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Humanitarian and Civic Assistance Health Care Training and Cultural Awareness Promoting Health Care Pluralism

Rose E. Facchini, BA

ABSTRACT Integration between traditional and contemporary health care in a host nation can be beneficial to nation- and capacity-building and, subsequently, to the overall health of the society. "Traditional" health care in this sense refers to the indigenous health care system in the host nation, which includes characteristic religious or cultural practices, whereas "contemporary" health care is also known as "conventional" or "Westernized"; integration is a synchronization of these two health care forms. However, the choice of integration depends on the political and cultural situation of the nation in which the Department of Defense health care personnel are intervening. Thus, cultural awareness training is essential to ensure the success of missions related to global health and in promoting a health care system that is most beneficial to the society. The present study attempts to show the benefits of both cultural training and health care integration, and how adequately evaluating their efficacy has been problematic. The author proposes that determinants of this efficacy are better documentation collection, extensive predeployment cultural awareness and sensitivity training, and extensive after-action reports for future development.

INTRODUCTION

The Declaration of the Alma-Ata "reaffirms that health, which is a state of complete physical, mental, and social well-being...is a fundamental human right and...is a most important world-wide social goal..." (World Health Organization, 1978 Declaration of the Alma-Ata). If we accept this statement, it is clear that socioeconomic factors must be recognized as significant to the host nation's health care system. Culture, including religion, shapes perceptions of health and illness, which shapes the medicinal methods and traditional values surrounding general health care practices.

Maintaining the balance between respecting traditional health practices as culturally significant and improving the health system with "scientifically sound" methods remains a challenge for humanitarian assistance (HA) missions. Some traditional practices that violate human rights and prove detrimental to the health of the patient create ethical dilemmas for the intervening personnel. For example, post-traumatic stress disorder is treated with whipping in some cultures (HA Conference 2012, Naval War College, Newport, Rhode Island).[1] It must be noted here, however, that such practices are usually isolated incidents and do not represent the entirety of traditional health care; there have been recent efforts to reduce or eradicate malpractices such as these in several African countries. Muller and Steyn propose a pluralistic approach that combines traditional and contemporary or Westernized health practices to combat such situations, for "generally, traditional medical systems are adaptable systems, capable of incorporating new elements necessary for contextual demands in society."[2] This not only maintains the relationship and ethical balance between the host nation and intervening personnel but also reduces the generally high costs of Western medical provisions such as pharmaceuticals or supplies.

Integration and pluralism can help promote capacity-building for the host nation's health care system. Previously, capacity-building during humanitarian and civic assistance (HCA) missions has been an incidental byproduct, but initiatives such as those by the San Antonio Military Pediatric Center (SAMPC) emphasize cooperation with traditional health care personnel to help maintain the infrastructure. SAMPC is a pediatric residency program that has successfully implemented this level of collaboration through various medical projects since 2001. Such programs realize the importance of traditional systems that both benefits the sociocultural health of the population and maintains a positive perception of the intervening personnel.

The integration of traditional and contemporary health care for HA requires culture-specific training to strike the correct ethical balance, yet the extant training for said missions is often too generic and brief (Interview with Dr. Shakir Jawad, November 16, 2012). In addition, there is a dearth of reports documenting the efficacy of these training programs. Indeed, a February 2012 Government Accounting Office (GAO) report states that "incomplete project information because of data management problems" and "the absence of post-project evaluations for determining the effects of DOD's efforts" were two of the three "key weaknesses in management oversight" that led to ineffectual use of resources and training development (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3] These key missing factors of training, namely cultural specificity, extent, and correct documentation, negatively affects the development of related HA missions.

METHODS

Several variables support the need for an ethically balanced integration of traditional and contemporary health care, and require a more detailed analysis to elucidate their contributions.

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Global Health Within the Department of Defense

Training and education in global health (GH) is considered one of the main focus areas for Department of Defense's (DOD's) GH-related activities. However, "most DOD personnel who work in or are interested in pursuing global health related work face an unclear training and career path in the department, with training and career development in this area limited to a few programs with low visibility and priority" (Kaiser Family Foundation, "U.S. Global Health Policy," September 2012).[4] This remains an internal policy issue within DOD; dedication for improving this system of training and expertise will only occur if GH is considered a top priority within the military health system. The two suggested methods of improving internal expertise is "greater support for existing global health instruction into personnel development" and "regular instruction at military service academies" (Kaiser Family Foundation, "U.S. Global Health Policy," September 2012).[4] In addition, one study found that the majority of graduates from Army internal medicine programs involved in HA believed that they would benefit from additional training.[5]

This policy problem depends on other issues such as whether DOD engagement in GH is necessary to meet primary objectives and national security (Kaiser Family Foundation, "U.S. Global Health Policy," September 2012).[4] The Naval War College's 2012 HA Conference attempted to address this issue, albeit with much debate. However, it was clear in the discussions that HA operations require significant experience, education, and skill among personnel, as well as scrupulous reporting to establish an efficient database, particularly with HCA missions for which the primary purpose of deployment is for training and readiness exercises for U.S. forces (HA Conference 2012, Naval War College, Newport, Rhode Island). Several studies have concluded that "the paucity of information sharing and lesson learning from previous HCA missions limits their [personnel] training benefits and humanitarian effectiveness." HCA missions contribute to HA training for both the military and civilians; "U.S. armed forces personnel participate in HCA efforts for strategic, operational, or tactical purposes that support military objectives while concurrently reinforcing skills required for the operational readiness of the forces executing an HCA mission" (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3] HCA missions are particularly useful for technical assistance and dissemination of educational information to indigenous health care personnel, as they provide services and care "including education, training, and technical assistance" (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3] This cooperation with traditional health practitioners is essential to strengthening the infrastructure of the host nation and promoting a pluralistic approach to medical treatment that upholds an ethically balanced relationship. The DOD has had an overbearing leader rather than a cooperative assistant (HA Conference 2012, Naval War College, Newport, Rhode Island); their "'let me do it for you' approach still applies to many DOD humanitarian assistance projects."[6]

Evaluating the Efficacy of Predeployment Training

Quantitative data in the form of after-action reports (AARs) are necessary to evaluate the effectiveness of "lessons learned."[6] One study proposed the incorporation of a logframe matrix (a document indicating features of a program to achieve an intended goal) into AARs, which would allow "HAP [Humanitarian Assistance Program] managers to prioritize limited resources, show sustainable program impact, and align individual HA projects with the overarching national defense strategy and overall U.S. government foreign policy."[7] The combined efforts of monitoring and evaluating are necessary for a retrospective analysis for further development and to improve efficiency in future efforts, while showing the relevancy and importance of GH missions in DOD.

When predeployment training is deemed necessary, outcomes are positively affected. Although military medicine's primary goal for HCA is to provide military training, the byproduct of improving the condition of the host nation is considered less important. SAMPC's HCA program attempts to transform this incidental byproduct into a formally stated goal, with principles based on long-term commitment, coordination with the host nation, and public health.[8] This program demands predeployment training for military preparedness and medical readiness. SAMPC has completed 11 missions between 2001 and 2007 and found that knowledge and military training among the personnel was greatly improved with predeployment assessment, and at minimal cost to the military. In addition, public health surveillance of the host nation is more accurately achieved by SAMPC, greatly increasing capacity-building as well as training and educating indigenous personnel. "By combining predeployment international health didactic teaching with realistic, hands-on, field experiences, the SAMPC program provides the missing piece in the training puzzle."[8] It is apparent that their efforts in HCA missions are greatly supported with adequate training in cultural sensitivity and awareness, which holds significant promise for the success of other prospective programs dealing with HA missions.

An affiliated organization with similar efforts is the Defense Medical Readiness Training Institute (DMRTI). In tandem with the Center for Disaster and HA Medicine (CDHAM), the DMRTI has created the Medical Stability Operations Course (MSOC), which offers training for medical military engagement and stability operations, as the name implies.[9] In a recent study, Ilcus evaluated the effectiveness of MSOC with an "objective survey tool that can actually measure (and trend) the effectiveness of MSOC training" (inherent emphasis). She argues that her tool could detect flaws in the training program and found "resilience and health diplomacy" to be of concern. Regardless of these flaws, MSOC's efforts have proven useful.[10]

The Importance of Language and Culture for Training

CDHAM created a Health and Language Curricula within their larger program, the Defense Medical Language Initiative. It is designed to train DOD health personnel in the necessary skills for engaging the indigenous population and health care system of the host nation, particularly the "health unique language and culture of the location."[11] Dr. Shakir Jawad, a former Brigadier General in military medical affairs in the Iraqi Ministry of Health and current senior analyst at CDHAM, believes health care systems are an important cultural factor within a society; as with any health care system, it accounts for providers, recipients, and health care delivery in general, but it also includes the culture's perception of health, illness, and wellness as well as traditional forms of medicine (Interview with Dr. Shakir Jawad, November 16, 2012). Familiarity with the host nation's traditional medicine and cultural perceptions of health are essential for the success of any HA engagement.[11] Furthermore, proper cultural and language competency could encourage "comfortable" relationships between intervening personnel and the host nation, and ease the process of the mission as a whole.[12]

The perception of health and illness is an essential part of culture, for "healthcare systems originate and develop on the basis of health views. At the core of people's health views are culturally determined beliefs and values."[2] The history of Western medicine promotes the notion that illness is bodily (a nonpersonalistic view of health) and sociocultural influences are somewhat illusory. Unlike most Western cultures, some non-Western cultures often include the external spiritual and social factors to describe the causes of illness (a personalistic view of health), as with such traditions that include the balance of humors (Indian Ayurveda tradition) or between ancestors and the individual (traditional South Africa). "It is evident that efforts aimed at restoring health to individuals who are ill are shaped by the cultural and social realities of a particular society or culture."[1] To the health care personnel intervening in a host nation, diagnosing and treating the illness should be just as important as reintegrating the individual into his or her culture.

Traditional, Contemporary, or Integrated Health Care

The most effective form of treatment and health care within a nation depends on the situational desire of the recipient population, at times regardless of cultural influences. Muller and Steyn found that while some preferred traditional medicine, others either preferred the combination of traditional and contemporary or whichever proved to be the most expedient cure. However, this can become problematic; although some patients tend to combine the elements of traditional and contemporary medicine in an attempt to achieve better results, others use contemporary medical treatment incorrectly and wrongly deem it ineffectual.[2] Jawad particularly emphasizes the inherent problem with the latter, stating that a patient who prematurely abandons contemporary treatments simply passes it off as useless and resorts to traditional treatments that may be inappropriate (Interview with Dr. Shakir Jawad, November 16, 2012).

Even pragmatic factors such as accessibility and cost-effectiveness of treatment types are situational. Although "traditional health practitioners...tend to be more accessible than conventional healthcare services in many rural areas"[13] within conflict zones and vulnerable refugee camps, Muller and Steyn offer an opposing view; "African governments increasingly view the inclusions of existing community resources, and thus indigenous healers, into the health system as the only relatively inexpensive way of expanding health services. However, traditional healing is not necessarily affordable for all. Costs in terms of transport, training, and acquisition of medicinal plants render treatments very expensive."[2] However, the Mestizo population of Pichataro in West Central Mexico preferred traditional over contemporary health care because of cost and accessibility. A 1980s study of Indo-Chinese refugees in Southern California found that if cost was not a factor, then contemporary care was preferred over traditional care because of its expediency.[14] Thus, the cost-effectiveness and practicality of traditional, contemporary, or an integration of the two would seem to depend largely on the political situation of the country.

Integration can prove challenging. Sodi and Bojuwoye describe these various obstructions, particularly the philosophical origins of health in culture and malpractices within traditional health care systems. For instance, an understanding of the cultures' perception of "self" will increase cultural awareness and will likely result in a more balanced ethical situation. The more immediate concern of the medical ethical issues related to traditional health care can result in misdiagnoses, incorrect use of medicine, and human rights abuses.[1] Human rights abuses and inaccurate medical treatment is exemplified by such treatments as hydration deprivation treatment for diarrhea and female genital mutilation for treatment of hygiene (HA Conference 2012, Naval War College, Newport, Rhode Island). However, Sodi and Bojuwoye[1] note that such practices are isolated cases within traditional health care and are currently being addressed by such organizations as World Health Organization and the University of Kwazulu Natal Medical School. Again, such issues are situational and culture-specific, and thus must not be generalized to all traditional forms of health care.

Several studies on the exclusivity of contemporary health care in refugee situations have proven its weakness, particularly during the 1990s. Concerning the Thai–Burma border refugees in the early 2000s, "Western physicians and treatments were not able to address these cultural constructs or practices [such as the 'hot' side effects of tuberculosis treatments], resulting in incomplete care or unreliable treatment outcomes." Yet once "refugees were allowed to pass freely between the traditional and contemporary healthcare facilities,"

their overall health greatly improved.[13] In this situation, cultural familiarity among refugees in the form of traditional treatments is necessary to maintain their psychosocial wellbeing. Early results from these integrative actions show the positive outcome of adequate cultural awareness training, the value of community-based programs for capacity-building, and the importance of proper documentation to assess the efficacy of cultural training.

The findings of Frye show this complication of cultural differences by evaluating the complication of cultural differences within the United States' own health care system. She focuses on the health care decision of Cambodian refugee women in American health care and its implications for nursing as a source of cross-cultural mediator. "If one seeks to understand the process of health care decision making among an ethnic minority group, the critical element is to identify the cultural theme driving the behavior."[14] She identifies the four foundational influences as beliefs about disease causation, the pragmatics of the situation, language and cultural factors, and familism. The first factor is particularly important for American health care providers since a culture's worldview, such as the Buddhist principle of equilibrium in Cambodia's case,[14] significantly influence an individual's perception of health and illness and can expedite the healing process.

Utilizing traditional or indigenous health care infrastructures can be a valuable resource for skill improvement as well as host nation capacity-building; the cooperation between the two can result in mutual health care skills as well as nation- and capacity-building. Such initiatives as the herbal database project for Thai–Burma refugees "highlight the existence of indigenous networks in refugee communities that are largely overlooked by aid agencies and workers, yet which serve as powerful sources of continuity and identity among people who have few external links back to their original culture and social identity."[13] This construction of health care networking and medicinal databases significantly taps into an underused resource and improves the sociocultural health of the population.

RESULTS

As a result of assessing the aforementioned variables, two fundamental complicating results have materialized and must be addressed to recommend possible solutions.

Issues of Integration

Muller and Steyn elucidate the various surrounding issues that could accompany integration between traditional and contemporary health care approaches in the host nation. They state that "constraints to the incorporation of traditional healers into the national health care system, to a large extent, stem from the cultural differences between the two systems and the concomitant suspicions and fears."[2] Using the concept of "civility" as an economic proponent of suspicions for integration, Pye argues that cultural norms differ according to relationships, whether impersonal or familial. In China, familial relationships demand formality and strangers are treated with mistrust, so there is "little social integration beyond family, clan, and personal relationships."[15] This lack of trust can extend beyond the economic implications of society and into the sociocultural aspects, including health care.

A host nation's openness to integration of traditional and contemporary health practices into their health care system can greatly influence the success of capacity-building missions and likely provide a more well-rounded and extensive approach to medical treatment of patients. If they find that integration is ineffectual to their specific culture and situation, then intervening personnel may want to promote the traditional health care practices to preserve sociocultural wellness and the relationship between the host nation and intervening practitioners, assuming that human rights abuses are not present.

Issues of Military Bureaucracy

A combination of several variables is responsible for the difficulties within DOD. Archaic organizational structure, legislative stagnation, interagency miscommunication, and decentralized management all contribute to such issues as database gaps, informational overlap, contradictory policy, and budget issues (Kaiser Family Foundation, "U.S. Global Health Policy," September 2012).[4] Among these, "bureaucratic protectionism" is one of the several issues of DOD's involvement with cultural awareness initiatives.[16] The February 2012 GAO Report and the September 2012 U.S. GH Policy contest to such flaws within DOD's structure and policies, focusing on GH strategies and HCA missions. Particularly detrimental is the lack of proper database collection; "DOD does not have complete information on the full range of HA projects it conducts, which creates uncertainty as to whether DOD is able to provide accurate, complete project information to other offices within the department, to interagency stakeholders, or to Congress" (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3]

DOD database's antiquated maintenance is largely because of the widespread dearth of internal communication and record-keeping personnel; the project tracking in the Overseas HA Shared Information System is particularly concerning, as it varies by combatant command that subsequently inhibits common understanding and terminology. Prospects of a new version of this system anticipate resolving such issues, however, but the results are yet too early to determine (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3] Nevertheless, these issues in organization and database management affect cultural awareness implementation; indeed, "with no centralized office for cultural knowledge, no natural home exists for programs. . .on the cultural preparation of the environment. . . As a result, such programs become

buried within the bureaucracy and are not distributed or used in a timely and appropriate fashion."[16] Interagency information formalization and timely updates to the database were among the several recommended solutions in the GAO Report (GAO, "Humanitarian and Development Assistance," February 8, 2012).[3]

DISCUSSION

Formalized Health Care Training

A possible solution to the problem of ineffective cultural awareness training is to offer formalized and mandatory cultural health care methods specific to the intended missions to foster cooperation and eliminate mistrust in the host nation. This is accompanied by retaining an understanding that sociocultural well-being is an important aspect of the overall health of the host nation. Personnel must overcome the possible "negative attitude [which] particularly manifests with regard to difficulty with getting Western-trained or oriented practitioners and traditional health care practitioners to work together."[1] If the situation demands, health care workers must be cognizant of possible human rights abuses and detrimental effects of traditional health care, so they may aid in the initiatives that eradicate such abuses. However, the complete replacement of traditional health care should naturally be avoided; for example, "separation from ancestral spiritual practices and shrines in the home country may exacerbate and even prolong mental health conditions."[13]

Cultural training is often brief and lacking cultural specificity to suit time constraints and diverse mission necessities. Concerning online training, one study found both advantages and disadvantages for cost with synchronous online training that implemented video teleconferencing; although it eliminates travel expenses, it is likely to increase its cost with equipment and technical training.[17] Even without the complicating factor of video teleconferencing, the benefits of online training also depend on several variables such as learning styles and access to the Internet. Optimistically, one study on law enforcement training measured the educational effectiveness of online courses with the indicators of learning, motivation, and attitudes; although the author found that there was higher motivation to learn among the face-to-face synchronous group, online learning provided the same educational effectiveness as classroom learning and excelled in cost–benefit gains.[18] This is but one example, but online courses have significant potential to offer cost-effective and educationally beneficial training; DMRTI offers basic Emergency Preparedness Response Courses through the virtual training portal Joint Knowledge Online.[19] Online courses may better suit basic training, whereas on-site instruction would prove more useful for culture- and host nation-specific training.

The issue of motivation may be more complex, however. The military's own source of motivation through self-discipline has been somewhat controversial over the last few decades with one particular 1978 study chastising the lack of obedience without direct supervision.[20]Of course, it must be noted that this study is antiquated and influenced by the political situation of the time. In this context, however, it is important to distinguish between self-discipline and motivation; the former manages the "what" and "how" of an action, whereas the latter is concerned more with the "why." Motivation is a skill that is acquired throughout one's life, occasionally encouraged by situational instances. Thus, any training, be it virtual or tangible, is not a repository of motivation but rather a depository from which success can be drawn in its place.

Extensive and Dedicated Database Collection

A complimentary solution to specific and extensive predeployment training programs is to improve AARs so that they successfully evaluate the efficacy of training programs or initiatives; this will greatly benefit strategies for medical readiness and performance as well as the development for future training. For example, Rasmussen and Sieck[21] provide suggestions to improve the mental habits of personnel for cross-cultural adaptation by "adopting a cross-cultural stance, seeking and extending cultural understanding, and applying cultural understanding to guide action." Their mental strategies for mission performance and readiness are applicable to both experienced and inexperienced personnel: (1) "know yourself and how you are different," (2) "know the value of a little cultural understanding," (3) "frame intercultural interactions as opportunities to learn," (4) "pay attention to surprises," (5) "test your knowledge," (6) "reflect on your experiences," (7) "adapt what you express and how you express it."[21] Extensive documentation can also greatly benefit the development of online training.

CONCLUSION

There is not a lack of cultural awareness training within DOD, but rather a lack of framework for implementation and measures of effectiveness. The historical separation of DOD services had led to uncoordinated and varied approaches to HA activities. This, compounded by the concurrent lack of interagency synchronization, can result in redundancy and miscommunication.[22] As showed above, it has been made clear by numerous studies and interviews with DOD personnel that an understanding of the cultural practices of a host nation greatly affects the success of intervention missions. Cultural sensitivity encourages cooperation between the traditional and contemporary health care systems, which can quite possibly result in a pluralistic approach aimed at improving overall health and capacity-building of the host nation. However, the success of such initiatives depends on rigorous database maintenance and emphasizing cultural specificity in training programs; as a result, GH-related missions can be more successful based on the improved cultural skills among response personnel and specific metrics for success.

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