

The Psychology of Diversity across Nations: An Analysis of Foreign Health Practice in Haiti and Rwanda

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This paper addresses psychological aspects of health that are particularly important when working in international healthcare. The psychological aspects are primarily examined from the perspectives of Haiti and Rwanda. Primary importance within the paper is granted to stigma as it pertains to a country or culture, structural violence that exists within the country, and the explanatory models that prevail within the culture. Conclusion of the paper emphasizes the importance of awareness on the part of those working internationally in healthcare, be they doctors or volunteers, to maximize positive impact within the country and culture.

Throughout the last several decades, the world has increased its focus on health in countries with significant economic inequality whose people have an extreme lack of access to health knowledge and facilities that are commonplace in the more prominent parts of the world. An exponential growth in healthcare needs in developing countries corresponds with the increase in international health and aid programs, such as Doctors Without Borders. Another one of these international health programs is a non-government organization led by Dr. Paul Farmer called Partners in Health, which predominantly operates in Haiti and Rwanda. When operating such an organization that exists across nations and cultures, it is especially important to note psychological and cultural differences that accompany such a change. When entering into new situations with a different country or culture, three primary factors arise that should be considered for those practicing international healthcare: stigmas that are attached to the country or culture, structural violence that exists within the country, and the explanatory models of a given culture.

The first-world nations frequently aid developing countries in the event of crises or with more commonplace matters such as health and education. However, one of the problems that arise with the proliferation of such transnational relief programs is an increase in psychological and cultural miscommunication. For example, when the tsunami hit Sri Lanka in 2004, the United States sent psychologists to offer assistance for residents of Sri Lanka to recover following the destruction of towns and the death of thousands of people. One of the problems, though, was that the psychologists had no, or extremely little, information regarding the psychological beliefs of residents of Sri Lanka. The residents in Sri Lanka had never heard of Post-Traumatic Stress Disorder, but it became introduced by the psychologists who continued to use impractical means of “helping” (Watters 8). As a lesson from this, it is incredibly important to be aware of psychological and cultural aspects that separate cultures.

One of the primary factors that should be considered upon beginning work in a different cultural setting is awareness of the stigma that is attached to that culture or country. As was warned by Chimamanda Adichie in “The Danger of a Single-Sided Story,” it is of utmost importance that people not accept one side of a situation as being the absolute truth. For example, with both Haiti and Rwanda, in the United States they are nearly always presented the same way: as remote places in the world filled with poverty and/or violence. After enough times of hearing the ‘single-sided story,’ this is the only information that we know and the sole means that we have to formulate our opinions (Zimbardo 11).

Haiti is labeled as a poverty-stricken, disease-ridden country with virtually lawless people practicing strange religion. It is labeled as a country that spawned the spread of Acquired Immune Deficiency Syndrome (AIDS) throughout the world (Farmer 136); a country whose entire population had AIDS (Farmer 137). The unwavering blanket of racism is also attached to Haiti as a stigma. For a health practitioner seeking to work in rural Haiti developing a health program to treat tuberculosis and develop more effective medication administration to the populace, stigma can clearly play a significant role. Another stigma that is attached to Haiti comes as a result of their practice of voodoo. In the United States, many harbor a rather negative view of voodoo and also of those who practice it. The voodoo priests are ridiculed as the primary source of the spread of AIDS, as well as other diseases through their consumption of blood and homosexual practices (Farmer 78). The stigma surrounding Haiti and AIDS is so great that employers in the United States have fired workers from Haiti because they are assumed to have AIDS (Farmer 66). As one can see, the stigma associated with a country can play a large role in effectively developing outreach programs for the country, especially convincing people to contribute time and resources.

The stigma surrounding Rwanda is similar; it is perceived as a country of lawlessness and consumed by disease beyond ability to save. For Rwanda, the stigma exists that the people there would not use the healthcare system even when it was available (Farmer 142); however, once the services became more available, it was found that many Rwandans did, in fact, seek help. One of the many stigmas that surround the majority of Africa is the lack of cohesiveness and, essentially, the idea that it cannot be helped. The idea exists that the culture cannot be understood and that it is impossible to communicate with the people. The importance of language is understood as being one of the prominent means of connecting with a culture (Mio 245). When trying to make contact with rural Rwandans, especially with something as intricate as developing a healthcare program, having knowledge of Kinyarwanda, the language, is a necessity despite the potential difficulties of acquiring such knowledge (Farmer 143). This is an example of one of the many differences that one encounters when working and transitioning between countries and cultures, such as between Haiti and Rwanda. In both Haiti and Rwanda, French is spoken; however, in rural Rwanda the language is Kinyarwanda. Both psychologically and anthropologically, one of the key ways to identify with a culture and truly understand the functioning and mechanics of everyday life is to know the language. Thus, transcending that cultural barrier can often be incredibly challenging, and transcending the stigma attached to a country and culture is incredibly important as well.

The next factor that should be considered for an individual practicing international healthcare is the structural violence in the area of practice. Structural violence is social determinants of health that are ‘constructed’ and occur on a systemic level including economic policies, international relations, and historical events. Structural violence is a hallmark of existence in both Haiti and Rwanda. Structural violence is particularly important psychologically because it contributes overwhelmingly to a feeling of learned helplessness, a sense of resignation when one “perceives no control over repeated bad events” (Myers 59). As a result of learned helplessness, one’s desire to continue to work hard for themselves in an attempt to better their life situation strongly decreases.

In Haiti, structural violence exists primarily on the level of government, extreme poverty, and history. For thirty years, the people of Haiti lived under the dictatorship of Francois Duvalier, where they experienced tyranny and bloodshed. It was not until late in the Duvalier dictatorship that foreign investors were encouraged to conduct business enterprises in Haiti, in the form of industrial factory growth and tourism (Farmer 112). While the tourism in Haiti was able to grow for a couple years, with the spread of AIDS and the stigma that surrounded Haiti as being the source of AIDS, the tourism virtually stopped. Unfortunately, with the extreme decline in tourism came an extreme increase in prostitution at continually decreasing cost (Farmer 112). The extreme poverty in Haiti is equally a component of the structural violence, contributing more to the learned helplessness than perhaps anything else. When one is in such a situation of poverty with an overpowering feeling that there exists no way out, they are led to more drastic actions to acquire money. Also, when one is unable to find employment and they have to support others, it becomes of necessity that they find money and food at, literally, all costs. The combination of extreme poverty, extreme economic inequality, and an extreme feeling of helplessness also contributed to the exponential increase in red-light districts in Haiti, such as Carrefour. Even with the growth of HIV/AIDS, prostitution increased. The choice was essentially: acquire AIDS or starve to death with one’s family. Given that choice, the decision is unfortunately easy. Structural violence in Haiti, as it pertains particularly to government, poverty, and history is thus noteworthy for one practicing international healthcare.

For Rwanda, the story of structural violence is distressingly similar. The perils of government, poverty, and history all stand as barriers to truly efficient healthcare and contribute overwhelmingly to a nearly insurmountable feeling of learned helplessness. As was the case with Haiti, government, poverty, and history are all interwoven together to contribute to an overall level of misery. The primary problem in the history of Rwanda was the genocide in 1994, where the Hutus massacred between 800,000 and one million Tutsis (Zimbardo 12). The government was ultimately responsible for the massacre, which is the point in Rwanda where the government is tied into the structural violence story. The government purchased thousands of machetes in the weeks leading up to the massacre and had them distributed to the Hutus. Largely contributing to the effectiveness of the genocide was the group conformity by the Hutus and the blind obedience to the government. One woman “reported that someone from the government had told her that the Tutsis were their enemies and had given her weapons to use against this threat” (Zimbardo 13). In terms of effective healthcare and an economic standpoint, the Rwandan genocide was responsible for a battering to the Rwandan economy and, as a result, everyone suffered. The

extreme poverty that comes from such an event is extraordinary and creates devastating feelings of learned helplessness. For health practitioners involved internationally, having at least slight knowledge of the history of a country will contribute to one's understanding of some of the practices of the people and the mindset. Structural violence in both Haiti and Rwanda play an incredible role in the behavioral and psychological state of the people there.

The third primary factor that should be considered when practicing healthcare internationally is the explanatory models of illness of a given country or culture. Explanatory models of illness encompass a person's idea of illness, such as where they think the sickness came from and what type of course they think the illness will take. Differing explanatory models across cultures can help one communicate interpersonally much more effectively and reach a solution more quickly.

In Haiti, illness is primarily understood as coming from one of either two places. Illness can occur both naturally and unnaturally. Natural illness ("God's illness") results from germ contact from someone else, whereas unnatural illness is 'sent' by someone with malicious intent through sorcery (Farmer 84). Having an understanding of this interpretation of disease and illness upon arrival can help tremendously. If a person with AIDS believes that it was acquired because someone hired a sorcerer to 'send' it upon them, it can be hard to work with them and their family. During the reign of the dictator Duvalier, it was even believed that some of his minions were in the employ of the North Americans and that they were utilizing knowledge they learned to contaminate the water supply with infectious microbes (Farmer 80). When coordinating a health program, having this knowledge is incredibly pertinent, especially as it relates psychologically. The people one is attempting to help would be much more receptive of someone with at least a slight understanding of their explanatory model. One example of this outside of Haiti is demonstrated in a Hmong family has a significantly different view of what is actually epilepsy than the American biomedical doctors do. As a result, an extraordinary amount of conflict originates between the two parties, to the point where the girl is removed from the family (Fadiman 59). By understanding that differences exist when one arrives, the chances of success increase.

In Rwanda, the understanding of illness aligns with the view of contemporary Western biomedical ideas of the origins of illness. While there may be some discrepancy in the farthest reaches of rural Rwanda, the extreme majority of Rwandans share the biomedical view of illness (Farmer 145). While the explanatory model of illness in Rwanda does share the similarity, it becomes even more important to note the other factors that play into health, such as psychological factors and, again, the insurmountable inequality. Although Rwandans understand the origin of the illness, they are likely distrustful of those administering the remedy. As was previously discussed, the history of Rwanda is not particularly favorable for establishing a setting of trust. As such, medicines and preventive measures that should be available throughout the country are not. Thus, when a health practitioner is working internationally, he or she must not only have an understanding of the explanatory model of the given culture, they must also have a general understanding of social barriers that exist beyond that explanatory model. If accepting treatment for a disease or accepting preventive medical assistance creates a rift for a woman with her husband, it is incredibly unlikely that she will accept that assistance. On the

whole, having an understanding of the explanatory models for a country and culture can be imperative to the overall success of international healthcare.

International healthcare practitioners experience many challenges as they work towards their goal of health development in developing countries. As these practitioners enter different countries with different cultural values, they must be aware of the psychological and behavioral differences because a desire to help is, unfortunately, often not substantial enough to transcend such differences. Three primary factors arise as pertinent to diversity when a change of culture or country does happen: Western stigmas attached to the country or culture, structural violence within a country, and the explanatory models of illness within the country. An international aid worker entering a country needs to be particularly aware of each of these things because they will undoubtedly affect interpersonal interactions as well as the inherent trust in an individual. Examining political and health differences between Haiti and Rwanda contributes overwhelmingly to one's understanding of the issues of diversity that arise upon working between the two countries and cultures. In relation to Paul Farmer, who does, in fact, work between these two countries, one is able to better grasp the true magnitude of the challenges that must be surmounted when establishing efficient healthcare transnationally, and, ultimately, glean a high respect for it.

Works Cited

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