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# Inter Health

Intercultural Competences  
for Healthcare Professionals



**Erasmus+**

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Culturally diverse groups experience a burden of unmet health needs attributed to their beliefs and attitudes. Understanding patient's illness beliefs is critical to improve diagnosis and management of a disease.

It is worth noting that illness is the individual's perception of being sick while disease is referred to altered bodily state or any process that deviates from norms as demonstrated by Western biomedical science.<sup>1, 2</sup> Illness has three definitions. Two of them prevailed up to the 18th century describing illness as "wickedness, depravity, immorality" or as "unpleasantness, disagreeableness, hurtfulness". The third and modern term which is dating from the 17th century means the state of being ill. According to the medical definition, disease is a deviation from a biological norm or a pathological process having an objectivity which enables health professionals to see, touch, measure, etc. Illness is a feeling or a personal experience of unhealth and is interior to the person of the patient. The difference between illness and disease is that illness often accompanies disease or may exist in the absence of disease whereas disease may be undetected mainly in the early stages (cancer, diabetes, etc.).<sup>1</sup>

Generally, culture context explains the inherited, unquestioned and structured way individuals understand and respond to illness.<sup>1-4</sup> There are three main cultures regarding illness beliefs that health professionals should be aware since they shape health attitudes. **According to "personalistic culture", illness is linked to transgressions of a moral and spiritual nature.** The general belief is that the sick person either deserves a punishment or is a victim of evil spirits for reasons referred only to him such as contradiction to accepted customary practices, etc. For example, the fall from a tree is viewed as the result of a supernatural agent acting against the individual. This culture is found mostly in America, Africa (south of the Sahara desert), Oceania, and in tribal peoples of Asia.<sup>5</sup>

**In "naturalistic culture", illness is caused by energy imbalance with natural environment (equilibrium model) mainly due to excess heat or excess cold,** etc. For example, in many Latin American communities, the person doesn't stand on a cold floor in bare feet, doesn't wash hands after whitewashing a wall and several others. Additionally, in India, the ancient system of Ayurveda includes pharmacopeia made from herbs and minerals as well as dietary advice. Belief in naturalistic causes of illness is found among people of South India and China.

Finally, **Germ theory or biomedical model which is the basis of the Western medicine demonstrates that tumors, abnormal cells and chemicals are the causes of illness.** According to this model, specific diseases have specific causes. Therefore, each disease is having distinguishing and universal features for all human species. Taking into consideration all above illness beliefs, it is crucial for health care professionals to have a clear comprehension of what people believe to be the causes of illness, and all associated behavior following these views.<sup>5,6</sup>

Illness beliefs and perceptions about health differ from one culture to another. For example, in Western countries, the biomedical model is recognizing obesity as a determinant to adverse health outcomes whereas in Nigeria, women are fattened to improve fertility. In other cultures, obesity reflects wealth and good living. Consequently, the term "variability" is preferred to the term "normal" that is widely used in biomedical model.<sup>6</sup>

**According to the predominant biomedical model in the Western world, a disease is explained by evaluating measurable biological variables which however may differ among populations.** For example, osteoporosis in women is strongly associated with calcium intake implying that women need to drink milk whereas this is not compatible with South Asian women who at 80% are lactose intolerant. Likewise, in Western biomedical model the growth of children is calculated by height and weight however this calculation may involve risks for other ethnic groups of smaller height.<sup>6</sup> Freedman et al.,<sup>7</sup> showed during a 30-year period, that the prevalence of overweight increased approximately 3-fold (4% to 13%) among 6 to 11 years old white children but 5-fold (4% to 20%) among black children. The same researchers attributed these findings to racial and ethnic differences involving the way of living, habits and culture. Strikingly more, health professionals have to encounter with specific disease which seem to be more prevalent in certain areas or populations, such as sickle cell disease among blacks.<sup>6</sup>

**In non-Western societies, illness is figured out through social rather than biological processes with traditional healers to be the persons who manage a disease whereas in Western societies physicians are granted by**

**society to determine appropriate treatment.** <sup>6, 8-11</sup> Marshall et al., <sup>9</sup> who explored a church-going Afro-Caribbean population showed that they still rely on church leaders for guidance in health matters. Atwine et al., <sup>11</sup> in 2011 conducted a descriptive study using focus-group interviews of participants suffering from Diabetes Mellitus II (10 women and 7 men) aged 39–72 years in Uganda. Results showed the symptoms of diabetes as the main reason for seeking help to traditional healers. Additionally, they noticed that participants had sought help from different health facilities with the aid of their relatives and friends. According to Aborigo et al., <sup>10</sup> traditional medical systems remain in the first line of health services particularly in rural communities of low income countries. The same researches who conducted in Northern Ghana interviews with traditional healers having expertise in managing obstetric complications showed that most healers expressed a willingness to work with the formal health services. Therefore, the need for collaboration between all systems of care in cultural communities is emerging. <sup>11-13</sup>

**Indeed, close working between health care systems and traditional healers may be beneficial in obtaining information from all cultural sides in order to integrate different approaches of care.** Murdoch-Flowers et al., <sup>14</sup> who explored 17 adult, female Kahnawake living in Mohawk territory of Canada showed that culturally-based prevention programs regarding diabetes mellitus can facilitate modification of healthy behaviors including mental, physical, spiritual and social dimensions. Similarly, O' Mahony et al., <sup>15</sup> illustrated the socioeconomic and cultural factors along with social stigma as the main determinants for 30 immigrant and refugee women living in Canada to make decisions about health care practices. Understanding that culture may affect all disease areas such as symptom management, health seeking process, prevention, adherence to treatment, clinical care and cooperation or use of informal services is fundamental when developing transcultural nursing interventions. Boyle in 1999 declared that "Transcultural nursing is a body of knowledge that helps in provision of culturally relevant care." <sup>16</sup>

Furthermore, according to Mull et al., <sup>5</sup> expression of signs and symptoms of a disease should be distinguished from one cultural to another, thus health professionals should be urged to go beyond physical examination or medical record. **It is essential for health professionals to explore patients' lives in concordance with their social environment (naturalistic culture) or their traditional illness beliefs (personalistic culture) when describing their symptoms.** As a consequence, they will understand when the problem lies outside the realm of physical disease or when the patient complains about symptoms which are "impossible" according to the biomedical model. <sup>4</sup>

Meanwhile, **awareness of the above cultures, may help health professionals to estimate patient's role in disease management.** In personalistic culture where illness and death are believed to stem from the acts of an agent is presumed that patient adopts a passive role. In naturalistic culture where maintenance of health is ensured by avoiding behaviors producing illness, patients are usually more preventive against illness. <sup>5, 6</sup> Minas et al., <sup>17</sup> who explored the beliefs about physical and mental illness in a sample of 444 Turkish immigrants in Melbourne showed beliefs in natural causes to be more frequent than beliefs in supernatural causes. However, beliefs in supernatural causes persisted despite modernizing. The same researchers concluded that a better understanding of the diversity of illness beliefs is valuable in clinical process, and in developing effective health services and strategies.

Additionally, **it is not rare, that social, religious and cultural beliefs may limit access to health care services.** Low rates of health preventive care such as breast exams, mammograms, and cervical cancer screening were observed among immigrant Muslim women. <sup>18-22</sup> Shirazi et al., <sup>23</sup> who explored 53 non-English-speaking and first-generation immigrant Muslim Afghan women aged 40 years and older with no history of breast cancer showed low level of knowledge about breast cancer, low screening rates, and a lack of awareness of symptoms, risk factors, and screening procedures. Major barriers to screening included: absence of culturally breast health education, language difficulties, low health literacy, and embarrassment. Vahabi et al., <sup>24</sup> who explored 30 women in Toronto, between 21 and 69 years old, foreign-born and self-identified as Muslim with good knowledge of English demonstrated that health practices and beliefs in their home countries had an impact on utilization of screening services. Lee- Lin et al., <sup>25</sup> showed that an educational intervention changed

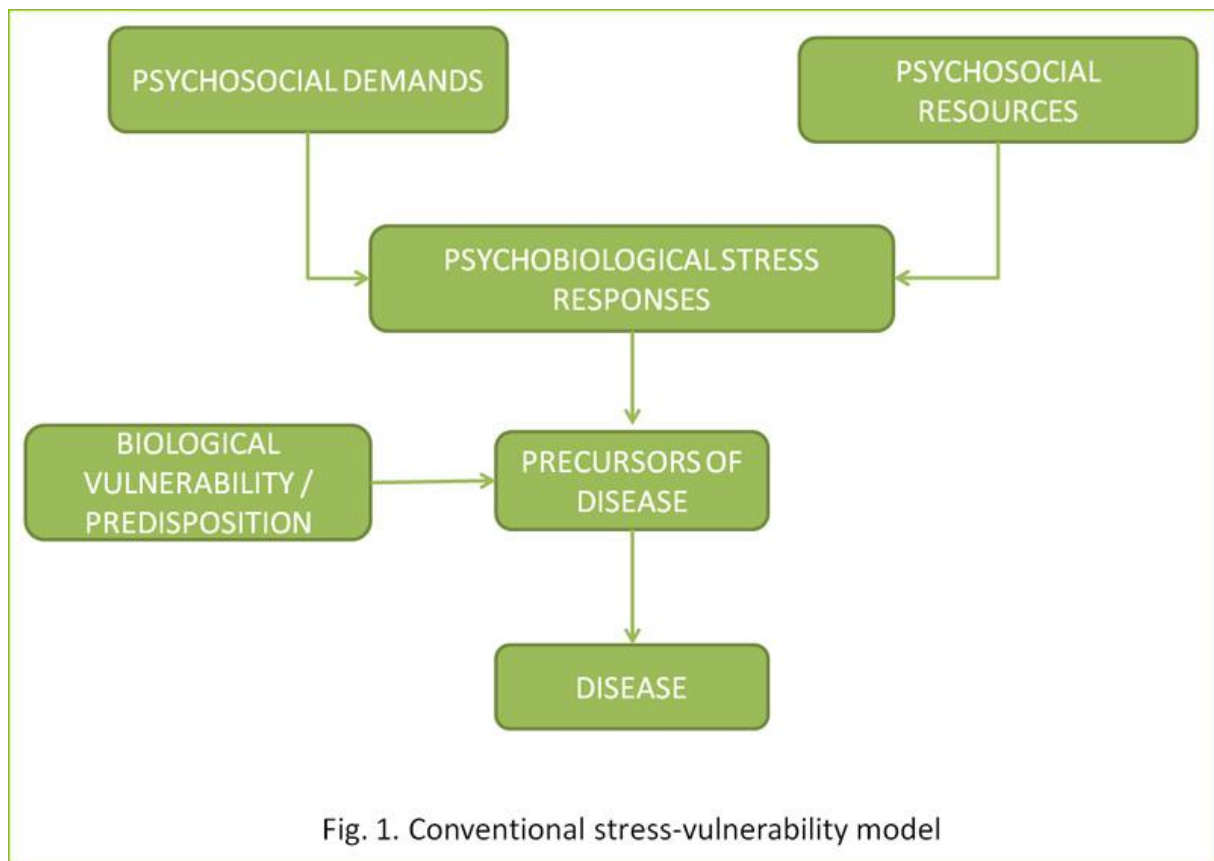
beliefs and screening attitudes in Chinese American immigrant women who were not adherent with mammography in the past 12 months.

Chukwunke et al.,<sup>26</sup> explored patients' health seeking behavior and Primary Health Care service in 10 health centers in five Eastern states of the Federal Republic of Nigeria. Results showed an underutilization of primary health care services because participants did not accept the provided health care system but they preferred traditional medicine. The majority of participants believed that diseases are caused by supernatural beings, the handiwork of neighbors or vengeance from an offended God. de-Graft Aikins<sup>13</sup> explored 26 urban and 41 rural people suffering from diabetes mellitus type II with diverse profiles (sex, age, education, socioeconomic status, diabetes status) in urban towns (Accra, Tema) and rural towns (Nkoranza and Kintampo), in Ghana. Results showed that most participants emphasized biomedical management as an ideal self-care practice. However, the high cost of biomedical care drove to medical inaction. A significant challenge for health professionals is to maximize commitment to biomedical management by providing both affordable pharmaceutical drugs and psychosocial support. The limited availability of Western medications along with the belief that medications are of high cost are held out to be the main determinants for persisting on traditional medicine.<sup>27</sup> According to Cocks et al.,<sup>28</sup> almost 27 million South Africans use indigenous medicines while remedies are including medicines which are believed to ward off evil spirits and bring good luck.

Finally, **reports of culturally diverse groups, illustrate the need for aware health professionals about their beliefs who speak their language and come from their own ethnic groups.**<sup>24</sup>

Another approach that **emotional and psychological states influence the etiology and maintenance of illness** has been gaining much attention during the last decades.<sup>29,30</sup> Pessimism and “negative” emotions (e.g. fear, anger, anxiety, depression) has been identified as a risk factor for poor psychological and physical health<sup>31</sup> fewer studies have explored whether a sense of optimism, which derives from the ways individuals explain causes of both good and bad life events, may protect health. An optimistic explanatory style is characterized by the belief that the future will be pleasant because one can control important outcomes<sup>31</sup>. A pessimistic explanatory style has been linked to a sense of hopelessness and is marked by the view that problems are permanent and reflect one’s shortcomings. Previous research has suggested links between pessimism, hopelessness, and risk of heart disease.<sup>32,33,34</sup> Further evidence relating emotional and psychological factors with illness has emerged from a variety of experimental, clinical and epidemiological research.<sup>35, 36</sup> The spectrum of studies has been wide, ranging from investigations of cellular phenomena relevant to autonomic-endocrine-immunological integration, to epidemiological studies of psychosocial factors and health.<sup>31</sup> Under the framework of this approach, **individuals’ attributions of illness, illness’ calling, causes attributed, coping mechanisms applied and concerns are linked with the belief that emotional factors are related with illness.**

The conventional stress-vulnerability model postulates that psychological stress responses emerge through an imbalance between demands and psychosocial resources, and many factors relevant to this transaction have been identified, including the chronicity and predictability of stimulation, opportunities for control, psychological coping responses and the availability of social supports<sup>29</sup>. By contrast, the mechanisms through which stress responses may increase risk of illness are poorly understood, and investigators are frequently obliged to fall back upon a poorly defined ‘biological predisposition’ to account for individual differences in susceptibility to disease or variations in clinical course. It is argued in this review that several distinct cognitive—behavioral and psychophysiological mediating processes may be postulated, and that these are relevant to different types of influence on health (acute and chronic effects, causal and facilitatory processes, impact on etiology, maintenance, relapse or recurrence).<sup>30</sup>



Steptoe, A. The links between stress and illness.  
*Journal of psychosomatic research.*, 1991;13(6): 633-644.

All the above research data:

- a) illustrate the need to implement educational campaigns in areas or countries where the socio-cultural model is prevailing and there is limited knowledge of health matters, or ignorance
- b) highlight the demand to develop evidence-based guidelines by obtaining information about heterogeneity within any cultural grouping or ethnic minority categories
- c) emphasize the need for thorough understanding of patient's health care beliefs
- d) require action in identifying factors related to health so as to guide culturally based interventions
- e) request health professionals who are aware of illness beliefs.

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