

## Cultural humility: a strategic concept for addressing refugee health in Brazil

Humildade cultural: conceito estratégico para abordar a saúde dos refugiados no Brasil

Humildad cultural: concepto estratégico para abordar la salud de los refugiados en Brasil

Carmen Santana <sup>1</sup>

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In order to contribute to the analyses of the *Thematic Section: Refugee Populations and Health* <sup>1,2,3</sup>, we will briefly discuss refugees in Brazil and present the concept of cultural humility as strategic for training health professionals, challenging the model of cultural competence presented in the article *Multicultural Skills, Health Care and Communication Disorders* <sup>1</sup>.

Brazil is viewed as a safe country for refugees. It has the largest refugee population in South America, with individuals hailing from 80 different countries. There are 10,145 people recognized as refugees in Brazil and 86,007 whose request for refugee status is currently under evaluation. They are concentrated in large urban centers. Women are 34% of this population. Most come from Syria (39%), the Democratic Republic of Congo (13%), Colombia (4%), Palestine (4%), Pakistan (3%), Mali (2%), Irak (1%), Angola (1%), Republic of Guinea (1%), Afghanistan (1%), Cameroon (1%) and others (3%) <sup>4</sup>.

Although they do not share the health risks associated with the “non-entry” regime described by Castiglione <sup>2</sup>, refugees in Brazil face obstacles to integration: cultural, ethnic and economic differences, language difficulties, loss of family and social relations, restrictions to the recognition of academic degrees, violence related to the circumstances that forced them to move. Additionally, they suffer from social problems that affect Brazilians: difficulties finding employment, accessing higher education, housing and health <sup>5</sup>.

The Brazilian Unified National Health System (SUS, in Portuguese) provides health care for immigrants, refugees and asylum seekers. Action plans should take into account the influence of culture on symptom expression, disease experiences, and on the evolution and progression of clinical cases. Applying the same protocols, diagnoses and treatments to a culturally different population means not recognizing the cultural validity of health actions. Diagnoses require a high level of cultural understanding. Health professionals communicate within the health/disease model they have learned. Refugees do not always share this model. The bigger the cultural difference between health professionals and service users, the bigger the chances of communication errors, which make diagnostic evaluations even harder <sup>5</sup>. Facing refugees’ cultural diversity, in practice, health providers complain about lacking information and preparation for providing care.

The model of cultural competence presupposes that health professionals learn a set of attitudes and communication skills that will allow them to work effectively within patients’ cultural context. Cultural humility is defined as the process of being aware of how culture can affect health-related

<sup>1</sup> Universidade Federal de São Paulo, São Paulo, Brasil.

### Correspondence

C. Santana  
Universidade Federal de São Paulo.  
Rua Teodoro Sampaio 744,  
cj. 118, São Paulo, SP  
05406-000, Brasil.  
carmen.santana@uol.com.br



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behaviors. Unlike cultural competence, cultural humility does not assume a quantifiable set of attitudes. It refers to a continuous process of reflection and critique. Developing cultural humility therefore enables health professionals to appreciate culture as a dynamic entity.

Although “cultural competence” is described as a strategy for addressing health disparities, the concept of “cultural humility” reformulates the health inequalities discourse and broadens the traditional understanding of race and ethnicity in order to include the culture of alliance-building between groups and individuals of different origins, genders, sexual orientations, (dis)abilities, educational levels, immigration status and other socioeconomic and cultural identity indicators <sup>6</sup>. A humble, reflexive approach requires an attitude of respect towards diversity and towards the individuality of cultural experiences and their meanings, including multiple points of view in the design of the therapeutic project. In practice, it means, for example, adopting a coordinated combination of treatments offered by “official medicine” with actions offered by popular healers.

Although the Brazilian Ministry of Health is part of the National Refugee Committee (CONARE, in Portuguese), we still do not have a national policy that informs health services regarding the risks of applying ethnocentric models in the team building and user service processes. Nor do we have a record of the services provided by SUS to refugees. Participative methodologies, on the other hand, have helped to develop a culturally-sensitive health care in Brazil, contributing to refugees’ insertion into the process of producing knowledge regarding the health/disease process <sup>5</sup>. Within this context, we believe that the strategic concept of cultural humility and the participative methodologies can contribute to improving the model of cultural competence. This new focus could be implemented through the inclusion of the concept of cultural humility in health professionals’ training curricula and in the permanent education activities offered to health providers who already work in SUS.

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