscuous sexual relations. The clinical interactions between providers and clients are created through broader cultural and social relations that provide content and structure for clinical relations. For example, the poor, who are considered beneficiaries of “free” public assistance in their health care, often fail to use it. Their reasons for refusing such free care generally involve the demeaning way in which they feel they are treated at these facilities by an unsympathetic staff. Social analyses might also point to the tendencies of lower-class people to delay care seeking until their condition reaches a critical stage, at which point it may be beyond treatment.

Cultural analyses of medical practices need to consider both **microlevel** approaches, where the interpersonal dynamics of care occur in the interactions between doctor and patient, and **macrolevel** approaches, the societal institutions that affect care through the ways in which it is provided (e.g., **socialized medicine**, where care is provided by the government, versus **capitalist medicine**, where care is purchased by consumers). All ethnomedical systems have characteristics related to the cultural systems that produce them. Consequently, a society’s total medical system must be studied to understand how health is produced through a number of interpenetrating realities: biological, personal, psychological, cultural, and social.

Knowledge of ethnomedical conceptual systems can also be an essential aspect of providing correct diagnoses and appropriate care. Cultural conceptions of health problems may not be accepted by biomedicine but may nonetheless be important in terms of care needs, as illustrated in the case of the Mexican *caida de mollera*.

CULTURAL COMPETENCE IN THE HEALTH PROFESSIONS

Health service professionals face common concerns in addressing how culture affects relations with individual clients and how their well-being is produced in interaction with many aspects of the environment. Effectively addressing these concerns requires

BIOCULTURAL INTERACTIONS

Clinical Significance of Mexican Illness Beliefs

The illness concept *caida de mollera* is important for medical practice because associated conditions require medical attention and can provide information about symptoms useful in diagnoses (Baer and Bustillo, 1993, 1998). *Caida de mollera* refers to a depressed, sunken, or fallen fontanel. A common belief is that it is caused by pulling the baby away from the breast or bottle too quickly or by falls, tossing the baby, or otherwise bumping the baby's head. *Caida de mollera* is all too often viewed as just a cultural belief by health care providers. This emic cultural concept, however, reflects something real: an entity with etic status and reflecting life-threatening conditions. The sunken fontanel likely reflects severe dehydration. Cultural treatments for it are not likely to be adequate, but a parent's diagnosis of *caida de mollera* can indicate recent dehydration in the child. Physicians presented with the symptoms associated with *caida de mollera* typically consider them to be life threatening and requiring medical attention.

In the vast majority of cases, however, mothers of the children with these illnesses do not present them for medical care unless symptoms persist for a long time and do not respond to ethnomedical remedies. Most patients never receive biomedical attention. Reporting these conditions to physicians is increasingly rare because of their negative and critical reactions. Given that these conditions reflect symptoms that physicians consider to be worthy of biomedical attention, the importance of the ability to communicate about these conditions is apparent. Culturally sensitive communication between mothers and physicians can provide patient education as to the necessity of bringing specific conditions for treatment. If health care providers continue to view these folk illnesses as superstitions, their ignorance will contribute to increased morbidity and mortality from treatable life-threatening conditions that Mexican Americans recognize (Baer and Bustillo, 1993). Appropriate care requires the development of cultural competence.

cultural competence, which includes both individual and organizational capacities, behaviors, attitudes, and policies that effectively address cultural differences through the use of cultural knowledge and intercultural skills. Cultural competence involves the ability to address a range of cultural factors. These include cultural knowledge and personal awareness, as illustrated in the classic assessments of areas of cultural knowledge required in social work practice (Bartlett, 2003):

- Cultural systems, including work organization and culture
 - The internal processes of communities, including their social resources
 - Health service resources and their access organization and procedures

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- —**Socialization** processes

- Economic, social, cultural, and interpersonal influences on human development

- The effects of group processes and influences on individual health behavior

- The effects on health of religious and spiritual beliefs

- Personal, interpersonal, and group dynamics

- How the interactional processes between groups affect health behaviors

- The culture's social psychology of providing and receiving help

- Patterns of expression, especially feelings and nonverbal communication

- The practitioner's awareness of how emotions and attitudes affect healing relations

Overcoming cultural barriers to clinical competence requires several distinct approaches:

- A systems approach to understanding the nature of culture

- Knowledge of the other cultures' health perspectives

- Assessment of the effects of socialization processes on health and health behaviors

- Cultural self-awareness, especially regarding health and care values

- Skills in managing intercultural dynamics

Knowledge of cultural systems and organizational culture is part of the ability to address clients' problems by recognizing economic, political, and other social factors that have effects on well-being and health behaviors. Effectively adapting to others' health behaviors requires knowledge of both their cultural influences and the effects of the provider's culture. These differences can produce conflicts that impede effective cross-cultural relations and clinical communication. Cultural knowledge and intercultural skills together can help overcome these barriers through an accommodation to the cross-cultural realities of clinical care and public health.

Cultural competence levels range from destructiveness (ethnocentrism), incapacity, and blindness through varying degrees of skill represented in the concepts of **cultural awareness, sensitivity, responsiveness, competence, and proficiency**. Awareness of cultural differences may be followed by sensitivity in response to them. Competence involves the capability to deal effectively with cultural differences. Proficiency involves the ability to transfer this knowledge and these skills to others. Cultural awareness and sensitivity assist in adapting to other cultures through a knowledge of specific cultural information and the ability to provide culturally responsive care by addressing general barriers to effective cross-cultural relations. The ability to deal with cultural differences begins with overcoming ethnocentrism and developing an awareness of other cultures that leads to an understanding of the

more sophisticated skills necessary to adapt effectively to cultural differences and intercultural processes.

Enhancing cultural competence requires the assessment of an individual's level of development and needed skills. A self-assessment is provided here (see Self-Assessment 1.4. Cross-Cultural Development) to help readers to assess their intercultural attitudes, beliefs, behaviors, and accomplishments. Cultural competence requires personal cultural awareness and an understanding of one's own professional culture and its unconscious assumptions, values, and motivations that affect patient relations (see Chapter Three). Learning about the effects of one's culture on health expectations and the medical encounter provides the basis for understanding intercultural conflicts in provider-patient relations and enhancing patient care by providing caregivers and consumers greater knowledge of one another.

Areas of Applied Medical Anthropology

The many different areas of medical anthropology reflect a growing trend of applying cultural knowledge to resolve health problems; a variety of aspects are listed below in "Applications: Areas of Medical Anthropology." Cultural knowledge and intercultural perspectives help facilitate relations among provider cultures, patient cultures, and institutional cultures. Cultural perspectives inform providers regarding how patients, families, and significant others conceptualize health problems and will respond to proposed care. Cultural perspectives enhance effectiveness in clinical practice and community health by enabling changes in professional style, institutional practices, and community behaviors where appropriate. Understanding a patient's personal and social life in relationship to the treatment plan helps ensure effective communication, appropriate resource utilization, and the success of treatments. Culturally sensitive approaches also help patients by helping providers accommodate to patients' concerns with alienation, powerlessness, distress, and despair (Kleinman and Good, 1985). Cultural approaches empower health care consumers by providing perspectives that enable them to respond to interpersonal and institutional aspects of health care.

Medical anthropology addresses interfaces between culture and health in the following ways:

- Training health care providers in cultural sensitivity and competency
- Mediating among the different community segments and between providers and clients
- Researching health threats and responses in a community
- Developing policies and programs to create culturally responsive health programs
- Participating in advocacy and community empowerment to ensure the development of responsive programs

APPLICATIONS

Areas of Medical Anthropology

Public Health

- Design primary health care programs and coordinate community development
- Develop immunization, family planning, and infant and maternal health programs
- Introduce oral rehydration and immunization programs
- Develop culturally based drug abuse rehabilitation and prevention programs
- Perform health education and preventive medicine
- Perform epidemiological studies and community assessments
- Provide health policy analysis and advocacy
- Supply international health and international medical relief (aid)
- Perform health systems integration (traditional and modern)

Physical and Biological Areas

- Provide nutritional anthropology: diet, culture, and infant nutrition
- Perform genetic anthropology and human genome studies
- Perform forensic anthropology, skeletal analysis, and medical examiner work
- Study ethnopharmacology and traditional healing practices
- Study evolution of the body in relation to disease and healing responses
- Create cross-cultural human development
- Study culture, drug use, and drug reactions

Clinically Applied Anthropology

- As cultural consultants and advisors, and sometimes as therapists, engage in mediation
- Serve as advocates, reformers, institutional change agents
- Serve as policymakers and program developers
- Perform program needs assessment and evaluation
- Teach **transcultural** nursing and transcultural psychiatry
- Identify culture-based mental disorders and “culture-bound syndromes”
- Identify or develop “cultural healing”: psychological, social, and mental healing processes
- Study cultural anthropology of ethnic health practices
- Develop alternative or complementary medicine traditions in the United States

Institutional Analysis and Culture Change

- Mediate between different groups and conceptual systems (patients and providers)
- Facilitate relations among staff (doctors, nurses, therapists, administrators).
- Represent community groups, organizers, advocates, and social reformers
- Perform research, assessment, and evaluation
- Develop programs and educate staff
- Serve as ombudpersons (patient advocates)
- Provide institutional assessment and organizational culture studies
- Assess politics and economy of medicine
- Enhance provider-client relations

PRACTITIONER PROFILE

Linda M. Whiteford

Linda M. Whiteford, Ph.D., M.P.H., is professor of the Department of Anthropology, University of South Florida. What follows are some of the things a medical anthropologist might do. Whiteford's research has centered on questions of equity and equality, access to resources, health behaviors, and health care policies and, most important, how they intersect.

In the 1980s, Whiteford participated in a nationwide project for the Children's Defense Fund on access to health care for poor children in Tampa, Florida. The research showed that, due to reduced federal funding for health care, no pediatricians would see Medicaid children in their private practices and that poor children were being denied access to health care. Policy was then changed to increase children's access to health programs. The medical anthropological approach of on-site observations, patient and practitioner interviews, and a community-based research team generated both the data and the community support necessary to change access to health care for poor children in Tampa Bay.

For the past ten years, Whiteford has conducted research on health care systems in Cuba and the Dominican Republic, which share geography, environment, history, and populations. But since the Cuban revolution, their health care systems have differed in important ways. Cuban political will translated into successful community-based health care programs, with radical reductions in infant and maternal mortality rates, rates of infectious disease, and the control of outbreaks of dengue fever. The Dominican Republic initially developed an extensive and effective primary health care system in the early 1960s and then, as politics in both the United States and the Dominican Republic changed, that community-based primary health care system was allowed to be replaced with a hospital-based system (see Whiteford and Nixon, 1999).

In 1989 Whiteford coedited (with Poland) *New Approaches to Human Reproduction*, discussing social and ethical issues around the evolving reproductive technologies. In 2000 Whiteford coedited a book on international health in which medical anthropologists from various countries addressed the question of how anthropologists can help level the playing field in international health, a field unlevelled by history, geography, and economics. The authors document how anthropological methods and theoretical approaches help us understand what happens when local needs and realities conflict with international health care policies, such as the availability of "super" antibiotics.

CONCEPTS OF HEALTH

Cultural concepts underlie people's health concerns, which involve broader issues than physical disease, including vague sensations; sharp, dull, or punishing pains; a lack of energy; and a loss of harmony involving personal, emotional, social, and spiritual dimensions. From the early work of anthropologists on spirit illness, witchcraft, and other supernatural causes of disease to the later-twentieth-century work on supernatural theories of illness (e.g., Murdock, 1980), cultural beliefs are illustrated as central

concerns of healing systems. Cultural perspectives on health as well as contemporary concepts used in public health and community medicine involve broader issues than physical disease.

What Is Health?

Conceptions of what constitutes health vary widely. This book takes Durkheim and colleagues' (1997) perspective that health involves not only physical, mental, and social well-being but also the ability to participate in everyday activities in family, community, and work, commanding the personal and social resources necessary to adapt to changing circumstances.

Ancient meanings of health implicating the sacred (holy, hallowed) illustrate a broad range of concerns still attested to in contemporary ethnomedical systems: wholeness, morality, wickedness, spiritual crises, soul loss, possession, bewitchment, and other maladies that afflict humans. To some people, health is a general sense of well-being, "feeling good." For others, health includes the expectations that they will not become ill or will be able to recover quickly. For most, health involves the ability to do what they want to do, with one's body not presenting difficulty in normal activities. For some, health has moral connotations, with disease the consequence of immorality. People's prominent concerns

CULTURE AND HEALTH

Etymological Views of Health

These wider concerns of **health** are reflected in ancient root meanings of "heal," "disease," "sickness," and "illness." **Heal** means "To restore to health . . . to set right, amend. . . . To rid of sin, anxiety or the like. . . . To become whole and sound" (*American Heritage Dictionary*, Morris, 1981, p. 607). *Heal* is derived from the Indo-European root *kailo-*, which means "whole," "holy," and "good omen"; Old English derivative forms include "holy," "hallowed," and "whole." *Disease* has its root meaning in "ease" and means a reversal of ease. *Sick*, meaning "ailing, ill, unwell," "mentally ill or disturbed," also refers to suffering or deeply affected by emotions, mental affliction, or corruption. *Sick* is derived from the Indo-European root *seug-*, meaning "troubled" or "sad." The linguistic roots of *ill* in the Middle English *ill(e)* mean "bad" or "sickness of body or mind"; older meanings emphasized evil and wickedness (Morris, 1981, pp. 655–656), still reflected in its use to refer to evil, hostile intentions, wrongdoing, wickedness, sin, and disaster. The responses to health maladies represented in the concepts of medicine and care also reflect broader concerns. *Medicine* derives from the Latin *medicina* and the Indo-European root *med-*, which means "to take appropriate measures." *Cure* means "restoration of health" from the Indo-European root *cûra*, "care" (Morris, 1981, p. 1510). *Cure* also has ecclesiastical or religious significance, meaning "spiritual charge or care of souls, as of a priest for his congregation," from the Medieval Latin *curatus*, "one having spiritual cure or charge" (Morris, 1981, p. 323).

with health generally encompass physical, psychological, emotional, and spiritual dimensions of well-being.

Biomedical concerns with health focused on biological diseases often clash with patients' conceptions, so much so that effective care is impeded. Even doctors and patients from the same culture have different views of health because professional education socializes doctors into a worldview that patients generally do not share. Health is generally poorly understood by physicians because their medical education emphasizes detection, diagnosis, and treatment of disease, rather than health and well-being.

Biomedical Measures of Population Health Standard biomedical measures of health include mortality, the incidence of causes of death, and morbidity, the frequency of disease. There are also positive measures based on population statistics, such as

- *Life expectancy*: The average length of life for members of a specific group
- *Span of healthy life*: Adjusted average life expectancy by subtracting years of poor health
- *Health behaviors*: Acts, activities, and lifestyles that may improve health
- *Reserve health*: Capacity to resist disease and stressors
- *Social support*: Relationships providing physical and emotional support
- *Overall birth rate*: Number of children born per year
- *Population growth rate*: Birth rate divided by death rate

The numbers alone, however, do not directly reveal a population's health. Health implications of fertility must be assessed in relation to the ecological system, the population's resources, and cultural priorities (e.g., population growth, stability, or reduction). A birth rate may be excessive if it will outstrip available resources. A low birth rate may be evidence of poor overall health if the culture values large families.

World Health Organization's Concept of Health The World Health Organization (WHO) characterized health as complete physical, mental, and social well-being and the capability to function in the face of changing circumstances. The WHO also emphasized the "highest possible level of health" that allows people to participate in social life and work productively (World Health Organization, 1992). Health involves social and personal resources in addition to physical conditions; a sense of overall well-being derived from work, family, and community; and other relations, including psychosocial and spiritual (Durch et al., 1997). Some consider the WHO definition to also have problems. Can people be healthy when others suffer from inequality and a lack of resources? What about emotional, spiritual, moral, and metaphysical effects on one's sense of well-being? What about one's sense of ill health from environmental circumstances, war, injustice, and violence? Would it make you feel sick to know that children were being massacred and tortured in a nearby country by extremists? Others' pain can be our own.

Critical Medical Anthropology Concepts of Health Critical medical anthropology adopts perspectives on health that emphasize the importance of access to resources (material and nonmaterial) necessary for sustaining life at a high level of satisfaction. Health is analyzed from the perspectives of the societal factors that affect the distribution of health resources and threats to health (e.g., environmental contamination). Health conditions are affected by political decisions regarding resources for immunizations provided for care, access to care and nutrition, and exposure to environmental conditions and socially produced risks such as poverty and crime. The recognition of health effects in social, economic, and environmental factors force attention to be paid to the interactions of biological and social conditions. Multiple environmental interactions, including a range of economic, social, political, and ideological influences, mold the interactions at the microlevel of interpersonal dynamics of community and family that consequently shape an individual person's physiological conditions.

Public Health Concepts of Health Public health models (see *Healthy Communities 2000: Model Standards* [American Public Health Association, 1991] and the Assessment Protocol for Excellence in Public Health [see Durch et al., 1997]) emphasize community involvement as key to a conceptualization of health. Healthy communities have health institutions that are accountable, incorporating community involvement from planning stages through implementation and evaluation activities (see Chapter Four). Community involvement facilitates incorporation of diverse cultural perspectives on health and the services required. Community health includes services provided (treatment, immunizations) and standard performance measures. Because availability of care is a major aspect of community health, health includes the capacity of the community's health institutions to respond to potential health problems. Responsiveness requires that health institutions understand cultural and social effects on health, incorporate community perspectives on needs and desired services, and assess perceptions of the quality of services.

Cultural and Organizational Concepts of Health The revolution in health care promoted by health maintenance organizations (HMOs) in the United States since the 1980s has emphasized assessment and monitoring of health and perceptions of quality of care. This has required an expansion of the concept of health from the "absence of disease" to views reflecting culturally valued functional abilities and conceptions of well-being. Quality of care is an experience based in patients' personal, social, and cultural expectations and has become a legitimate criterion in the health industry for assessing patient satisfaction and determining how to improve health care (Press, 1997). The organization, values, and roles of providers are cultural phenomena central to the overall quality of care that a patient experiences. The focus on quality and patient experiences provides roles for anthropologists in improving health care by the following measures:

- Determining the culturally based conceptions of what constitutes quality care
- Creating organizational change in health institutions to enhance their ability to provide culturally responsive care

- Instituting community assessment and organization to guide the development of institutional and personal resources to ensure health
- Providing staff training in cultural dynamics of interpersonal relations

Improving the quality of care requires the development of cultural measures that reflect community priorities for health and perceptions of well-being. Culture is central to health assessments because culture affects the interpretation of experiences, criteria for normalcy, social expectations, and expectations regarding quality of life. Cultural health concepts include

- Concepts of desirable physical abilities
- Views of ideal, normal, and problematic bodily conditions
- Preferred psychological dynamics, emotional states, and social relations
- Illness concepts and perceptions of symptoms
- Spiritual or metaphysical conditions and relations

CULTURE AND HEALTH

Native American Religious Health Beliefs

Religion is important in the traditional indigenous health care systems of Native Americans and their conceptual frameworks of disease. Health issues are not merely biological but are spiritual and religious issues as well. Native American concepts of health as situated in a balance of forces are expressed through the four aspects of the medicine wheel, involving the physical (body), mental (mind), spiritual (soul), and emotional (heart). Illness is the consequence of disharmony and imbalance, rather than just disease; even disease may be the consequence of imbalance. Consequently, healing must address not only symptoms of disease but also the root causes, healing the mind, spirit, and emotions. This religious view of health does not reject the views of biomedicine. Some diseases are considered to be “white man’s diseases” and require treatment by physicians. Even disease, however, may require treatment by traditional ceremonies that address the ultimate causes that placed one at risk of disease, taking spiritual actions to restore the personal and social harmony that permits good health. A Native American may receive healing of an illness (spiritual dimension) and experience enhanced health, even if the disease (biological problem) is not cured. This is the power of traditional healing ceremonies that make life more meaningful and balanced, as illustrated in Hammer-schlag’s (1988) *The Dancing Healers*. In his book *Indian Healing* (1982), the psychiatrist Jilek suggests spiritual concepts as key to indigenous healing rituals and vital to Native Americans’ health. These health practices reintegrate their identities, addressing the split in self and the conflicts from being caught in between Native American and European American models of self and well-being. Jilek discusses “spirit illness” as a manifestation of anomic depression, depressive experiences resulting from anomie—the breakdown of societal norms.

Assessing Personal Concepts to Improve Health Health is not merely the absence of disease or distress; it is also a positive state of physical, emotional, mental, personal, and spiritual well-being and a balance with nature and the social world. This notion of health as a relationship between the individual and his or her environment illustrates that what constitutes health differs from person to person and culture to culture. In some cultures, obesity is viewed as unhealthy and low body fat as healthy; for other cultures, it is the reverse: obese people are viewed as healthy and skinny people as sickly. Because perceptions of health are functional and related to the ability to carry out everyday activities, there is both cross-cultural and intracultural (within-culture) variation in the concept of health. People of different educational levels, social classes, and occupations (e.g., warehouse workers versus clerks) have different everyday activities and expectations about well-being. Self-assessments (see Self-Assessment 1.1 for examples) of health beliefs and behaviors provide an enhanced awareness of health concerns that facilitate the work of providers and empower patients. Differences in health conceptions affect the medical consultation process, but providers are often unaware of or ignore these differences, assuming that patients accept the medical view. Ignoring patients' perceptions undermines providers' ability to relate to patients to understand their concerns and to get them to accept treatments. Effective health care requires that practitioners understand patients' perceptions of health so that they can be integrated into treatment. Patients' perspectives are essential for developing prevention services because the recognition of conditions and the use of resources depend on people's perceptions of what constitutes a threat to health.

Awareness of the cultural basis of one's own health beliefs can facilitate relations of providers with patients and vice versa. Awareness by providers that their self-care practices often fall outside the biomedical paradigm can facilitate insight into clients' behaviors and promote empathy between provider and patient. If providers do not conform to the biomedical paradigm—agreeing that there is only biological cause of disease and depending on physicians for care—there is little reason to expect that their clients will. Health concerns can be best understood in relationship to culture. Biomedical views of health based strictly on biology impair understanding of underlying causes of disease that result from social conditions.

SYSTEMS APPROACHES TO HEALTH

Blum (1983) proposed that we need to recognize somatic, social, and psychic dimensions of health. *Somatic health* is based primarily on the functions of a person's bodily systems, *social health* derives from the appropriateness of one's behavior from perspectives of family and social others, and *psychic health* reflects a balance in sociocultural demands and perceptions. Somatic, social, and psychic health may be affected by perturbations in any aspect of the system: by national decisions (such as war), interpersonal relations (such as conflicts), and biological levels (such as bacterial infections). These levels interact, such as when bacterial infections increase because wars destabilize and contaminate ecological systems, or conflict in interpersonal relations causes stress responses and compromised immune systems. The "Practitioner Profile" of Whiteford (above) illustrates

how government policies lead to poor children's lack of access to pediatricians. These interactions among many parts of the natural systems are mediated by culture; the complex aspects of these interactions are illustrated through cultural systems models, which detail the many aspects of the physical, social, and cultural environments that affect health and well-being.

Biopsychosocial Model of Health

A **biopsychosocial model** was introduced by Engel (1977, 1980) as a corrective to the biomedical focus on disease as basically a physiological condition. The biopsychosocial model (see Figure 1.1) portrays health as related to both natural and cultural environments,

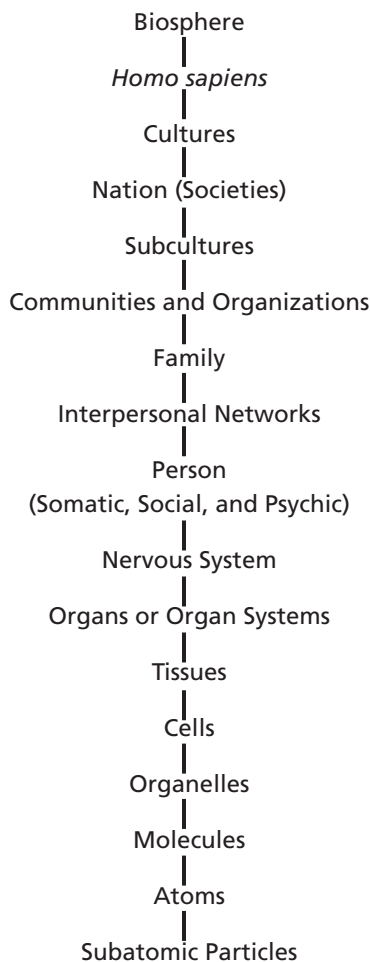


FIGURE 1.1. *Biocultural Interactions: Hierarchy of Natural Systems*

Source: Adapted from Engel, 1980, and Brody, 1973.

involving biological as well as psychological, social, and cultural contributions to patients' psychosocial factors and relationships to the health care system. A more inclusive scientific approach to the study of health requires addressing biological, psychological, social, and other cultural determinants that affect health and the physical environment. The biopsychosocial model presupposes many influences on health, including a number of aspects of culture—society, nation, community, and family—that affect biological processes. Addressing psychosocial dynamics also improves provider-patient relations and communication because understanding patients' complaints requires a perspective that links the individual to the social and cultural environments within which conditions are experienced and interpreted.

Human functioning within physical environments, cultural influences, and hierarchical physiological systems enables our health to be affected through influences at levels above us (e.g., political decisions regarding health care funding) or below us (e.g., contaminants absorbed by our lungs). Humans' biological processes operate in relationship to many influences from the social, cultural, and physical environments, causing disruptions of homeostasis (balance). These relationships allow perturbations induced at one level (e.g., discrimination-induced interpersonal stress or beliefs about exposure to germs or threats about terrorist attacks) to affect our psychological and biological well-being. Social stress and its physiological effects may be evoked by social or psychological factors and affect our organs and tissues. Political events may provoke psychological distress—for instance, stress in our interpersonal relations. Effects in the environment, such as the weather, can affect our moods and relations with others—and make our joints hurt! The numerous factors that impact health require general models to organize our considerations of the diverse inputs.

Cultural Systems Models

Culture provides the core conceptual framework for understanding all of human behavior, including health behavior. Cultural concepts provide an important corrective to the prevalent view that biology determines health, behavior, and intergroup differences. The effects of culture are found throughout human life, shaping even biologically based needs such as reproduction, diet, and elimination. Culture affects health through **risk factors**, conditions associated with an increased likelihood of diseases (e.g., smoking), and **protective factors**, behaviors that reduce disease risks (e.g., sexual restrictions such as monogamy). These cultural effects occur within a system of material, social, and mental (belief) relations that provide mechanisms through which cultural effects are basic to health conditions.

Cultural perspectives are essential to understanding ethnic differences in health status. Why, for instance, do African Americans have rates of mortality due to cardiovascular disease (CVD) that are about twice the rates for Hispanic Americans? These differences reflect influences of culture operating as risk and protective factors. African Americans face risks that come from numerous aspects of the environment—physical, social, and cultural. In this book, we explore these cultural dynamics of CVD for African Americans, summarizing at the end of each chapter some of the principal implications derived from the material covered.

Cultural effects on health are part of a system linking the physical environment, social institutions, and biology. Although they also include the physical environment, I refer to these systems as cultural systems models out of recognition that culture shapes our understandings of and interactions with the physical environment, including having effects on the physical environment. Similar cultural systems models have been proposed by physicians, nurses, and public and community health practitioners (Brody, 1973; Engel, 1977, 1980; Blum, 1983; Leininger, 1991, 1995; Baer, Singer, and Johnsen, 1986; Sallis and Owen, 1998), who use cultural systems approaches as conceptual frameworks for addressing health, disease, and care in relationship to the **ecology**, the total physical and social environment. These models also incorporate demographic, technological, economic, political, and other social conditions that affect the physical environment.

To understand the relationships of organisms to their physical environments, cultural systems models are essential because they are mediated through sociocultural systems. Cultural models direct attention to the many conditions that affect health. Cultural systems approaches expand the biopsychosocial perspective in recognizing social factors as fundamental causes of disease. The biopsychosocial approach called attention to the *individual* psychosocial determinants while neglecting the broader *social* factors that are fundamental causes of disease and necessary concerns in prevention efforts.

Cultural systems models help explain the many factors that affect health by illustrating conditions affecting the causes and distributions of disease and the responses of individuals and health care systems. Economic, political, and other social conditions, as well as cultural values, beliefs, and meanings, have active roles in the causation of disease and the allocation of remedies. Cultural beliefs and resources, sickness and healing roles, and the distribution of resources affect an individual's experience of a condition. Cultural beliefs and technological, economic, and political priorities are reflected in treatment. Effectively addressing health requires understanding the structural components of cultural systems and their influences on health. Cultural systems approaches to health examine the interaction of the physical and sociocultural environments. The "environment" is not merely physical but fundamentally cultural, which includes economic, familial, community, class, political, and religious dimensions and their effects on the physical environment.

Physicians, nurses, and public and community health practitioners (Brody, 1973; Engel, 1977, 1980; Blum, 1983; Leininger, 1984; Baer, Singer, and Johnsen, 1986; Sallis and Owen, 1998) have proposed similar systems approaches as conceptual frameworks for addressing health, disease, and care in relationship to the ecology. These models also incorporate demographic, technological, economic, political, and other social conditions that affect the physical environment. Cultural systems perspectives prominent in community health include the "environment of health" or "force-field paradigm" (Blum, 1983; Evans and Stoddart, 1994), which views health as a product of the relationships among many subsystems or fields:

- The physical environment, including sanitation, housing, environmental toxicity, and the physical infrastructure of health care
- The social environment, including family, work, class, education, and social networks

- Persons' individual behavior, especially lifestyle, that links them to the environment
- Medical care services, part of the social environment with a special role in health
- The genetic and biological level

These interdependent fields (or subsystems) affect one another, operating through natural resources, the population and its ecological balance, and cultural systems mediating human interaction with all of the fields: for example, resources, social networks, and medical services. Environmental influences include the reciprocal influences of human impacts on the environment (such as contaminants) and stressors produced by social conditions (such as crime). Lifestyle and behavioral factors affecting health involve many cultural and social dimensions, including risk behaviors, social support, and individual activities. The multiple determinants of health and their dynamic relationships illustrate that health is not strictly a function of disease, biology, or genetics but rather their complex interaction with social, economic, political, and other cultural conditions that produce the individual's behavior and biological conditions. Blum (1983) emphasized hereditary forces as last in order of relative importance for health and the environment, including physical, economic, and social dimensions, as having the greatest impacts on health.

Public health models of health (Sallis and Owen, 1998) emphasize the need to address interrelated levels, including the intrapersonal (psychological), interpersonal (primary groups, especially family), and institutions in community and society. For example, effective programs for improving health must address a spectrum of levels, going beyond personal and interpersonal approaches in identifying how cultural and ecological factors interact in producing influences on health.

Systems perspectives are important because health behavior is not merely a function of microlevel interpersonal interactions of family and community; they are also affected by our mesosystems linkages between our microlevel interpersonal relations and the macrolevel resources such as political power and societal resources that affect health. Does your family know how to obtain welfare, disability payments, or food assistance? These are mesolevel linkages to resources provided at the macrolevel by governments. Do you know how to obtain scholarships and grants to pay for medical school? These, too, are mesolevel linkages. Cultural approaches to health emphasize the necessity to direct interventions at the various environments that influence health and risk behaviors. Health problems created by ecological conditions such as air pollution and poverty cannot be eradicated in the clinical setting but only by altering those macrosystem conditions.

Clinical services are not passive agents affecting health but resources mediated by economic and political factors, especially health policies (e.g., who gets to receive federal funding for health services: individuals or only local governments and hospitals?). When there is government funding for public health, who are the real beneficiaries, the poor who receive free immunizations or the stockholders of the companies who may receive millions or even billions of dollars for providing the vaccines? Political effects on health are revealed in the enormously greater public investment in hospitals and biomedicine versus

public health activities and community health centers that can more directly affect the occurrence of disease. Public health approaches are more cost-effective in preventing disease, with systemic interventions such as public service announcements or free clinics affecting a large population, rather than the individuals seen in clinical treatment. Public health interventions directed at groups and communities require culturally informed approaches that use information on the environment, community dynamics, health resources, and social networks.

Sociocultural Theories of Disease

How does culture produce health consequences? In medical anthropology, explanations of the cultural effects on health have emphasized three basic theoretical approaches that supplement the biomedical approach:

- Medical ecology theories concerned with interactions with the ecology, the total environment affecting human adaptation, using human genetics and group behavior as principal levels of explanation
- Political economy and critical medical anthropology approaches that show how social relations, economic resources, and power are determinants of disease and disease outcomes through producing risks and distributing resources
- Cultural theories concerned with how beliefs, values, and customs are determinants of disease, operating through symbolic processes that have effects on biological levels

These three approaches are all concerned with the impacts of culture on biology, as illustrated in Hahn's (1995) discussion of mediation, production, and construction models of sociocultural disease causation.

Mediation Mediation approaches reflect perspectives similar to the biopsychosocial approach, emphasizing how sociocultural factors affect people's exposure to pathogens. Mediation models of sociocultural influences on health are partially recognized in biomedicine, manifested in the concern with health influences of lifestyle and personal habits (e.g., effects of diet, drugs, and sex on health). Mediation models view sociocultural effects on health as the differential distribution of the population with respect to the environment, risk factors, economic resources, occupational hazards, social activities, and other conditions that produce diseases and provide resources to ameliorate their effects. Cultural behaviors and social conditions affect exposure to pathogens and access to treatments, differentially affecting the well-being of different segments of the population (e.g., poor versus rich). These medical anthropology approaches are exemplified in the medical ecology perspectives presented in Chapter Seven.

Production Production perspectives emphasize how social conditions produce health maladies through the distribution of risks and resources and by social and symbolic effects on biology. Production perspectives recognize a stronger cultural determination of health in its potential to cause biological disorder. Cultural practices such as contamination, work

conditions, drug use, and unsafe sex directly cause disease. Culture directly affects biological processes through psychosomatic reactions, social stress precipitating the disruption of cardiac function, and social conditions (e.g., industrial waste, traffic, and labor accidents). Hahn suggests that the “production” model is ridiculed in biomedicine because it is seriously misunderstood and contradicts biomedicine’s model of biological determinism. Production perspectives challenge the traditional biomedical paradigm by showing the social and mental effects on physiological processes. Cultural influences provide more than just mediation of people with respect to risks: “sociocultural effects are causal in the same way that environmental carcinogens, toxins, and bacterial and viral pathogens are” (Hahn, 1995, p. 76). The placebo phenomena exemplify the cultural production of biological responses (see Chapter Eight).

Construction Construction approaches elucidate that a culture constructs how its members think about health conditions and their social, moral, and cosmological implications and, consequently, constructs their experience of health maladies. Construction perspectives emphasize that culture affects health, illustrated in the relationship of symptom recognition to cultural values and social norms. Cultural criteria determine whether a given condition is construed as a disease or is viewed as falling within normal human variation. This cultural determination also occurs in the activities of biomedical practitioners who define relevant symptoms and interpret them. Culture is the basis of this “social labeling,” where diagnosis involves a social process in which individuals are given disease labels. Ethnomedicines produce cultural realities of health by providing models of what diseases exist and their significance, causes, and available treatments. Construction approaches may also present models similar to production perspectives, noting that people’s beliefs can have physiological consequences, as discussed in Chapter Nine.

The different approaches to the relationship of culture to health also reflect theoretical and practical differences among medical anthropology. Should health be primarily concerned with addressing biological conditions? Or should we address the political and economic forces that produce contamination, food shortages, and available services, conditions that affect health? Should alternative medicine practices be accepted as equal in efficacy to biomedicine, or should they be opposed as outdated superstitions? Should medical anthropology help physicians with cross-cultural competency skills, or should they help patients develop an understanding of the politics of medicine to better resist medicine’s political control? Despite their differences, the various approaches all use concepts of cultural systems and systems models with multiple domains to assess the many factors affecting disease and health.

SUMMARY

Cultural systems models provide integrative cross-disciplinary approaches to understanding the multiple factors affecting health. These synthetic approaches are used in all health professions. Cultural systems models that detail the many factors affecting health are discussed in Chapter Four. An extensive model focusing on the more specific dynamics of specific health problems is provided in Chapter Four’s “Rapid Assessment, Response,

BIOCULTURAL INTERACTIONS

African American CVD in System Perspective

The higher CVD risks of African Americans can be seen as the outcome of all of the sociocultural models of disease. Environmental factors mediate CVD through increased high-risk behaviors such as stress, poor diet, alcoholism, and cigarette smoking. Racism, discrimination, and poverty produce CVD through stress, unequal distribution of health resources, and the fast-food industry that saturates inner-city areas. Cultural beliefs construct health beliefs and illness behaviors that affect how CVD is recognized and addressed through traditional ethnomedical systems. To use the force-field model, although genetics may play an important role in African Americans' higher rates of CVD, there are important influences in the physical environment and ecology, socially and culturally induced lifestyle patterns, influences in the social environment, and the quality and nature of medical care services.

When the multiple factors contributing to high levels of CVD in African Americans are examined, it quickly becomes clear why a cultural systems model is necessary. Factors affecting the manifestation of CVD begin with the general ecological system, where a dangerous inner-city environment increases stress and inhibits exercise, an important protective factor in CVD. There are further risk factors derived from diet, both traditional "soul food" and fast foods. Treatment utilization is affected by family, community, and religious self-care practices, which often preclude timely care. The lack of care caused by poverty, lack of education, and insufficient public care facilities all contribute to increased risks. Political factors further compound risks by neglecting public education programs, reinforcing feelings of racism that increase stress. The health beliefs may also complicate CVD problems, with the concepts about dietary treatment of "high-pertension" conflicting with medical advice regarding diet. We will explore these and other interacting factors further in the following chapters.

and Evaluation (RARE)" modules. Additional models are also provided in Chapter Six in the coverage of the psychocultural model. Effective adaptations to cultural differences require more than understandings of the structural models of culture.

CHAPTER SUMMARY

This book provides the basis for developing a cultural competency approach to health and health care. Health care providers, helping professionals, anthropology students, and consumers can all benefit from the basic understanding of how cultural processes affect health. Medical anthropology contributes to biomedicine and the study of health through an integrative study of humans across their physical, behavioral, social, and cultural dimensions. Anthropology's interdisciplinary biological and cultural approaches have practical applications in medicine, nursing, public health, community health, psychology,

PRACTITIONER PROFILE

Edward C. Green

Edward C. Green, Ph.D., is director of the AIDS Prevention Research Project at the Harvard Center for Population and Development Studies. He has worked for a number of international development or health organizations or agencies over the past thirty years, much of the time as an independent consultant based in Washington, D.C. Most of his work has been in Africa, but assignments or research have also taken him to Asia, Latin America and the Caribbean, eastern Europe, and the Middle East, adding up to about forty countries. He worked as an applied medical anthropologist for the ministries of health in both Mozambique and Swaziland. Much of his work since the 1980s has been in AIDS and STDs. He is currently involved in AIDS-related behavioral studies in Uganda and South Africa. Green has been a pioneer in integrating indigenous African and Western biomedical health systems and in promoting evidence-based AIDS prevention.

In addition, Green has worked in family planning including contraceptive social marketing, primary health care, maternal and child health, psychosocial issues of children affected by war, child nutrition, potable water and sanitation programs, environmental health, U.S. minority health issues, and biodiversity conservation. He believes that anthropologists are able to move among specialties and cultural areas more easily than those trained in other disciplines due largely to the holistic nature of anthropology and the steady demand for qualitative and survey research skills and experience.

Of Green's six books, *Rethinking AIDS Prevention* (2003) has had the most impact on global AIDS policy. He argues that the "generalized" epidemics of Africa are fundamentally different from all other HIV epidemics and that prevention requires reduction in multiple and concurrent sexual partnerships and cannot be left to technology transfer alone. He has debated this issue in Congress, on radio and television, in public debates, op-eds in leading newspapers, and on advisory councils (Presidential and National Institutes of Health).

and other disciplines. Health professionals need cultural perspectives because of multicultural societies' diverse health practices and the cultural differences between providers and the population at large. Cultural approaches contribute to the scientific concerns of biomedicine by providing culturally specific knowledge and cross-cultural perspectives. The basic ethnographic methods of cultural anthropology provide the "other's" perspective and a basis for understanding health beliefs and behaviors and their consequences for health. Anthropology also provides cross-cultural approaches that help establish perspectives, exemplified in transcultural psychiatry and nursing, that apply to all humans.

Health care practitioners need to understand cultural effects on health to improve relations between providers and clients. A major challenge facing biomedicine is people's behavior—compliance or patient adoption of medical recommendations—whether it involves changing risk behaviors, acceptance of public health directives, or adherence to

treatment plans. To address biomedicine's alarmingly high rate of nonadoption by patients of doctors' clinical recommendations (20 percent to more than 80 percent), effective relationships and communication need to be established between providers and clients. This requires an understanding of the patients' models of health and skills in negotiating between doctor and patient perspectives. Anthropology can enhance the effectiveness of biomedicine in helping to address patients' cultural concerns, perspectives that providers need to understand to achieve patient satisfaction and ensure treatment compliance. Cultural perspectives provide a range of clinical benefits, including accurate assessment, appropriate communications, and institutional goals such as reduced patient alienation and litigation and increased satisfaction.

Medical anthropology addresses concerns of the public, enhancing patients' care by improving providers' ability to provide effective care. Medical anthropology also increases the public's understanding of the cultural and political dynamics of health and engages in advocacy on behalf of those less able to secure needed resources and in regard to encouraging society to adopt educational approaches to empower consumers. Medical anthropology's studies of health and healing give both providers and patients an enhanced understanding of healing processes. A principal anthropological insight involves the effects of culture on physiological processes. Anthropology illustrates culture's role in shaping the organism's response to disease, providing a new paradigm for health that is more encompassing than the biomedical paradigm's emphasis on physiological causation. Medical anthropology integrates environmental, biological, interpersonal, political-economic, and symbolic perspectives in a cultural systems model that helps explain health effects and behavior.

Knowledge of cultural systems' effects on health and health care enhances the effectiveness of providers and empowers patients because culture provides the foundation for all health and health behaviors. Recognition of those cultural dynamics enables practitioners to enhance relations with diverse client groups, reducing the difficulties presented by cultural differences and enhancing the well-being of both providers and clients. Knowledge of the cultural, social, and political dimensions of health and health care can empower both professionals and consumers. These models allow them to address the systemic cultural effects on health; in addition, they provide cultural perspectives in training, research, community empowerment, and organizational change. Anthropology's perspectives provide a basis from which to understand

- Cultural effects on the conceptualization of health problems (Chapter Two)
- Cross-cultural relationship and communication skills for clinical consultation (Chapter Three)
- Cultural systems models for addressing diverse impacts on health (Chapter Four)
- Cultural effects on health behaviors and utilization (Chapter Five)
- Cultural effects on psychological normalcy, development, and identity (Chapter Six)
- Cultural-ecological perspectives on the evolutionary basis of health problems in interaction with the current environment (Chapter Seven)

- Critical social perspectives on the ways in which economic and political factors affect health (Chapter Eight)
- Interdisciplinary understanding of the ways in which cultural beliefs have effects on physiological processes (Chapter Nine)
- Ethnomedical models of healing processes, such as shamanism, that expand our conceptual frameworks beyond the mechanisms typically addressed in biomedicine (Chapter Ten)

KEY TERMS

Biomedicine	Emic
Biopsychosocial model	Ethnography
Capitalist medicine	Ethnomedicine
Competence	Etic
Culture	Macrolevel
Cultural awareness	Microlevel
Cultural competence	Morbidity
Cultural proficiency	Mortality
Cultural sensitivity	Protective factors
Cultural systems model	Psychoneuroimmunology
Culture	Risk factors
Ecology	Socialized medicine

SELF-ASSESSMENT 1.1. PERSONAL HEALTH ASSESSMENT

How do you personally define health?

What does it mean to you to be healthy?

What do you do to maintain your health?

What are some of the values you associate with health?

What personal values or failures do you associate with having health problems?

How are your health values related to your culture's values in general?

Do your values help or hurt your health?

Are there specific diseases that have a moral quality to them?

What are some of the things you do to reestablish your health when you have problems?

Have you ever used an alternative or complementary treatment? What was it and for what condition? What was the outcome?

SELF-ASSESSMENT 1.2. MINORITY HEALTH CULTURE ASSESSMENT

Using the above questions, interview one or more people from a minority, ethnic, or foreign culture, preferably someone with a traditional cultural orientation.

How is their cultural background reflected in their responses?
 What are major differences in their responses from your own?
 How could their health culture affect relationships with biomedical practitioners?

SELF-ASSESSMENT 1.3. CULTURAL DYNAMICS OF HEALTH

What are some of the physical and environmental conditions in your community that affect health status? For the better? For the worse?

What are some of the social conditions in your community that affect health status? For the better? For the worse?

What are some of the ideological conditions (beliefs and attitudes) in your community that affect health status? For the better? For the worse?

SELF-ASSESSMENT 1.4. CROSS-CULTURAL DEVELOPMENT

Respond to how you feel about each of the following statements by circling **No** (=0) or **Yes** (=1). See Exhibit 1.1 for the scoring. After you have assessed your responses on the scales provided, read more about them in Chapter Three.

1. **No** **Yes** I am just a normal person, without any special cultural identity or characteristics.
2. **No** **Yes** My principal characteristics as a person reflect basic aspects of human nature.
3. **No** **Yes** Immigrants to the United States should be expected to keep their own values and customs.
4. **No** **Yes** People of a racial group are generally all basically the same.
5. **No** **Yes** True Americans are all basically the same.
6. **No** **Yes** My cultural group is superior to most other cultures.
7. **No** **Yes** My basic values and beliefs are based in ethnocentrism and prejudice.
8. **No** **Yes** The government should control minority groups for their own good.
9. **No** **Yes** There is only one correct way to behave if you are going to live in the United States.
10. **No** **Yes** Cultures that do not have Christian values are basically immoral.
11. **No** **Yes** It would be better if people of different ethnic groups kept to themselves.
12. **No** **Yes** I would prefer to live in a community where foreigners are not allowed.
13. **No** **Yes** I think that we should treat everybody the same.
14. **No** **Yes** Minority groups would be better off if they “melted in” like everybody else.

15. **No Yes** I feel that we would be better off if we practiced color blindness.
16. **No Yes** People from minority groups are poorer because of societal prejudice and discrimination.
17. **No Yes** People of specific races are all basically the same.
18. **No Yes** Differences in personal success generally result from different opportunities in life.
19. **No Yes** I think that religious punishments should be outlawed everywhere.
20. **No Yes** Cultural background basically determines the way that people behave.
21. **No Yes** Cultural differences are less important than humans' biological commonalities.
22. **No Yes** Despite cultural differences, all human behavior is governed by the same principles.
23. **No Yes** There is only one true god who evaluates the morality of humans' behavior.
24. **No Yes** I am comfortable attending religious services of faiths other than my own.
25. **No Yes** What is normal behavior differs from one culture to another.
26. **No Yes** Other cultures' ways of behaving are as valid and legitimate as my own.
27. **No Yes** Politicians need to pass laws to help ensure that foreigners do not change our country.
28. **No Yes** It is dishonest when ethnic minorities try to act as if they are like other Americans.
29. **No Yes** Everyone should have to learn about the cultures of American minority groups.
30. **No Yes** I behave in different ways depending on whom I am with.
31. **No Yes** Islam is just as moral as Christianity or Buddhism.
32. **No Yes** People who practice animal sacrifice as part of their religion should be put in jail.
33. **No Yes** Cultures in which people eat dogs and cats are really evil.
34. **No Yes** Other cultures' values are as worthy of respect and tolerance as my own values.
35. **No Yes** There are no universal standards for evaluating what is right or wrong.
36. **No Yes** Americans would be better off if we adopted some practices from other cultural groups.

37. **No Yes** In Muslim cultures, women should generally appear in public only with their faces covered.
38. **No Yes** I have been able to show that I can view reality from the perspective of another culture.
39. **No Yes** There are many different cultural definitions of reality and morality that are equally valid.
40. **No Yes** It is important to me to be able to speak more than one language.
41. **No Yes** I have incorporated aspects of other cultures into my life and behavior.
42. **No Yes** I have established close friendships with people from other cultures.
43. **No Yes** You can relate better if you know a person's age, racial identity, education, and social class.
44. **No Yes** My culture makes me really different from the people with whom I regularly associate.
45. **No Yes** I do not identify with the traditions of my parents and grandparents.
46. **No Yes** I would be embarrassed if my friends found out about the cultural background of my family.
47. **No Yes** I feel like I have a split personality, that I am a different person at home than I am at work or school.
48. **No Yes** Some aspects of my parents' or grandparents' culture embarrass me.
49. **No Yes** Sometimes I feel like there are two different cultures fighting inside me.
50. **No Yes** I sometimes feel like I am putting on an act to fit in with others.
51. **No Yes** I feel more comfortable when I am with people from a culture different from my own.
52. **No Yes** I use the language and cultural behaviors in everyday life of groups other than my birth culture.
53. **No Yes** People in another cultural group have adopted me, considering me to be their own.
54. **No Yes** I can feel totally comfortable being in a culture different from my birth culture.
55. **No Yes** I can feel like a totally different person when I am with people of a different culture.
56. **No Yes** The way in which I evaluate a situation and behave depends on who is involved.
57. **No Yes** There is no objectivity; I create my own reality.

- 58. **No Yes** I do not adhere to the values and beliefs of any one culture.
- 59. **No Yes** Whether or not something is immoral depends on the situation and who does it.
- 60. **No Yes** Who I am depends on whom I am with.
- 61. **No Yes** Clients should be required to use English when seeking social services.
- 62. **No Yes** Services provided by employees of public agencies should always be provided in English only.
- 63. **No Yes** I am able to work effectively with clients from a cultural group different from my own.
- 64. **No Yes** Policies of social work agencies ought to reflect the expectations of the cultural groups they serve.
- 65. **No Yes** Public agencies should use the same procedures for dealing with clients of all ethnic groups.
- 66. **No Yes** Public service organizations should be required to hire personnel at all levels of the organization that reflect the ethnicity and culture of the community.
- 67. **No Yes** I have solicited suggestions from community groups on how to improve my professional practice.
- 68. **No Yes** Public agencies should support the alternative health services in their communities.
- 69. **No Yes** Community groups ought to have a say in the policy and practices of social service organizations.
- 70. **No Yes** Social service agencies should have advisory and review boards that include representatives from all of the major ethnic groups in their service area.
- 71. **No Yes** Public agencies should translate written materials into the major languages of their community.
- 72. **No Yes** Social service agencies should provide services in the language most comfortable to their clients.
- 73. **No Yes** I engage in activities to make sure the rights of minority groups are protected from discrimination.
- 74. **No Yes** Developing cultural sensitivity in staff is the responsibility of government organizations.
- 75. **No Yes** I have trained people to use knowledge of culture to understand others, communicate empathy, and use relevant skills in working with people from another culture.

EXHIBIT 1.1. Self-Assessment 1.4 Scoring: Cross-Cultural Development

For each answer on your self-assessment, assign the value of 0 for **No** and 1 for **Yes**. Write the answer (0 or 1) to each question in the space beside the question number. Add up the totals of your answers for each line, convert your answers where instructed, and add the subtotals for an overall score for each scale.

Scale N = N1 + N2 = _____ (range 0 to 12) **Normal/Ethnocentric**: higher values indicate higher levels of ethnocentrism

$$\begin{aligned}
 N1 &= 1. \text{ ___ } + 2. \text{ ___ } + 4. \text{ ___ } + 5. \text{ ___ } + 6. \text{ ___ } + 8. \text{ ___ } + 9. \text{ ___ } + 10. \text{ ___ } + 11. \text{ ___ } + 12. \text{ ___ } = \text{ ______ } (N1) \\
 N2 &= 3. \text{ ___ } + 7. \text{ ___ } = \text{ ______ } * \text{ If 0, N2 = 2; if 1, N2 = 1; if 2, N2 = 0 } &+ \text{ ______ } (N2) \\
 & &= \text{ ______ } N
 \end{aligned}$$

Scale U = U1 + U2 = _____ (range 0 to 11) **Universalism**: higher values indicate universalist assumptions rather than recognition of the importance of cultural principles

$$\begin{aligned}
 U1 &= 13. \text{ ___ } + 14. \text{ ___ } + 15. \text{ ___ } + 17. \text{ ___ } + 19. \text{ ___ } + 21. \text{ ___ } + 22. \text{ ___ } + 23. \text{ ___ } = \text{ ______ } (U1) \\
 U2 &= 16. \text{ ___ } + 18. \text{ ___ } + 20. \text{ ___ } = \text{ ______ } * \text{ If 0, U2 = 3; if 1, U2 = 2; if 2, U2 = 1; If 3, U2 = 0 } &+ \text{ ______ } (U2) \\
 & &= \text{ ______ } U
 \end{aligned}$$

Scale AC = B + V = _____ (range 0 to 12) **Acceptance**: higher values indicate higher levels of acceptance of other cultures

$$\begin{aligned}
 B1 &= 24. \text{ ___ } + 25. \text{ ___ } + 26. \text{ ___ } + 29. \text{ ___ } + 30. \text{ ___ } = \text{ ______ } (B1) \\
 B2 &= 27. \text{ ___ } + 28. \text{ ___ } * \text{ If 0, B2 = 2; if 1, B2 = 1; if 2, B2 = 0 } &+ \text{ ______ } (B2) \\
 V1 &= 31. \text{ ___ } + 34. \text{ ___ } + 35. \text{ ___ } = \text{ ______ } &+ \text{ ______ } (V1) \\
 V2 &= -32. \text{ ___ } + 33. \text{ ___ } * \text{ If 0, V2 = 2; if 1, V2 = 1; if 2, V2 = 0 } &+ \text{ ______ } (V2) \\
 & &= \text{ ______ } AC
 \end{aligned}$$

Scale AD = E + P = _____ (range 0 to 8) **Adaptation**: higher values indicate higher levels of adaptation to other cultures

$$\begin{aligned}
 E &= 36. \text{ ___ } + 37. \text{ ___ } + 38. \text{ ___ } + 39. \text{ ___ } = \text{ ______ } E \\
 P &= 40. \text{ ___ } + 41. \text{ ___ } + 42. \text{ ___ } + 43. \text{ ___ } &+ \text{ ______ } P \\
 & &= \text{ ______ } AD
 \end{aligned}$$

Scale C = C1 + C2 + I = _____ (range 0 to 10) **Cultural Competence**: higher values indicate higher levels of cultural competence

$$\begin{aligned}
 C1 &= 63. \text{ ___ } + 64. \text{ ___ } = \text{ ______ } (C1) \\
 C2 &= 61. \text{ ___ } + 62. \text{ ___ } + 65. \text{ ___ } * \text{ If 0, C2 = 3; if 1, C2 = 2; if 2, C2 = 1; if 3, C2 = 0 } &+ \text{ ______ } (C2) \\
 & &+ \text{ ______ } (I) \\
 & &= \text{ ______ } C
 \end{aligned}$$

Scale M = _____ (range 0 to 8) **Marginalized**: higher values indicate higher levels of experiencing a *marginalized* biculturalism

$$M = 44. \text{ ___ } + 45. \text{ ___ } + 46. \text{ ___ } + 47. \text{ ___ } + 48. \text{ ___ } + 49. \text{ ___ } + 50. \text{ ___ } + 51. \text{ ___ } = \text{ ______ } M$$

Scale B = B1 + M = _____ (range 0 to 12) **Bicultural**: higher values indicate higher levels of biculturalism

$$\begin{aligned}
 B1 &= 52. \text{ ___ } + 53. \text{ ___ } + 54. \text{ ___ } + 55. \text{ ___ } = \text{ ______ } (B1) \\
 & &+ \text{ ______ } (M) \\
 & &= \text{ ______ } B
 \end{aligned}$$

Scale I = _____ (range 0 to 5) **Integrated**: higher values indicate higher levels of ethnorelativism

$$I = 56. \text{ ___ } + 57. \text{ ___ } + 58. \text{ ___ } + 59. \text{ ___ } + 60. \text{ ___ } = \text{ ______ } I$$

Scale P (range 0 to 10) **Cultural Proficiency**: higher values indicate higher levels of cultural proficiency

$$\begin{aligned}
 P &= 66. \text{ ___ } + 67. \text{ ___ } + 68. \text{ ___ } + 69. \text{ ___ } + 70. \text{ ___ } + 71. \text{ ___ } + 72. \text{ ___ } + 73. \text{ ___ } + 74. \text{ ___ } + 75. \text{ ___ } \\
 & &= \text{ ______ } P
 \end{aligned}$$

ADDITIONAL RESOURCES

Books

- Albrecht, G. L., R. Fitzpatrick, S. C. Scrimshaw. 2000. *Handbook of social studies in health and medicine*. London: Sage.
- Henderson, G. E., N. M. P. King, R. P. Strauss, S. E. Estroff, and L. R. Churchill. 1997. *The social medicine reader*. Durham, N.C., and London: Duke University Press.
- Jamner, M. S., and D. Stokols, eds. 2000. *Promoting human wellness: New frontiers for research, practice, and policy*. Berkeley: University of California Press.
- Kahssay, H. M., M. E. Taylor, and P. A. Berman. 1998. *Community health workers: The way forward*. Geneva: World Health Organization.
- Reid, R., and S. Traweek, eds. 2000. *Doing science + culture: How cultural and interdisciplinary studies are changing the way we look at science and medicine*. New York/London: Routledge.

Journals

- Anthropology and Medicine*
Medical Anthropology
Medical Anthropology Quarterly

Web Sites

- Medical Anthropology*: <http://www.medanthro.net>
National Institutes of Health (NIH): <http://www.nih.gov>