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Challenges of the Cultural Competencies Approach to the Health Care of Migrant People in Chile

Desafíos del enfoque de competencias culturales para atender la salud de personas migrantes en Chile

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ABSTRACT

The objective of this qualitative research is to identify the factors that facilitate or hinder the acquisition or strengthening of cultural competencies in the work of primary health care professionals in Chile. Based on semi-structured interviews carried out with 32 professionals who work in a municipality of Santiago, a content analysis was performed, considering four dimensions of cultural competencies: awareness, knowledge, skills, and motivation. This analysis was discussed in eight conversation groups with primary care professionals, academics, and members of migrant groups. This made it possible to identify patterns in treatment and attention that support certain practices and values. It is concluded that the factors analyzed challenge the professionals and constitute an input to stimulate the individual and team reflection processes.

Keywords: 1. health inequalities, 2. Haitian migration, 3. transcultural nursing, 4. Chile, 5. Latin America.

RESUMEN

El objetivo de esta investigación cualitativa es identificar los factores que facilitan u obstaculizan la adquisición o el fortalecimiento de competencias culturales en la labor de los profesionales de atención primaria de salud en Chile. Con base en las entrevistas semiestructuradas realizadas a 32 profesionales que trabajan en una comuna de Santiago, se efectuó un análisis de contenido considerando cuatro dimensiones de las competencias culturales: conciencia, conocimiento, habilidades y motivación. Este análisis fue discutido en ocho conversatorios con profesionales de atención primaria, académicos/as e integrantes de colectivos migrantes; esto permitió reconocer los patrones en el trato y en la atención que avalan ciertas prácticas y valores. Se concluye que los factores analizados interpelan a los/as profesionales y constituyen un insumo para estimular los procesos de reflexión individual y de los equipos.

Palabras clave: 1. desigualdades en salud, 2. migración haitiana, 3. enfermería transcultural, 4. Chile, 5. Latinoamérica.

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INTRODUCTION[7]

International migration is one of the most impactful processes of recent decades worldwide. In 2019 there were about 272 million international migrants, that is, approximately 3.5% of the world's population (International Organization for Migration [IOM], 2019). In the case of Chile, this country has been a pole of attraction since the 1990s, especially for people from other Latin America countries and the Caribbean. It is estimated that as of December 31, 2021, there were 1 482 390 migrants, translating into 7.7% of the total population, of which 30% came from Venezuela, 16.6% from Peru, and 12.2% from Haiti (National Institute of Statistics and National Migration Service [Instituto Nacional de Estadísticas y Servicio Nacional de Migraciones], 2022).

One of the most sensitive aspects of the migrant condition pertains the access to health services. According to the International Organization for Migration (IOM), migrants may be subject to discrimination, violence, and exploitation, which directly affects their physical and mental health. Likewise, they may suffer from diseases unknown in the destination countries, which is aggravated by legal and/or socioeconomic setbacks that limit their access to health care. Moreover, those who manage to access these services still consider that their needs are not always adequately met, due to cultural or language barriers (IOM, 2013).

Current regulations in Chile establish that documented migrants can access the health system on the same basis as nationals. The same right has been established (regardless of immigration status) for pregnant women, children, and teenagers, people in life-threatening situation, refugees, and others who demonstrate a lack of resources (Ministry of Health [Ministerio de Salud], 2017). However, barriers remain that limit the access and effective use of health services: discriminatory and racist practices, which discourage consultation; lack of knowledge of migrants about their health rights and duties; a vacuum of protocols that guarantee the right to health and prevent arbitrariness, and, finally, denial of care to irregular migrants (Veliz-Rojas et al., 2019). Likewise, Liberona Concha, and Mansilla (2017) identified that the access to health services is affected by the perception of health officials, who deem this vulnerable population as a burden on the system and not as legitimate health care users.

General Observation 14 on the right to health establishes that cultural applicability is a requirement for the acceptability and quality of health services (CESCR General Observation 14 of 2000). Concern about the issue arose, especially the United States and Canada, in the 1970s (Osorio-Merchán & López Díaz, 2008) in response to the cultural diversity of societies in developed countries, and was expressed in terms of cultural sensitivity (Sue et al., 2009). The term *cultural competence* was proposed in the late 1980s (Hernández Plaza, 2014) for mental health, understood as a congruent set of behaviors, attitudes, and policies that come together in a system, an institution, or a professional sector, and enables them to work effectively in cross-cultural

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situations (Cross, et al., 1989). Since then, the notion of cultural competencies has broadened, the contributions of transcultural nursing (Campinha-Bacote, 2002; Giger & Davidhizar, 2002; Leininger, 2002,) and the critical positions of medical anthropology (Kleinman & Benson, 2006) standing out.

This article presents the results of a qualitative research that allowed identifying the factors that enable or hinder the acquisition or strengthening of cultural competencies for the care of migrants by primary health professionals in Santiago, Chile. First, the notion of cultural competencies for health care, its critical aspects, its enabling factors and barriers, and the situation in Chile are discussed. Thereafter, the theoretical approach and methodology of study are presented. Then, the results are shown and discussed. Finally, the main conclusions of the research are addressed.

THE CONCEPT OF CULTURAL COMPETENCES IN HEALTH CARE

Culture and Health/Illness/Care Processes

From medical anthropology, transcultural nursing, and other disciplines, it has been identified that cultural conditions influence the interpretation, explanation, and recognition of health care and disease care (López-Díaz, 2016). However, the dimension of culture is always challenging, whether due to the diversity of definitions, the approach or discipline employed, and its myth of functional integration (Archer, 1997). Therefore, the notion of culture is a sensitizing concept (Abreu, 2020).

Culture is a "complex and dynamic set of beliefs, pieces of knowledge, values, and behaviors learned and transmitted among people by means of language and their life in society" (Alarcón et al., 2003, p. 1062). From the perspective of medical anthropology, a health system is understood as a cultural system, whose form of organization and coherence depend on the sociocultural model in which medicine is developed, comprising both a conceptual and a behavioral dimension (Alarcón et al., 2003).

Addressing the role of culture in health care requires understanding that culture is a dynamic reality, inseparable from political, economic, religious, psychological, and biological conditions. The fact that a person belongs to a specific cultural environment does not imply that they have a set of univocal, homogeneous, and static characteristics (Kleinman & Benson, 2006). Understanding this requires overcoming a stereotyped image of rather complex social groups.

One of the approaches proposed to address cultural diversity within the hegemonic medical system (Menéndez, 2020) is the implementation of cultural competencies. Although some authors recognize three levels: individual, organizational, and system, most of the discussion and proposed models have centered around health professionals (Hernández, 2014).

Cultural Competence Models

Cultural competencies include knowledge, attitudes, behaviors, and consistent policies that allow a professional to work adequately within different intercultural contexts (Marrero González, 2013).

Transcultural nursing has made significant contributions to the discussion on cultural competencies and the proposals for their development. Albougami et al. (2016) identified four main models.

The first is the Sunrise Model, developed by Leininger (2002) in the early 1990s; this model proposes that nursing professionals carry out cultural evaluations of patients, including a number of factors (religious, economic, educational, legal) that, altogether with language and social environment, significantly affect the provisioning of services.

The second model is that of Transcultural Assessment, proposed by Giger, and Davidhizar (2002) in 1988, which states that every culture has six dimensions: communication, space, social organization, time, environmental control, and biological variation. These dimensions constitute themselves into a framework for the assessment and design of culturally appropriate health care (Albougami et al., 2016).

The third model was developed by Purnell in the mid-1990s, aimed at all health professionals (Purnell, 2000). This model accounts for global society, the community, family, and the individual, distinguishing 12 domains: general vision or heritage (country of origin, current residence, occupation, and others); verbal and non-verbal communication; family roles and organization (gender roles, parenting); personal issues (autonomy, acculturation, assimilation, gender roles); biocultural ecology (variations in ethnic and racial origins); high-risk behaviors (alcohol consumption); nutrition; pregnancy and maternity practices; death rituals; spirituality; health care practices; and concepts of health professionals (biomedical model). These domains are key to assessing the traits and characteristics of various ethnic groups.

The fourth model was proposed in 1998 by Campinha-Bacote (2002). This model understands cultural competencies as a process through which nursing professionals attempt to achieve greater efficiency and ability to work in a culturally diverse environment, while caring for the patient, whether an individual, a family or a group. This process is understood as including five dimensions of a cultural nature: awareness, skills, knowledge, encounter, and desire.

According to Albougami et al. (2016), all four models have contributed to the training and practice of nursing, and none of them can be considered better than the other. However, the model by Campinha-Bacote is comprehensive enough to serve as guide for the research and development of educational interventions for health professionals.

From medical anthropology, Kleinman, and Benson (2006) propose a critical and alternative vision to these models. These authors set forth that the notion of cultural competencies became a trend for clinical care and research, yet without a punctual definition that can be operationalized in clinical training and thus result in best practices. One of the main problems identified by them is the idea that culture can be reduced to technical skills, which can then be incorporated into professional training. Culture has been conceived as synonymous with ethnicity, nationality, and language, an understanding of it that encourages homogeneity. In this framework, according to the authors, cultural competence becomes a kind of “recipe” that defines how to treat a patient of a certain ethnic origin.

Understanding culture as a non-homogeneous or static entity, linked to economic, political, religious, psychological, and biological conditions, the authors propose a strategy of micro-ethnographies in six steps, so that health professionals can become aware of cultural differences. If it were a single step—the authors point out—it would mean routinely asking patients (and family members, if applicable) about what matters most to them in terms of their illness and treatment experience. Professionals can make use of that information to address treatment decisions and negotiate them with patients. From the perspective of this research, this proposed approach brings in respect for the patient's autonomy in the clinical relationship, not viewing autonomy as individualism, but rather in terms of relational autonomy (Gómez-Vírseda et al., 2019; Jennings, 2016).

Cultural Competencies, Inequality, and Health Rights

One of the main reasons behind the interest in cultural competencies in health has been the confirmation of important inequalities in health conditions and access to health services between migrants and non-migrants. It has been proposed that culturally competent interventions in this area can reduce disparities in access to health services and their quality, which in turn would contribute to reduce inequalities in health conditions (Hernández Plaza, 2014). For Latin America, considering the close relationship between migration status and social vulnerability, authors such as Veliz-Rojas et al. (2019) propose teaching cultural competencies, particularly in primary health care. This would allow teams of professionals to understand relevant aspects to providing care for migrants, such as their culture, beliefs, practices, and customs, which would reduce health inequalities. However, such deficiencies are known not to be exclusively or primarily related to cultural factors. The focus on this aspect corresponds to what Fassin (2008, p. 24) calls "the acculturalization of objects" as a dominant trend in public health. This trend prevails over the definition of the fight against inequalities as a priority, and at the same time a criterion for assessing *the making of public health*.

The conditions in which migrants live or work impact their health/illness/care, conditions that in the literature are known as social determinants of health (Vega et al., 2005). Recognizing such determinants underlies the understanding of health as a human right, and is directly related to health equity (CESCR General Observation 14 of 2000). However, the global neoliberal transformation ongoing from the 1980s, shifted the conception of health from a human right to an individual responsibility and, therefore, to the duty to be healthy (Gaudenzi & Schramm, 2010). In the field of public health, this notion has been operationalized in the concept of *healthy lifestyles*, understanding the differences in people's health as a result of their decisions and behaviors, defined as morally correct or incorrect, and not by the material and social conditions of their existence (Ferrer-Lues, 2015). Under this paradigm, *the victim is blamed* (Crawford, 1977) for their illness, and the limitations that people face in caring for their own health are not acknowledged. The importance of this is central in the case of migrants, given the implicit link between *lifestyle* and *culture* in the notion of cultural competencies.

The incorporation of cultural diversity in health requires transcending the notion of culture as linked to ethnicity, and acknowledging its intersection with other social and economic dimensions (Hernández, 2014). This involves realizing the way in which gender, age, social class, and other factors combine and translate into an unequal distribution of power, producing inequalities in health, as well as in access, use, and quality of health services. This approach is expressed in the proposal of "structural competencies," as a response to the cultural competence model (Metzl & Hansen, 2014).

Enabling and Hindering Factors to the Acquisition or Strengthening of Cultural Competencies

As for the acquisition and strengthening of cultural competencies, each professional is expected to develop them in a non-linear process. As pointed out by Vásquez (2006), the role of professionals is essential: to acquire cultural competencies, they must begin a personal and continuous process of constant review and reflection, through which they identify their values, beliefs, forms of communication, body languages, among other factors.

Several authors propose that one can be trained into cultural competencies (Jenks, 2011; Sue, 2001), positioning it as a relevant topic for different health disciplines. Díaz (2015) proposes a strategy for its inclusion during undergraduate nursing training, based on four principles: comprehensiveness, communication, complementarity, and flexibility/adaptation. However, the literature is inconclusive about what would the most effective form of training be (Beach et al., 2005; Gallagher & Polanin, 2015; Horvat et al., 2014). Furthermore, the development of cultural competencies does not depend exclusively on the will of the health professional, as it also responds to the institutional framework in which the professional-patient encounter occurs. As such, different levels must be accounted for (Sue, 2001; Sue et al., 2009).

Various authors have described the barriers perceived by health workers in providing care to migrants; among them, the differences in verbal and non-verbal communication stand out, which prevent, for example, assessing the severity of an illness; the diversity of languages; the lack of professional training on beliefs about health/illness and on the expectations regarding care for migrant patients; the lack of organizational support and recognition to provide culturally competent care based on the time allocated to care, the availability of interpreters, and administrative support; intolerance of cultural differences, and the imposition of own beliefs on migrant patients (Díaz, 2015; Hultsjo & Hjelm, 2005; Lindsay et al., 2012; López-Díaz et al., 2018; McKenzie et al., 2015 ; De Oliveira Moreira & Branco Motta, 2016; Taylor & Alfred, 2010). As a framework for such barriers, it has been pointed out that the structure and culture of biomedicine constitute the main barrier to delivering effective multicultural health care (Holmes, 2012).

On the side of enabling factors, contact between professionals and migrant patients is identified as key: a longer consultation is required to establish a relationship of trust. Additionally,

professionals should be trained on how to provide culturally relevant care and in the exchange of good practices (Lindsay et al., 2012; López-Díaz et al., 2018). Taylor, and Alfred (2010) point out as a critical element that organizations offer expectations and incentives to health workers, so that culturally relevant behaviors are maintained over time. For example, incorporating cultural relevance into job descriptions or performance evaluations or organizational goals.

The Chilean Context

In the current migratory context of Chile, inserting interculturality in the health system has become a necessity. Doing so implies understanding diversity as something positive, a normative horizon for a better, more equitable and participatory society (Walsh, 2010). For several authors, it is a priority for health professionals to acquire cultural competencies for care (Bernales et al., 2017; Correa-Betancour, 2019; Pedrero et al., 2020; Pérez et al., 2018; Veliz-Rojas et al., 2019). Likewise, the migrant health policy (Ministry of Health, 2017) acknowledges interculturality as a guiding principle.

Research has been carried out on the development and meanings of cultural competencies among health professionals in the country. Pedrero et al. (2020, p. 1) developed and validated an instrument to measure cultural competencies in health workers from different disciplines, considering three dimensions (sensitivity, knowledge, and skill). The results indicate that knowledge recorded the highest score, while "sensitivity to one's own prejudices" ranked last.

Pérez et al. (2018) organized focus groups aimed at learning about healthcare workers' perceptions of cultural competencies. Their findings show that professionals face various barriers to delivering culturally relevant health care to diverse groups, migrants included. The authors propose professional training for health workers in areas such as self-knowledge, non-discrimination, and sensitivity.

Finally, Bernales et al. (2017) investigated the perceptions of primary health workers on the challenges of providing care for the migrant population in eight communities. It was found that professionals perceive technical and administrative difficulties: lack of reliable figures, which implies not knowing how many and who the migrants are; lack of financial resources for care; frustration with centralist regulations; and lack of information at different levels. Workers point out that they frequently face a culturally alien and unknown world, especially when it comes to aspects pertaining beliefs on health. This implies cultural challenges that become barriers to the integration of migrants due to differences between visions, traditions, and lifestyles. As one of the first measures, Bernales et al. (2017) propose raising awareness on cultural competencies.

FOCUS OF THE STUDY

The concept of cultural competencies in health, whatever its definition, is aimed at building patterns of respectful treatment for the migrant population, reducing social distance and exposing stigmas (Goffman, 2006) that hinder care. This would strengthen relationships of trust between migrants and health teams, help circumventing barriers to access, and improve the quality of service.

From a sociological perspective, however, advancing towards an adequate implementation of cultural competencies in health requires acknowledging and accounting for the social and institutional context in which care is provided. Individuals are constructed according to the models of the world that they have been taught, which transcend the local environment and their inner life and, in turn, constitute an essential part of their biography (Mills, 1995). Therefore, in caring for migrants, health professionals face their task from their conceptualizations of migration and migrants, acquired throughout their lives. These conceptualizations will have a positive or negative impact on the interactions they establish with migrant patients and, therefore, on the possibilities of putting into practice the cultural competencies that permeate the health treatment and care patterns.

Given the above, it is very likely that this process will be hindered by racialized and discriminatory views on the migration phenomenon and migrants themselves, perceptions that have been hegemonic so far in Chilean society (Tijoux, 2016). These difficulties are reinforced by the characteristics of the relationship between the health professional and the patient, supported by an asymmetric and unequal distribution of power (Beauchamp & Childress, 2001), rooted in the public system due to the *user and migrant* situation, instead of that of *client* as in the private system.

Considering that the notion of cultural competencies has an analytical and propositional role to address the challenges posed by the health care of migrants, it is asked: what are the enabling factors and barriers found in the acquisition and strengthening of cultural competencies for the care of migrants among primary health care professionals? This study focuses on primary health care professionals as they constitute the gateway to health systems, and as a basic strategy to improve the living conditions of communities, alleviate the burden of disease, and enhance health equity (PAHO, 2003).

METHODOLOGY

A descriptive and interpretive qualitative research was carried out, based on the phenomenological paradigm (Taylor et al., 1992). The experiences that professionals have had during the health care of migrants, and the meanings they attributed to these experiences, were investigated; this made it possible to identify enabling factors and barriers in the acquisition or strengthening of cultural competencies in health care. Data were produced through semi-structured interviews with health professionals working in primary care centers.

32 interviews were conducted with health professionals working in primary care centers in a low-middle and low-income municipality in the Metropolitan Region of Santiago, with a noticeable presence of migrant communities (around 12% of the total population), coming mainly from Haiti. The interview guideline was developed by the research team, from the theoretical approach and the objectives of the research. The initial version was piloted in two initial interviews, which allowed the final guideline to be adjusted.

The questions inquired on their work history in public health services; opinions on international migration in Chile; the migrant people and patients served at health centers; the practices and main health problems of migrants; the learning and changes in work patterns and the obstacles to care; and the repercussions of caring for migrants in health centers. Some of the questions were: a) What would you say are the main care services provided to migrant patients? Are migrants prone to same diseases as Chileans? Why? What challenges has this posed to you? b) Have you had to adapt and/or change your ways of working so as to care for migrant patients? Which ways of working? What was the process like? and c) If you had to guide a colleague who is starting to work in this center and has never worked in the public sector, what recommendations would you give him or her regarding care for migrants? And what about care for Chileans?

The research team carried out field work between June and October 2019. Interviews were carried out in the health centers included in the study. The professionals interviewed were contacted by the municipality's Migrant Office. The composition of the sample responds to this selection, and to the characteristics of the group of professionals who work in health centers. All interviews were audio recorded, with prior consent of the interviewees, and had an average duration of 30 minutes. The composition of the sample is presented in Table 1.

Table 1. Composition of the Sample by Profession, Nationality, and Sex

Profession	Male	Female	Total
Nurse	1	10	11
Doctor	3	3	6
Midwife	1	5	6
Nutritionist	-	2	2
Dentist	-	2	2
Psychologist	-	2	2
Social worker	-	2	2
Occupational therapist	-	1	1
Nacionality			
Chilean	4	23	27
Bolivian		1	1
Cuban		1	1
Ecuatorian	1	1	2
Venezuelan		1	1
Total	5	27	32

Source: Own elaboration based on the sample of the FONIS Project SA1810123.

A content analysis was developed with the purpose of identifying enabling factors and barriers in the acquisition or strengthening of cultural competencies in health. The analysis was carried out using the NVivo 10.0 software.

As part of the present research, four dimensions of cultural competencies were defined: awareness, knowledge, skills, and motivation, inspired by Campinha-Bacote's approach, deem

sufficiently comprehensive so as to guide research among health professionals (Albougami et al., 2016). A definition of each dimension was developed as a starting point, based on the theoretical discussion and the criterion of reinforcing the construction of a reciprocal relationship of acknowledgment and respect between health professional and migrant, based on equal rights among human beings. This definition was then reviewed and broadened, as part of the interview analysis process.

The initial analyzes developed by the team were discussed in eight discussions held with professionals in primary health care services, academics who work on the topic, and members of migrant groups, from different regions and health centers. 51 people participated in the conversations, held virtually in 2020 due to the COVID-19 pandemic. The discussions produced in the tables of analysis served as input for the definition of the cultural competencies dimensions, and for the identification of enabling factors and barriers in the acquisition or strengthening of said competencies.

The research was approved by the Research Ethics Committee of the Faculty of Social Sciences of the University of Chile. All participants gave their informed consent; given that this is a limited group of professionals who addressed a sensitive topic, the quotes presented in the results refrain from any data that would allow the participants to be identified, who are in turn referred to with a code. For the same reason, the municipality in which the study was carried out is not mentioned.

RESULTS

The enabling factors and barriers that were identified for each dimension are presented below. These dimensions are understood as analytically independent; however, in practice they are interrelated, which makes it difficult to establish clear dividing boundaries.

Awareness

The dimension of awareness is understood as self-examination and exploration of one's own culture and vision of other cultures. It involves working on the recognition and critical approach to the stereotypes constructed about migrants. Lacking this awareness, the healthcare professional may impose his or her own beliefs, values, and behavioral models on the healthcare process.

We found that the barriers that hinder the emergence of this awareness mainly pertain various stigma-producing stereotypes, which Goffman (2006, p. 14) classifies as *tribal*, a deeply discrediting attribute of individuals due to their membership to a *race*, nation, religion, or class. Stereotypes comprise an immutable notion that professionals hold regarding migrant patients in terms of their origin, skin color, features, nationality, and cultural or psychological characteristics, from which they interpret their health behavior.

The main stereotypes observed refer to migration as a process and to the migrant patient as a subject. The idea of a *Haitianization of migration* stands out. The figure of the migrant and that of

migration are related and reduced to the Haitian community, thus accentuating racialized differences between Chileans and migrants:

> The overall feeling is that there are more Haitians; I know for a fact that there are more Venezuelans, but Haitians stands out more, because it is harder to communicate with them. Also, Venezuelans go to private health. Haitian immigrants are more noticeable than Venezuelans, so that is how I see things when it comes to associations (E10, personal communication, June 19, 2019).

There is the idea of massive migration, that of a supposedly overflowing influx of migrants, signifying a huge burden for the country:

> I feel that there has been an explosive increase in foreign people and that, in a certain way, it is affecting the Chilean population, because they are invading. I feel it so; I don't know if it's only in this municipality, but in general they have taken over huge space in the country (E31, personal communication, August 14, 2019).

The culture of migrant communities is seen as inferior to Chilean culture. This establishes a cultural differentiation, which classifies migrants hierarchically and racially according to criteria such as language, skin color, or national origin:

> It's just that in the area—well, at least where I used to work—it's not the case. That is, there were foreigners, but no Peruvians or Haitians. I worked at [a private high-income clinic]. So, the population there is of another social, cultural profile... a different one (E18, personal communication, July 31, 2019).

Among the stereotypes regarding migrant patients, the notion that Creole hinders the interaction between the professional and the migrant patient stands out: "Because, it really is true that the language is off putting, you are afraid of not being able to deliver or provide the appropriate care, as we always do" (E05, personal communication, June 27, 2019).

> Look, we rather provide super basic information, because the more we talk, the more it gets tangled. So here we have to be super specific with the instructions, and we try to write down the things that are most relevant. As of late, there are some instructions that have been translated, in order to make things a little easier for them (E09, personal communication, June 19, 2019).

The challenge posed by Creole is perceived as a problem attributed mainly to the migrant, for them not having the ability to convey and/or communicate. The migrant is considered responsible for not understanding instructions and not making it clear what is happening to them or what they need. Although there are intercultural facilitators[8] to whom it is possible to turn, they are viewed with suspicion, as they interfere with the care and direct communication with the patient: "Newcomers have to be assisted by a facilitator so that they can loosen up and learn how to do it,

[8] A worker responsible for linking people from different cultures in the Chilean public health system.

how to organize themselves to provide care without a facilitator" (E05, personal communication, June 27, 2019).

> Of course, the only bad thing about that I see is that, I mean, the way I see it, it takes privacy away; but we have no other way, because if we believe that their head hurts, and in reality, they are trying to tell us that they are dizzy and can't see, then we would provide unsuitable medication (E30, personal communication, August 13, 2019).

As for enabling factors that lead the professional to interact free of stereotypes, the identification of positive effects of migration was found, as well as the questioning of the superiority of Chilean cultural norms and practices, and the identification of the need to provide diagnoses and treatments with cultural relevance:

> But socially speaking, they also have a good impact in, let's say, work issues, right? Some see it as if they would come and take away some jobs from the people, but the way I actually see it is that they come and contribute to the country (E27, personal communication, August 28, 2019).

> That what we think is not necessarily the right thing […] I think you have to have an open mind, that is, you cannot try to change a person's life and believe that maybe you can [tell them]: "Now you have to do this, this and that," and the person will pay attention and do this, and this, and that (E03, personal communication, May 28, 2019).

Knowledge

Knowledge is understood as the acquisition and/or apprehension of knowledge about migrant communities, in relation to aspects of their culture and its connection with health/illness/care and bodily issues; their living conditions; previous health background; migratory trajectory and health conditions of their countries of origin. The integration of this knowledge aims at shortening the social distance inherent to the unequal power relationship between a health professional and a migrant.

The barriers consist of ignorance and disregard for aspects such as the health system of the migrants' countries of origin. This makes it difficult to understand the particularities of this population sector, such as the relationship of patients with the Chilean health system; the elements of their culture that may be relevant to diagnosis and treatment adherence, as well as access to health services. All of this prevents us from understanding the problems they experience at different stages in the flow of care in Chile, which is further aggravated by the Creole language, which limits the care process.

Another set of barriers related to migrants includes ignorance of their clinical manifestations, which are significant for the diagnosis and its approach. Particularly noteworthy are the manifestations in "black" skin that are conceptualized as biological or racial differences, in some cases associated with cultural traits: "a Haitian comes to you and has something strange on his skin and I don't know, you say it's scabies, but it's not, man, you can't blame on scabies everything weird that they have on their skin" (E04, personal communication, July 23, 2019).

> The thing is that the Haitian national is more prone to atopic dermatitis. I mean, there are more... in fact, dark skin is sometimes more susceptible to dermatological diseases. And they come dehydrated. I don't know if it's their self-care too, in general, I don't know if it's their [...] I don't know, the ways they coexist (E26, personal communication, July 26, 2019).

> Due to race, they have higher blood pressure. So, there have been many pregnant women who have blood pressure problems; Yes, we have many mothers who find out that they have high blood pressure and we have to put them into the cardiovascular program due to high blood pressure (E16, personal communication, September 10, 2019).

There is also a lack of knowledge of the epidemiological situation in the countries of origin of migrants, knowledge that would contribute to properly diagnose them and to understand their health background:

> How do they approach it, what is the health system like, what are the most prevalent diseases in them, I don't know, the types of cancer. I think that is important because it makes one focus on diagnostic thinking, for example, if I know that [among] black Haitian people the main cause of death is gastric cancer, so to say for the sake of an example, and a patient comes in with symptoms of it, I can right away tell "I got it, it's this." That's how it works in medicine (E17, personal communication, July 31, 2019).

For their part, the experiencing of enabling factors have favored the process of acquiring knowledge about migration in Chile and about the migrant communities that attend health centers; examples of this are the migrants who share about their culture and living conditions, and the possible implications of them for medical care; the information provided by foreign professionals from health centers, regarding health systems, epidemics, and treatment options in other countries; the notions obtained from intercultural facilitators; learning Creole, which allows greater closeness with Haitian patients; acquiring information about materials in the language of migrants, and the willingness to use that information in the consultation; and spaces for conversation with other members of the team, which contributes to getting closer to migrants and to the comprehensive understanding of their health situation.

Motivation

Motivation, which in Campinha-Bacote's (2002) approach is presented as desire, seems to be the most difficult dimension to implement, since it implies acquiring a commitment to generate intercultural spaces in the health care process. These types of spaces involve feelings and emotions that allow building positive relationships with migrant patients, expressed in enthusiasm, perseverance, support, and understanding. Motivation is linked to achieving new experiences and knowledge able to establish an intercultural encounter.

The barriers to the emergence of this motivation include negative behaviors towards the migrant, which manifest themselves in unfavorable emotions during interactions, such as frustration; helplessness; little motivation to coordinate objectives and tasks, to develop horizontal relationships, or to communicate to provide continuity to the care process. The stigmatizing

concepts built about migrant patients play a significant role, linking their origin with their health behavior and their way of facing life:

> They tend to be less clean, as insulting as it sounds... But it's true, they tend to be a little less clean, like they have less tolerance to the cold, so they dress three times as warm... and then they indeed have a different type off smell, so to speak (E02, personal communication, May 28, 2019).

> I believe that this is a purely cultural issue, due to poor education. Overall, the Peruvians I have met have very limited education [...] and one notices it more than anything, more than in the way they speak, rather in the comments they suddenly make, in the perceptions they have of some things. They have many perceptions that are almost mythical, almost based on legend; almost like old-lady perceptions (E11, personal communication, July 31, 2019).

In turn, the enabling factors encompass positive behaviors towards the migrant patient, expressed in motivation to learn from the lived experience, to understand the situation of said patient, and the role that the professional plays in this situation: "So later I started to learn gestures, at some point I learned them from deaf-mute patients. Then I realized that this way I could get closer to them and bond" (E06, personal communication, June 27, 2019).

Skills

Skill is understood as the ability to apprehend the signals that are given during health care, an encounter between individuals or groups of diverse cultures seeking to communicate. It involves an exercise in building communicatively positive relationships, by reacting to those signals in a reflective and creative way.

The barriers to the construction and acquisition of these skills include the difficulties in understanding care as an intercultural encounter, mainly those preconceived ideas about the interaction with the migrant patient. This in turn includes the conception of the cultural difference and of Creole as insurmountable obstacles to such interaction, and also the idea that knowing the sociocultural characteristics and the differences in the functioning of health systems between the country of origin and Chile is unnecessary for diagnosis and treatment:

> Patients who do not understand or do not want to understand; you ask them to get examined, for example, to get something as basic as a hip x-ray, to see if there is any type of dysplasia, and they don't bring it, that is, they don't realize, they don't give it importance. Because in their countries that is not important, and it's mainly the Haitian population the one that is more problematic when it comes to language, and maybe they do understand what we mean if x-ray is said similar in Creole as in Spanish, but they still don't get one because it's not important to them (E04, personal communication, July 23, 2019).

> The Haitian population... they don't have a health plan—or I don't know if it's wrong to say that they don't have one—but what I have seen is that they lack prevention culture; "prevention and control." They only care when they are sick. "My head hurts: I'm going to

> the SAPU" (Primary Emergency Care Service [Servicio de Atención Primaria de Urgencia]) (E18, personal communication, July 31, 2019).

The enabling factors include actions that contribute to the fruition of the intercultural encounter. Such actions have been generated in practice, at the initiative of the professionals themselves, and largely based on a kind of trial and error, which has allowed them to identify better ways to ensure that care constitutes a successful intercultural encounter. One of these ways is to consider cultural characteristics that may influence the assessment, diagnosis, treatment, and follow-up:

> I don't take it away [solid food before six months], because the children tolerate it well, they don't vomit, they don't have reflux, they don't get colic. So, they have a very good tolerance, so it makes no sense to take it away it for a simple rule […] the ministry recommends incorporating solid food at six months and that's what we do, but if we are faced with a child who tolerates it well and who meets all the criteria to get solid food, you just have to allow it; you have to adapt to situations (E27, personal communication, August 28, 2019).

> It's like, foreigners usually come only when things are already complicated; Chileans come when they begin to feel minor discomfort, yes. So, when you see a foreigner, generally in your consultation, you have to think that they already come with a greater issue than you would expect from a Chilean (E01, personal communication, June 25, 2019).

Other enabling factor are language adaptation (vocabulary, expressions, sentence length, speed of speech, use of pauses) and the use of gestural, audiovisual, translation, or other means; allocation of longer consultation time, modification of consultation frequencies and adaptations of the space to create an environment of trust:

> Because you have to use here the terms they use: "lie down *guatita* [belly] up"; "then they understand me right away." Yes, yes, one has to change certain words to the ones they use, but one also has to speak slower, not so fast, so that they can understand you (E17, personal communication, July 31, 2019).

> So, I looked for a video on YouTube, and I played the video for the mother, then I grabbed the baby and explained her while holding the baby right here how to do the *puffing*.[9] So, I leave with the peace of mind that the mother at least knows how to do the puffing (E04, personal communication, July 23, 2019).

Finally, other enabling factors include coordination with the intercultural facilitator; the creation of spaces for members of the health team to exchange information on the medical background of migrant patients and to follow up the care itinerary, as well as for the mediation of conflicts between Chilean and migrant patients, caused by care times, prioritization and differentiated treatment, among other factors.

[9] This refers to the indications for using an inhaler in the treatment of respiratory problems.

DISCUSSION

The results evidence a set of barriers and enabling factors for the acquisition or strengthening of cultural competencies in health. Regarding barriers, the discourses of professionals express various stereotypes about migrant patients, based on their origin, skin color, features, nationality, and cultural or psychological characteristics, which serve as explanations for their health behavior, and reproduce stigmatizing views, as discrediting attributes of said patients. These stigmatizing views play a central role in generating negative emotions in the interactions during care. Particularly relevant is the conception of cultural difference and, in the case of the population of Haitian origin, the Creole language, as insurmountable obstacles to the interaction with migrant patients. These findings coincide with various studies that show how the beliefs of health professionals play a central role in the care of migrants (Díaz, 2015; Hultsjo & Hjelm, 2005; Lindsay et al., 2012; McKenzie et al., 2015; De Oliveira Moreira & Branco Motta, 2016; Taylor & Alfred, 2010). They also match with the results of the cultural competencies measurement among health workers in Chile, corresponding to the study by Pedrero et al. (2020), who found a lower score in the dimension of sensitivity to one's own prejudices, compared to that obtained in the dimensions of knowledge and skills. Likewise, our findings match with the need for health professionals to be trained in sensitivity, non-discrimination, and self-knowledge, as pointed out for Chile by Pérez et al. (2018).

Other barriers found in the discourses analyzed include lack of knowledge about aspects of migrant communities and their countries of origin, such as their health systems; sanitary and epidemiological conditions; cultural elements relevant to diagnosis, and adherence to treatment, and in particular, the clinical manifestations on "black" skin, which are understood as biological or racial differences and, in some cases, also associated with cultural traits.

It might be thought that the solution to the barrier of ignorance is to implement training programs for professionals. Solving this is nonetheless not so simple. The culture of migrant communities cannot be reduced to a set of univocal, homogeneous, and static characteristics (Kleinman & Benson, 2006), which would allow the construction of a standard procedure on how to care for patients according to their ethnic origin. Furthermore, the present study found that this barrier comes together with a disregard for the importance of this knowledge for health care, its quality, and results, which Holmes (2012) identifies as the main difficulty for culturally appropriate health care. This evidence the hegemony of biomedicine in the Western medical system, which "has established itself worldwide as the model capable of solving, if not all, most of the population's health problems, regardless of the social and cultural contexts in which illnesses may arise" (Alarcón et al., 2003, p. 1063).

The barriers found limit the possibilities for professionals to achieve new experiences that may result in feelings, emotions, and practices that would allow them to build positive relationships with migrant patients. However, a number of enabling factors were also observed that can lead professionals to interact free of stigmatizing concepts; among them, the acknowledgement of positive effects of migration, the questioning of the "superiority" of Chilean cultural norms and practices, and the identification of the need to provide culturally appropriate diagnoses and

treatments. This comes with a series of experiences that have facilitated the process of acquiring knowledge about migration in the country and about the migrant communities that attend health centers, including the adaptation of language (vocabulary, expressions, length of sentences, speed of speech, use of pauses), and the use of gestural, audiovisual, translation, and other means; as well as extending the consultation time and adapting the space so as to provide an environment of trust.

Other enabling factors include working together with the intercultural facilitator; the creation of spaces for exchange and discussion within the teams on relevant information regarding migrant patients; the accompaniment or monitoring of migrants during the care itinerary, and the creation of mechanisms for the mediation of conflicts between Chilean and migrant patients. All of these points at the importance of professionals' daily experiences, also noted in other studies (Lindsay et al., 2012; López-Díaz et al., 2018; De Oliveira Moreira & Branco Motta, 2016).

Most of these experiences have not been the product of institutional devices, but rather efforts by the professionals themselves, often in isolation, based on their experience and life history, and trying to find the best way to respond to the demand for intercultural care.

The barriers and enabling factors identified respond to practices and values that are expressed in the interactions produced during care. Although more barriers were found, the presence of enabling factors shows possibilities to advance in the acquisition or strengthening of cultural competencies, as well as to implement them in care. The most immediate route seems to be working among members of health teams to exchange positive experiences, which until now has only happened rather spontaneously and on an individual basis. These exchanges can enhance the recognition of the need for interculturality, not only in terms of respect for the rights of migrants, but also pertaining the quality of care and its results.

Consciously accounting for these barriers and enabling factors can lead to an individual self-examination of the professionals and a collective assessment of the teams that contribute to deepening this process. However, this alone will not ensure the acquisition of skills, as there are greater challenges, typical of the health field, in terms of reflection and practice.

One of the main challenges is the hegemony of biomedicine, which reinforces the legitimation of a hierarchical relationship between health professional and patient, based on an unequal distribution of power. This makes it difficult to establish relationships that respect the autonomy of migrants in their role as patients. The reductionist conception of culture held in health systems also represents a challenge, as it often makes use of strategies that respond to a fixed system of customs and beliefs (Kleinman & Benson, 2006), ignoring the multiple cultural systems present in the different territories, as well as that biomedicine is a cultural system (Alarcón et al., 2003; Kleinman & Benson, 2006).

In the daily practice of health professionals, caring for another constitutes a subjective and intersubjective experience, characterized by continuous tension, in which emotions and personal experiences clash with the ethical-professional responsibilities of the discipline (Spence, 2001). Therefore, the prevalence of negative attitudes, racism, and discrimination towards migrants can unfavorably impact health care. In Chile, the increase in the migrant population has led to an

increase in expressions of xenophobia, discrimination, and attacks towards different migrant groups, due to skin color, ways of dressing, or language (INDH, 2017). All of this poses enormous challenges for health professionals to acquire or strengthen cultural competencies.

CLOSING REMARKS

Both the barriers and enabling factors identified build patterns of health care treatment, and require deep reflection on the part of professionals and their teams. To guarantee the emergence and consolidation of this process, it is necessary to implement institutional policies built on principles of equality, acknowledgement, and horizontality, able to face the challenges posed. More so important is that migrants have effective access to health care under the same conditions as non-migrants. Access to health is a prerequisite to any questioning of the cultural relevance of health care.

The need to modify the notion of *cultural competencies*, which takes national culture as a reference, into that of *intercultural competencies*, is thus realized. The latter concept highlights a reciprocal relationship of acknowledgment and respect, based on equal rights among human beings.

The relevance of the migration phenomenon in Chile and the world challenges health systems to examine the discourses and practices of their professionals, so as to reduce social distances and promote a respectful treatment of migrants. This research provides diagnoses to advance the construction of forms of (inter)cultural relationships based on critical communication between cultural groups in conflict, in order to overcome these conflicts (Walsh, 2010). By identifying enabling factors to enhance and barriers to intervene, primary health centers can work to achieve a full guarantee of the right to health of migrant people.

Translation: Fernando Llanas.

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