

*The Peter and Katherine Tomassi Essay*  
CULTURALLY INCOMPETENT?  
ANTHROPOLOGICAL ASSESSMENT  
OF MEDICAL INTERVENTIONS

*Irit Rasooly*

In many ways anthropology is as dynamic as the cultures it studies. Today's anthropologists analyze not only isolated tribes, but have also adapted their ethnographic methods of inquiry and traditional questions of structure, power, determinism, and change to help communities and peoples interact with the "empowered" of the world. As students of culture, today's anthropologists have found "fields" in a diverse range of places; the homeless of New York, abandoned persons in Brazil, Ivy League academics, patients with sickle-cell anemia, and the mentally ill in Asia have all been subjects of anthropological analysis.

Anthropologists have not only expanded their scope of study, but also extended the applications of their analysis. Terms like "activist," "militant," "political," and "barefoot" have been used to describe a newer application of anthropology, which has sought to study cultural processes in order to empower and assist the peoples being studied. However, anthropologists have stayed surprisingly distant from "cultural competence" interventions, which seek to tailor programs to the needs of particular populations by accounting for their culture. Cultural competence was first defined by Cross et al. as "a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations" (Cross et al. 13) and has been applied to education, medical care, and a variety of other settings. Applications of cultural competence include clinics and interventions tailored to particular populations as well as general guidelines for health professionals.

While one might expect anthropologists to be engaged in

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Irit Rasooly is a 2007 graduate of Princeton University, where she concentrated in anthropology. She is currently a US-Canada Fulbright Fellow.

any discussion of culture, anthropology has been critical of medical “cultural competence” for several reasons, most often because those defining the “culture” are outsiders seeking to impose their own ideas of “culture.” However, “community based” interventions overcome this definitional problem.

Analysis of “cultural competence” and anthropological critiques of that framework, followed by a description of an intervention, the Starr County Border Health Initiative, which has had success in helping residents of one of the most underserved communities in the country control diabetes, will demonstrate the power and potential of community-based, culturally competent medical interventions. Given an “activist” framework that understands research as incurring some form of “debt” to those studied, anthropologists should embrace community-based cultural competence as an important area of study.

## EVOLUTION OF CULTURAL COMPETENCE

Awareness of the need for “cultural competence” stems from observations made by social and epidemiological scientists. What’s a doctor to do when he or she learns that the mortality rate from diabetes among Hispanics is 50 percent higher than that among non-Hispanic whites (National Center for Health Statistics 2007: Table 29)? While the question of “why some suffer more than others” has been at the forefront of social science research since its inception, only recently have members of the medical community begun to tackle the issue of “health disparities”: conditions which disproportionately affect select groups. Twentieth century private practice style medicine lends itself to a more individual understanding of illness, unlike the social sciences which take a collective approach (Kleinman 37). Doctors work with patients to modify their particular behaviors or treat various symptoms, rather than contextualizing the illness within social frameworks.<sup>1</sup> The medical

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1 Beyond simply focusing on individuals rather than their group context, biomedicine has been critiqued for training practitioners to see patients as a collection of “parts.” Byron Good has written extensively on how medical school is structured to teach physicians an

community's approaches to diabetes and obesity are prime examples. Doctors have long simply encouraged diabetic patients to diet or prescribed them insulin therapies. The focus has been on how to solve the problems of a particular person rather than on examining the environment that causes such symptoms.

The lack of understanding of environmental factors forces treatment and prevention programs to rely on overly simplistic causal relationships between individual behaviors and medical conditions. Anthropologist Arthur Klienman faults biomedicine for this; he argues that its "requirement that single causal chains must be used to specify pathogenesis ... and its particularly powerful commitment to an idea of nature that excludes the teleological" are reinforced by attention to the particular (29). While one might assume that an individual approach focusing on patients' actions would empower people with agency over their condition; if they have a false sense of agency, patients are left frustrated. This is the case for diabetes; there are myriad factors including genes, personal behaviors, socioeconomic status, race, access, cultural barriers, and discrimination that contribute to diabetes, so focusing on just personal behaviors is not effective.

Using the example of diabetes, the focus on weight-management ignores larger questions of social culpability and emphasizes the relationship between health and personal behaviors. Individual treatment cannot account for social issues such as lack of access to healthy foods, poverty, which makes it difficult for individuals to monitor and control their blood sugar, and lack of education about dietary measures that need to be taken to control diabetes. Sharp increases in rates of obesity and diabetes as well as alarming disparities between ethnic groups have made it difficult to ignore the social factors at work, and therefore the medical community has had to broaden its "gaze" to see more than just individuals.

When conventional approaches fail to address the disparities highlighted by social scientists, medical providers must answer larger anthropological questions such as "how does this group op-

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"alternative way of seeing," a "medical gaze" in which doctors see diseases residing in bodies, cases, patients, and cadavers rather than "people" (Good).

erate,” “what are the driving forces in this community,” and “what makes them different from/similar to other populations” to begin to address disproportionate suffering. Medical anthropology has always employed such a gaze; “anthropological interventions ... focus on the ways social, economic, and political contexts shape the formation, distribution, and manifestation of disorders, thus in the anthropological perspective, health problems and social problems are inseparable” (Kleinman et al. 6496). Anthropology notices that behaviors and preferences of people in a particular group are prescribed partially by what is available to them (economically, culturally, etc.) as opposed to being static.

Yet rather than discovering and comprehending complexity or moving toward more anthropological methods, medical researchers have traded one simplistic approach for another. When holding the individual accountable fails, they find the culprit for disease in what they term “culture,” and seek culturally-based interventions to consider more than the physical symptoms of the individual. The focus is shifted to questions such as “What is the most convenient way of measuring one’s blood sugar in terms of “the culture” of the patient?”

## DEFINITIONS AND THEORETICAL CRITIQUE OF CULTURAL COMPETENCE

Incorporating fluency in culture into medical care is difficult when, as one recent report on legislative policy found, “there is not yet a universal agreement on the definition of ‘cultural competence’ in healthcare,” (Ladenheim and Groman 172). However, definitions have become somewhat more specific and focused than Cross et al.’s original formulation which focused on the “adaptation of services to meet culturally unique needs” (Cross et al. 13). Current understandings incorporate ideas like “overturning institutionalized disadvantages to certain groups of people, and working for justice” (Briggs et al. 1986). The National Center for Cultural Competence (NCCC) lists three requirements for organizations to be “culturally competent”: (1) a defined set of values, demonstrated behaviors,

policies, and structures which enable a group to work cross-culturally, (2) the capacity to value diversity, conduct self-assessment, acquire cultural knowledge, and adapt to cultural contexts, and (3) the ability incorporate those values into all aspects of the institution (National Center for Cultural Competency Website). These definitions focus on how clinicians can educate themselves about different cultures in order to improve patient compliance and enhance outcomes. Measures of cultural competence for clinics include the number of workshops and training programs about diversity, the degree of outreach to culturally diverse families, and the level of participation by culturally diverse people as volunteers, members of boards of directors, and paid personnel (Briggs et al. 84). Often, interventions seek to make healthcare accessible to patients of different cultural backgrounds by making medical professionals students of their patients' cultures.

Surprisingly, as pointed out in a recent article in *Medical Anthropology Quarterly*, medical anthropology's engagement in this discussion of culture has been, with important exceptions, "less visible" than expected (Shaw 291). As an indication of this, the term "cultural competence" is not widely employed in the published anthropological literature.<sup>2</sup> How, one might ask, can anthropologists not be involved in discussions of culture? The answer is that anthropologists are not always convinced that in these cases what is being discussed is "culture."

Anthropologists offer three central critiques of "culturally competent" interventions, all of which focus on the functional definitions being employed by these interventions:

- (1) Definitions of culture employed are too broad and often conflate poverty and culture
- (2) Such understandings are artificially static and fixed
- (3) They ignore the culture of the clinic

Examining these critiques both in the context of modern anthropological theory and in the context of a medical intervention

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<sup>2</sup> A preliminary search of AnthroSource, for instance, came up with only two articles.

that aimed to overcome them sheds light on the space for anthropology in refining and strengthening “cultural competency” interventions.

### **Conflation of Poverty and Culture**

One article from *Diabetes Educator* addressing culturally competent programs defines culture as “shared beliefs, values, and habits” and points to culture as the “major external factor necessary to consider when addressing the issue of noncompliance and diabetes” (Oomen et al. 222). Oomen, et al. go on to call for doctors to address cultural obstacles by adhering to a “comprehensive, ecological model that incorporates the constructs of social support, environment, socioeconomic status, gender roles, language, and values that are relative to the patient’s ‘culture’” (223). The descriptions of cultural competence exemplified above seem to depict a nuanced understanding of the variety of factors contributing to a particular condition. Why then do they persist in grouping the sources of patient “noncompliance” under the heading of “culture?” Articles like this seem to argue that an effective model would “emphasize the complex interplay of forces that impact this population, ranging from social to economic to religious” (224). If economics, environment, religion and language barriers are all to blame, why fault culture?

This critique is far from semantic. Though anthropology as a field struggles to define culture, most anthropologists today agree that the term is used to refer to the broad explanatory frameworks and systems of meaning that people possess and transmit. Clearly, the way in which one interprets the world is intimately tied to the context in which such analyses are made, yet this is not to say that the two—context and culture—are one and the same. If patients cannot afford transportation, or have trouble reading the signs in the waiting room, it does not seem necessary or appropriate to fault “culture.”

There is also a serious danger of conflating issues of class and culture when interventions address the realities of life in poverty

rather than any inherent group trait. When the issues are confused, there is a risk of addressing only one in the hope that the obstacles posed by the other will consequently be eliminated. More fundamentally, can we really understand poverty as a culture? Is poverty pathological? By using culture as a stand-in for the more polarizing issues of class, are we obscuring the real forces at work? Working “within the system” of poverty and disguising it as culture may in fact limit our ability to notice or question inequality by re-assigning the “blame” for disparities away from general society and onto individuals and their heritage.

In a society where poverty is associated with lack of agency and responsibility, there are practical reasons why it might be easier to attempt to discuss “culture” rather than attacking the problem of poverty. It is often more socially acceptable to talk about tailoring care to accommodate the needs of people from a particular cultural background rather than those of low-income individuals. Medical anthropologist Susan Shaw, in her article “The Politics of Recognition in Culturally Appropriate Care” describes and discusses a clinic opened in the late 1970s by two low-income women in New England to serve the needs of their “neighborhood,” the geographic and social area “defined by economic need, marginalization, and lack of quality primary care” (296). While the clinic closed in the 1980s due to lack of federal funding, it was re-opened in the 1990s with funding for a “culturally competent” healthcare center which employed minorities and bilingual staff in order to reach out to members of this community.

The staff members and directors were ethnically similar to the community but, to quote the original founders, “all professional people” whose lives were very different from those of their patients (304). According to Shaw, “the language of ... cultural differences shaped claims participants made about the need for a health center” so that the clinic could both obtain funding and maintain clientele in a competitive world (305).

The people who re-opened the clinic assumed that issues of poverty and access were fundamentally cultural issues (that needed to be addressed by ethnically matching patients and clinicians).

They found that while they could not find either subsidies or a patient base by talking in terms of class, they were able to successfully market the clinic when they redefined their understanding of “culture” to include race.

## Static Definitions

Defining a “culture” at all is a persistent problem for anthropologists. The act of definition for the purposes of application seems to “fix” culture as a static entity, particularly when it is done in the essentialist manner necessary for interventions. Typically, such a process entails boiling down a culture to basics in a way that creates rigid, homogenous categories that can be analyzed and employed. For example, an article in *Cultural Anthropology* which analyzed a mental health clinic aimed at Latino inpatients described some of the ways in which culture can be used as a stereotyped, static, and simplistic entity (Santiago-Irizarry). Though the (largely Latino) staff admitted many of the symbols had little meaning to them, they assumed that the ethnic décor, programming, music, and food were important for reaching the patients (12). They were planning programming that expressed the way they thought “Latino” culture should look like, and were surprised when the patients were not completely receptive.

This approach is antithetical to the conceptual framework of anthropologists, who attempt to illuminate cultural complexity. In particular there seems to be little room for evolution over time or space, or for diversity of any sort in these definitions. The classic text used to make the case for cross-cultural understanding in medical practice, Anne Fadiman’s book, *The Spirit Catches You and You Fall Down*, can be critiqued similarly. As medical anthropologist Janelle Taylor points out, while Fadiman gives careful consideration to both Hmong and hospital culture she does so in a way that that portrays “Hmong culture” as “an unchangeable unstoppable entity, bound to crash into whatever gets in its path” (Taylor 166). In spite of Fadiman’s rich descriptions of Hmong life, which discuss creative ways in which the Hmong have adapted to

life in America, Taylor argues that the book is premised on a “determinist” understanding of their actions (167). The book identifies “cultural practices” such as defrauding the government, misunderstanding medical treatment, and kidnapping brides as fixed aspects of identity, resulting from historic discrimination and unrelated to the contemporary power dynamics or situation.

This “billiard ball” (as termed by anthropologist Eric Wolf) understanding of culture as an inherited, bounded, homogeneous entity which is fixed and incapable of change and thus on the course to collision is “quite different from the current state of debates in the discipline of anthropology, where “culture is now viewed by many to consist of sets of competing discourses and practices within situations characterized by the unequal distribution of power” (Frank 48 as cited in Taylor 166). Taylor’s analysis that culture is a process rather than a bounded, uncontrollable entity is a sharp critique of common misperceptions of culture and functionally employed in many culturally competent interventions. From an anthropological perspective, culture is dynamic, cannot be stereotyped or distilled, and must be examined in the context of its place and time.

Absent meaningfully derived definitions of culture, the biomedically based culturally competent interventions that have been successful for patients’ health have worked primarily on an individual rather than a cultural level. One example that is often cited as an exemplary step toward culturally competent work is instructing doctors to look at patients rather than interpreters (HIV/AIDS Bureau). One wonders what this has to do with culture. In what cultural framework would a patient respond well to being marginalized and ignored by a healthcare practitioner who spoke only to the interpreter? The good judgment of these “exemplary” policies employ seems to stem from a recognition of shared humanity—not from any particular understanding of culture. While this show of empathy and respect is praiseworthy, it is not sufficient to overcome the cultural and structural barriers that have led to health disparities—in fact, it is merely a reformulation of the original focus on the individual which was deemed inadequate.

## The Culture of the Clinic

The danger of drawing on generalizations based on a static definition of culture is not only that they re-enforce or impose stereotypes in a way that makes change seem impossible, but also that it is not particularly constructive. When medical professionals assume that someone from Spain or New York speaks the same Spanish as a newly arrived immigrant from rural Guatemala or Mexico, all “black” people share the same cultural identity or that they know what “Mexican-American food” is made up of, there can be serious clinical repercussions. Anthropologists are certainly justified in contending that culture is a highly variable, dynamic entity not given to quick “competence” that can be mastered from the arm-chair or office.

Even programs that attempt to “match” doctors and patients of the same racial, ethnic, or cultural background (so as to avoid some of these issues) have limitations. Though these programs have shown some benefit, (see review in LaVeist, et al.) one main “cultural” difference between doctors and patients almost implicitly overlooked in “matching” is that biomedicine itself has a distinct culture and subcultures which may be foreign to patients, even if they are precisely matched (Fox 1316). Medical students are schooled to speak and think in specific ways and the American medical system relies on basic principles, which greatly inform the ways in which medicine is practiced.<sup>3</sup> Even if a doctor comes from a similar cultural background as a patient, his culture will be different since medicine itself comes with a particular set of rituals, language, priorities, and belief structures. This “culture of medicine” influences the ways healthcare professionals practice, consider, and speak about their trade and can be at odds with the ways in which patients think of their illnesses (Good, Mary 463).

A central anthropological observation is that, as Ruth Benedict put it, one’s own culture often has “its existence outside the field of conscious attention” — meaning that it is difficult to be cognizant

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<sup>3</sup> Many thanks to Michal (Cohen) Moskowitz and Professor Mary-Jo DelVecchio Good for references on this subject.

of one's own interpretative framework (9). Therefore, when biomedicine alone is defining the culturally competent intervention, it often does not recognize the role of the culture it participates in, or even that it has a culture. Absent self-reflection about the role that its own culture might play, from the medical perspective culture competence often means overcoming the barriers posed by the patient's culture rather than mediating between the culture of the clinic and the culture of the patient.

## ALTERNATIVE METHODS

What would anthropologists do differently to overcome these critiques? How could they use local understandings to develop meaningful programs? Community-based cultural competence may provide solutions to these problems, as seen through one example: the significant health gains caused by the diabetes intervention in Starr County, Texas. In the face of diabetes prevalence that had reached near epidemic proportions, groups from the University of Texas, Houston relied on anthropological techniques and theories to design a set of materials and programs that allow participants' needs to shape the intervention. Though genetics, poverty, illiteracy, poor "lifestyle," lack of physical activity, and poor access to healthcare seemed to doom the residents of Starr County to life with diabetes, these programs have made a measurable difference in what seemed like an impossible environment.

Arguably, this success is a result of the effective culturally competent framework provided by community-based programs. Because program staff continually turned to the community for guidance and allowed residents to determine and shape ways in which "culture" is understood, the program was able to: (1) separate forces of poverty and forces of culture, (2) create interventions specific to the community with room for heterogeneity and change, and (3) account for the challenges posed by the "culture of medicine," counteracting each of the traditional criticisms voiced by anthropologists about cultural competence.

## Starr County

To many, the situation in Starr County seemed intractable. Articles about the Starr County community rattle off a list of diabetic risk factors that make residents three to five times more likely to develop diabetes than the average American. Unhealthy distribution of body fat, a mixture of Native American genes (which have been associated with diabetes), sedentary lifestyles, access barriers to healthcare, dietary factors, lack of education about healthy behaviors or the healthcare system, physical inactivity, and low socioeconomic status are listed as ingredients for a fatal “genes v. environment” interaction which created a “perfect diabetic storm” (Brown and Hanis 1995: 259).

Ironically, the poor in America suffer most from obesity and its consequences,<sup>4</sup> and Starr County is no exception (Poston and Foreyt 205). Average per capita income in the migrant worker community along the Texas/Mexico border was just over \$7,000 in 1990, one-third of the national average, making it one of the poorest counties in the United States (US Bureau of the Census). It is the type of place profiled by charities such as “Save the Children” (Save the Children 22). Studies since the 1960s have attributed an inverse relationship between socioeconomic status and obesity in the developed world to a variety of causes ranging from stress to lack of access to affordable produce (Morland et al.; Sobal and Stunkard).<sup>5</sup> By the time children in Rio Grande City, Starr County, reach kindergarten, 28 percent of them are obese or overweight (Weil 36).

Deep poverty makes the population difficult for traditional interventions to reach. Living in colonias, unincorporated make-shift settlements along the Mexican border, few of these residents are insured (Weil 36). Ninety-one percent speak Spanish at home,

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4 Type-II diabetes is highly correlated with obesity; over 80 percent of those with Type II diabetes are overweight and even small-moderate weight loss can help prevent or stop diabetes (Weight-control Information Network).

5 The current NHANES survey records that 36 percent of poor people are obese, as compared to just over 29 percent of non-poor people (National Center for Health Statistics 2005).

only approximately one-third have high school diplomas, and 40 percent are immigrants (US Bureau of the Census). Often they do not have the time, money, transportation, or skills to seek out medical care for a condition that has become so prevalent it has almost come to be understood as “normal” (Brown et al. Apr 2002: 156; Brown et al. Feb 2002: 436). Residents instead turn to family or folk healers (*curanderos*) for advice (Brown et al. Apr 2002: 156). Furthermore, the tools on which healthcare workers rely for managing diabetes—dieting programs, educational curricula, etc. are not particularly relevant to the Starr County population (Brown et al. 1998: 338). Because this is not a population that has much control over its environment, traditional behavior suggestions to “getting more exercise” or make particular food substitutions are not very helpful.

The biology of diabetes also works against Starr County residents. Ninety-seven percent of Starr County residents are Mexican-American, the demographic group most at risk for being overweight and having diabetes. The most recent National Health and Nutrition Examination Survey (NHANES) found that nearly two-thirds of Mexican-American adults between the ages of 20 and 74 are overweight and close to 40 percent of Mexican-American women were obese (National Center for Health Statistics 275–276). The percentage of Mexican American women below the poverty line who are overweight is 13 percent higher than that of their more affluent counterparts (American Obesity Association). This deadly mix of poverty, lack of access, and biology has had a terrible impact on life in Starr County; in 1983 half of Starr County residents had diabetes or had a first degree relative who did (Hannis et al. 671).

The Starr County Border Initiative has been able to find ways to overcome these significant challenges and develop effective diabetes care, prevention, and self-management programs for residents. Since 1981 researchers at University of Texas, Houston have been interested in the diabetic population in Starr County, TX as they are a severely affected, genetically homogeneous population. In the early 1980s the group published articles describing

and analyzing the disease demographics (see for instance, Hanis et al.; Samet, Coultas, Howard, Skipper, and Hani). In 1988, faculty from the School of Nursing partnered with the group conducting epidemiological research in an attempt to create interventions that would address some of the health issues being identified. In 1995 they began to publish their preliminary findings based on small pilot studies on the efficacy of their holistic program (see Brown et al. 1995; McPherson et al).

The original goals articulated in these publications were to develop a diabetes education program (and the necessary tools to carry it out) which would be consistent with national standards, yet community-based and designed specifically for the “Mexican-American” population of Starr County, TX. Plans included group support in Spanish involving family members of patients, directed by a bilingual nurse and implemented by lay community members (Brown and Hanis 1995: 204). Researchers in what was known as the “Starr County Border Health Initiative” or the “Starr County Diabetes Education Program,” worked from 1994–1998 to test the efficacy of self-management education that addressed specific “cultural characteristics” of Mexican-Americans.

The group published preliminary findings in 1998 and 1999, before publishing the results of the 256 person randomized trial in 2002 (Brown et al. Feb 2002; Brown and Hanis 1999; Brown et al. 1998). They also published papers on the various tools developed for the program such as a specific “food frequency questionnaire” (FFQ), a Spanish language Diabetes Knowledge Questionnaire, a Behavior Checklist, Focus Group evaluations, and an assessment of appropriate length of an intervention (Benavides-Vaekki et al.; Brown et al. 2005; Garcia et al. 2003; Garcia et al. 2001). In attempting to improve the program, researchers were interested in learning about the “health beliefs” and cultural practices that interfered with treatment as a way of augmenting their understanding of “culture.” They published their findings as they pertained to the studies (Brown et al. April 2002; Brown et al. 2000).

The results of the study were significant. In the randomized trial of 256 individuals diagnosed with diabetes, each of whom par-

anticipated in the program with a friend or family member, patients were able to significantly reduce HbA1c levels and fasting blood glucose levels relative to the control group after six months and a year. Diabetes knowledge also improved markedly (Brown et al. Feb 2002: 256).

The success of these studies demonstrates the power of cultural competence when implemented as a community-based intervention, utilizing anthropological modes of inquiry to establish a flexible but comprehensive understanding of the forces influencing clinical outcomes. Analysis of some specific examples from the Starr County Boarder Initiative illustrates how the community-based methodology can be applied successfully to reflect local reality. Close examination of the tools that they developed and the ways in which such tools were used reveals the level of engagement and understanding the researchers had about the community.

### Methodology Matters

Rather than advocating a specific method for addressing health disparities, anthropology offers a set of questions and research methods that challenge understandings of particular situations by articulating implicit assumptions about the situations. By living with, talking to, and participating in activities of daily life as a means to understanding practices, one could move away from stereotypes of groups or of behaviors based on “facts” divorced from context. This is important as often the very questions asked can limit the scope of inquiry (Briggs, Charles 68). For instance, the question: “What about Mexican-American culture makes them resistant to weight loss,” highlights many questions and assumptions. Is the cause cultural? Are they resistant? Do they see themselves as resistant? Are they trying to lose weight? Are they resistant to the concept of weight loss or its forms?

The definitions of culture that anthropologists are so critical of are often the product of a process that anthropologists see as misguided. While modern anthropology attempts to learn about the ways groups understand and structure themselves, it seems as

though the medical community often assumes definitional power in “culturally competent” interventions. For example, a list of recommendations for “Assessing the Cultural Competence of Organizations” written for doctors and clinics begins with the instruction: “describe the culturally diverse populations your healthcare organization serves” (HIV/AIDS Bureau). This begs the question, who should be doing the describing and on what basis? Do all Asians/Latinos/African Americans (or any other group) fit this category? To whom should such definitions be applied? Isn’t this task more appropriate for the targets of the intervention? Central to anthropology is the idea that knowing comes from experiencing. In fact, anthropologists often rely on the “participant/observer” approach, in which the observations are made by an individual attempting to participate in the culture as a means of learning about it. Any move to imply that a removed party could define a group from afar is viewed skeptically.

The researchers in Starr County avoided imposing any external definitions. They learned about Starr County by listening to it. They attempted to assess the needs and perspectives of residents at every stage of planning, implementing, and evaluating the program. The researchers maintained “open ears” and resisted drawing unconfirmed inferences or making presumptions. First and foremost, they figured out what the community actually wanted (for example, Brown et al. 2005: 267). This openness proved fundamental in designing an effective program, enabling the Starr County programs to succeed where many such interventions have failed (Brown and Hanis 1999: 228).

For instance, an initial focus group showed that residents were adamantly opposed to another dieting program (Brown and Hanis 1999: 228). Tired of being told that restricting consumption of their favorite Mexican-American foods was their only hope for recovery, they warned the architects of the intervention that they would “rather die younger than live a miserable life not able to eat foods [they] like” (Brown and Hanis 1999: 228). They explained that they had no desire to repeat failed weight loss experiences (Brown et al. Feb 2002: 266). The community resisted the

notion that the problem lay in their food or culture, and did not want to relinquish either one. Engaging in discussion about what a community wants in terms of medical intervention recognizes that the facts, namely that people in Starr County suffer from diabetes which can be controlled through diet and exercise, do not imply a way of dealing with those facts. Assumptions about how such issues “should” be addressed will often be met with resistance from communities and therefore not achieve the desired result.

Engagement with residents helped researchers avoid formulating or relying on stereotypical understandings of the community. One key thing the researchers did was to update the “food frequency questionnaire” (FFQ), a tool used in diabetes and nutritional management to help patients record and recall the foods and portions they have consumed in a given period of time in order for them to assess and make appropriate changes to their diets. Researchers noticed quickly that the list of foods typically used did not at all reflect the diets of Starr County residents, so they designed new questionnaires that better reflected the residents’ diets (McPherson et al. 378). In evaluating the FFQ, researchers learned much about the community.

The importance of defining all terminology, even Spanish terminology, was highlighted in the reformulation of the FFQ. For instance caloric calculations had assumed that the commonly consumed dish “refried beans,” refritos, was produced using corn oil whereas people in Starr County often used solid shortening comprised of half lard and half vegetable oil (McPherson et al. 379). Had researchers merely assumed that Mexican participants ate “refritos” without defining “refritos,” they would have greatly overestimated polyunsaturated fats and underestimated saturated and monounsaturated fats per serving. This example illustrates the danger of assumed knowledge.

Local knowledge also helped differentiate between culture and poverty. The new FFQs also found that whereas typically a group might consume between 340 and 1145 different foods in a given week, Starr County residents found that they eat only around 188 different foods each week (McPherson et al. 383). This find-

ing recasts food choices of residents. Diet was not the product of a culturally limited palate, but of limitations income and access in Starr County imposed on food choices. Poor eating habits may result more from poverty than culture. Other research has clearly demonstrated the restricted access poor people have to supermarkets (Morland et al. 23). Furthermore, produce and expensive diabetic substitutes may simply not be available or affordable in a place where, in 1993, almost half of residents were on food stamps (Brown et al. 1998). Information about the limited food choices in the community changes our understanding of their “agency” and challenges the notion that all the dietary issues in the county are “cultural,” since it seems that many stem from poverty. Such knowledge reaffirms and explains the frustration expressed by residents toward diets which focused on the cultural nature of their food consumption.

Some issues associated with noncompliance were also clearly attributable to poverty rather than culture, and were addressed as such. Issues such as transportation and the affordability of glucose monitoring supplies were factored into the cost of the intervention and thereby allowed researchers to determine if issues of “compliance” were associated with “Latino culture” of Starr County or merely byproducts of or cultural responses to poverty (Brown et al. 2005: 267). Calling poverty by its true name rather than attributing its effects to culture or some other entity is one way in which the intervention preserved the dignity of Starr County residents and addressed both issues of poverty and culture. In openly acknowledging the fact that most participants would not have the money to purchase costly monitoring supplies, they combatted the stigma of poverty and brought the issue into the open. In fact, Medicaid distributed the lancets, monitors, and glucose strips free of charge through the program (Brown and Hanis 1999: 234). Aware of the cultural responses to poverty, everyone, including “support relatives” received the materials as well as instructions on how to use them, which ensured the participants’ access to the necessary supplies and reduced any pressure to forgo testing themselves in order to share with others (Brown and Hanis 1999). The fact that these

measures succeeded is a further testament to power of detailed knowledge and the ability to separate poverty from “culture.”

### Dynamic Definitions

Paying attention to beliefs about health and determining which interventions appeal to the community are central to designing a program that can either work within the framework of participants’ beliefs or constructively address the limitations of those conceptions. In the case of Starr County, where weight reduction alone was not well received by residents, researchers learned that people did want to learn more about diabetes and be able to manage and monitor glucose levels on their own (Brown et al. Feb 2002: 266). While residents might not have participated or stayed in a dieting program, they responded eagerly to diabetes-management education, which ultimately facilitated weight loss. Through focus-group conversations, researchers also learned that the prevalence of diabetes had caused many to feel that it was inevitable and uncontrollable. Some expressed lack of concern for symptoms that had become part of every day life (Brown et al. 1998: 336), others mentioned that they thought the illness might have come as a punishment to them (Brown et al. Apr 2002). From these conversations with members of the community as well as with community leaders, it became clear that a self management program would work best, and that it was important to address and ultimately dismantle residents’ fatalistic attitudes toward diabetes through successful programs and effective treatment.

Engagement with the community’s preferences was only the beginning, however. Knowledge of the community proved critical in ensuring the researchers were able to design a program that would meet residents’ needs. Before beginning the first pilot course, for instance, they randomly phoned fifty people who had participated in previous diabetes studies and asked where they would prefer to go for such educational programs (Brown and Hanis 1995: 204). Respondents identified the county’s agricultural extension office. This is an instance in which “rules” based on outside information

rather than insider engagement can be misleading. Researchers, in suggesting the possible locations, had also offered to conduct the programs in personal homes (where people might feel more comfortable) and churches (familiar communal meeting spaces in a deeply religious population), yet both might have been less successful. This initial step, at which the researchers immediately handed authority to the population and refused to rely on any assumptions about the community, set the tone for the rest of the intervention. Humility and inquisitiveness rather than a drive to formulate, interpret, or impose “rules” were central features of the project. This sensitive approach allowed them to account for the complexity, unpredictability, what anthropologists refer to as “messiness,” of their field.

The Starr County Project also exposes ways in which close community contact helped overcome some of the barriers posed by the medical culture to which the researchers belonged. Implicitly the researchers demonstrated a willingness to leave their own comfort zone in proposing the intervention be done outside of a clinical setting. This step signaled that they sought to impart scientific and medical knowledge rather than force Starr County culture to conform to their own clinical culture. Instead of creating a “clinic” for residents, they looked beyond the clinical confines. The alternative setting enabled researchers to overcome barriers resulting from participants’ unfamiliarity with and apprehensiveness about clinical culture.

There are other, more explicit, ways the community based nature of the program accomplished this goal of putting medical knowledge to work outside a clinical culture. Videos educating participants about diabetes featured county residents, filmed in Starr County (Brown and Hanis 1995: 205).<sup>6</sup> This was particular helpful in discussing misconceptions about the illness; the videos featured prominent local religious leaders who addressed potential concerns of “interfering” with God’s will by taking responsibility for one’s health, something residents had mentioned as a concern (Brown and Hanis 1995: 207).

Not surprisingly, evaluations of the program found the videos

to be an effective teaching tool (Brown et al. 1992). Participants were most interested when their friends, neighbors, and leaders were featured and when the message of diabetes management was transformed from an external medical message to one from members of the community (Brown and Hanis 1999: 229). Yet the videos were not just a matter of getting particular key figures to parrot a particular refrain. Instead, they allowed local people to claim their illness and explain it to their peers in their own terms. The films were entirely in Spanish spoken by local residents; presented little medical terminology, and displayed graphics instead of words (low literacy is confounded by loss of eyesight in this population). Quite literally these videos were in the participants' language. The development of specific materials was critical in giving definitional power to participants and recognizing that the terminology, framework, and assumptions of medicine might be quite foreign to residents. By creating new educational videos specific to Starr County, the intervention allowed the community not only to articulate their needs, but actually to frame the shape of the program.

### Putting It into Action

Successful interventions that consider and address the health barriers on the ground can be designed to work effectively within the frameworks of communities only with the input of community members. For instance, the researchers realized based on their evaluation of the FFQ that food choices in Starr County were extremely limited (McPherson et al. 383). This not only revealed the prevalence of poverty in the neighborhood but suggested that changing the community's eating habits would be difficult. This degree of consistency in food choices meant that even if residents had the resources at their disposal to change their eating habits they might not have the support of the community. It is difficult to make changes in isolation since one often depends on reinforcement from friends and the community. Even with friends and family to rely on, patients face many obstacles in making changes to their diets. How will children react to changes in diet? Patients

from communities that prize self-sacrifice on behalf of one's family may view self care as "indulgent," particularly if it involves added expense or imposition on the family. Forcing one's family to eat different foods or spending too much time preparing one's own food might be viewed as selfish (Oomen et al. 221). Clearly, interventions working to modify the environment as well as to inform individuals are indicated.

The researchers dealt with these "cultural" issues by integrating family members and friends into the education and support group sessions. Recognizing the importance of strong family ties in this community, the researchers required all participants to bring a relative or close friend for "support" (Brown et al. Feb 2002: 260). This stipulation also allowed the researchers to make sure that participants had the family resources to make significant lifestyle changes and build a community of people working to change their own behaviors. Some groups continued to meet after the formal program ended as they felt having people to turn to when discussing concerns, challenges, and results helped them maintain lifestyle changes (Brown and Hanis 1995: 209). Integrating family into the intervention validated the importance of diabetes management and combated notions that self-care selfishly detracted from the family's needs (Brown et al. 2000: 436).

Interventions must be designed with the beneficiaries in mind, and the best means of helping them is not easily seen from the purely clinical perspective. To this end, the Starr County interventions involved Starr County residents in the actual education. In addition to interventionists (all of whom were bilingual) the program hired community workers as on-the-ground facilitators to assist with preparations and programs. As the workers were often a critical link, criteria for selection as a community worker included residency in Starr County, diagnosis of Type II diabetes, graduation from high school, and fluency in both English and Spanish (Brown and Hanis 1995: 229). This specificity implicitly recognized the heterogeneity of broad categories such as "Latino" culture. Unlike other "matching" done based on broad, generalized categories of race or ethnicity, this sophisticated type of involve-

ment allowed people who knew the community to help the intervention navigate the social terrain efficiently. As the researchers involved and engaged actual community members, they could root their project in a particular community rather than rely on presumptions or stereotypes.

Participant evaluations elucidated the clear advantages and drawbacks to this approach. As the researchers assumed, the community workers were very helpful in building connections to the community and “grounding” the intervention, but participants reported that they preferred to have professional nurses or dietitians leading support groups (Brown and Hanis 1999: 229). This finding again speaks to the “messy” nature of the field. Researchers were incorrect in assuming that participants would prefer to have the non-clinical or educational portions of the project (the support groups) led by trained members of the Starr County community. By speaking to participants they found that they would much prefer to have every aspect of the program facilitated by professionals. The intervention was adjusted so that community members provided support to the project rather than actually conducting any educational interventions.

Researchers found that they could learn more by asking and listening. The participants’ preference for 12 week sessions instead of condensed 8 week sessions, and the efficacy of monthly calendars in maintaining attendance compared with weekly reminder phone calls, were not things that the researchers could have “known” other than by engaging with the participants in the intervention (Brown and Hanis 1999: 209). The process of evaluation and conversation must also be sustained as culture varies and changes in unpredictable ways. The researchers account for this. The group published the findings of follow-up focus groups done several years after the original studies were completed, using the feedback to outline ways in which the program ought to be modified (Benavides-Vaello et al.). The same paper incorporates findings from the neighboring Hidalgo county, which the researchers hope to use as “a foundation from which to develop an[other] intervention” (Benavides-Vaello et al. 254). The continued evaluation and the recognition

that seemingly small geographical distances can make significant cultural differences represent a willingness to adapt to the needs of the community fundamental to community-based interventions.

In addition to evaluation, one can achieve such flexibility and attention to difference by avoiding generalizations (even well informed ones) whenever possible. The program, for instance, did not try to come up with definitions of what “Mexican-American” food meant in Starr County, as these types of generalizations have varying degrees of relevance to the population. Instead they worked with people to change the things that they actually ate. Members of the small intervention groups were asked to bring in favorite recipes, in which they then reduced the fat, sodium, and caloric content with the guidance of a nutritionist (Brown and Hanis 1995: 207). Because the classes were held in a place with a kitchen, the group often participated in cooking demonstrations (Brown et al. Feb 2002: 261). This approach defines cultural cuisine as what people in a particular group are eating at a particular time rather than as a fixed list of foods. They also made sure that participants had the ability to carry out the suggested modifications by taking group trips to local food stores to help participants implement the recipe modifications discussed in the programs (Brown and Hanis 1999: 231). This is not to be confused with “individualism,” as it is rooted in knowledge of circumstances and does work with a group to change norms and behaviors, yet is specific enough to be relevant to the individuals within the group. In pilot studies, these aspects of the program were praised for their relevance and applicability (Brown and Hanis 1999: 228). These flexible tools avoid the issues of definitional power raised by anthropologists by avoiding definitions.

## A Role for Anthropology

Why had I refused to work with them when they had been so willing to work with me? Didn't I care about them personally anymore, their lives, their suffering, their struggle?  
... The women gave me an ultimatum: the next time I came

back to the Alto I would have to “be” with them ... not just “sit idly by” taking field notes.

Nancy Scheper-Hughes  
*Death Without Weeping*

Activist anthropology, as described by Nancy Scheper-Hughes and others, has given the methods of anthropology a new mission. The goal of activist anthropologists is not only to draw cultural analysis about the people they engage with, but also contribute to the communities they write about—to in some way answer the demand of the Alto women and “be with” those whose lives and societies they study. This call to action responds to Geertz’s stipulation that anthropologists “converse” with those they study (1973). To converse with someone as an equal is to contribute to the conversation; activist anthropologists understand the contribution to be tangible and look for ways to assist the communities they come to know. Culturally competent interventions, when community-based, could be among those ways. Though anthropology is critical of conventional cultural competence, interventions like the one in Starr County demonstrate that these critiques can be addressed and that often such programs share anthropology’s goal of comprehending culture.

Just as there is room in anthropology for such medical work, there is room in this type of medical work for anthropology. Most of the knowledge utilized in this program was derived either from health workers who resided in Starr County, focus groups, or survey evaluations after the program. While there is clearly significant overlap with fieldwork here, ethnographic methods could clearly be relevant in contributing to such a study. Such projects generate knowledge on a “need to know” basis; they ask questions directly relevant to aspects of their project. Yet by identifying and analyzing underlying health beliefs or forces driving social structure, anthropology might have helped researchers gain a broader view of their communities before they begin such interventions. Ethnography and the questions that guide anthropological inquiry could augment the statistically derived data collected by such programs

and help both the community and the researchers articulate the cultural and environmental forces that they may not realize are at work. Furthermore, anthropologists can shed light on where such programs are needed and what needs they should aim to address. Such partnerships would be anthropologically informative and, if done well, contribute significantly to the community in which they are based, thereby allowing anthropologists and doctors to truly “be with” those who otherwise might stand alone.

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