AM
Rivista della Società italiana di antropologia medica / 11-12, ottobre 2001, pp. 239-241

Introduction

Josep Canals
Escola Universitària de Treball Social, Universitat de Barcelona (Spain)

Migrations is a subject that always involves a tension between two poles: social inequality and cultural difference. Between these poles, pressure from the labour market, political and economic manipulation, national political traditions of social integration and migration policies in the receiving countries – for practical reasons this is the most important factor – create a complex set of problematic constructs that conceal the real questions. In order to simplify such a complex landscape and provide the agents involved with easier explanations, cultural difference becomes an axial ideological tool that encapsulates in a single factor the causality of a situation perceived as a problem. In this way, the sense of identity in the receiving society is strengthened because it is in opposition to potentially dangerous others, hiding their own inner conflicts and fractures in relation to immigrants. Therefore, cultural differences are perceived as an obstacle to living together and to maintaining cultural identity in the receiving society. Social inequality and the place reserved in it for minorities may be hidden in this way, so that we do not have to deal with a facet of our societies that is both ugly and contradictory to the official ideology of human rights and equality of opportunity.

The first consequence of mistakes being made from a simple explanation of cultural difference is the confusion between *social integration*, which refers to equality in rights and social and economic opportunities, and *cultural assimilation*. In this confusion, and in some countries, migrant people are driven to lose their culture or to constitute separate communities that keep their cultural references but which are outside the main receiving society; that is to say, in an excluded position which is legitimated by the discourse on cultural rights.

Anthropologists are considered to be specialists in cultural diversity and sometimes we agree acritically with the narrowest version of this idea. In

this case, the main danger is the temptation to reinforce our role and, perhaps in order to find work, cooperate in the problematisation of others in the name of the need to take into account cultural specificities. This involves the risk of falling into cultural determinism, symmetrical in its effects to what Taguieff calls 'differentialist neo-racism'. Immigration introduces more diversity in societies that already have a high degree of inner diversity. Health is a field where this kind of inner diversity is a permanent object in anthropological research. Therefore, in theory, we have good tools to respond to questions related to migrations and health.

Of course, cultural differences and specificity's are very important and they must not be neglected. An anthropologist has a big role to play in this field. But pointing out the interest of this field is not the same as reducing all aspects of illness and health in migrant populations to the cultural difference problem. Sometimes we are surprised to find beliefs and behaviours related to illness and health in people coming from outside Europe which are the same as those in people belonging to the poorest and least educated classes in the receiving society. Usually, health professionals do not consider these last kinds of cultural settings as «cultural problems» and, as anthropologists, we must point out that cultural competency in health services means being able to deal with culture in all cases.

Understanding beliefs and practices related to illness and health in all populations coming from a lot of different countries and ethnic groups are an almost impossible task. Moreover, individual migrants are not always representatives of a supposed original culture. The effects of medicalisation all over the world must also be taken into account. But it is possible to know something useful about specific conceptions of illness, or of practices related to preventing sickness, healing and caring in people from different cultural backgrounds. As medical anthropologists we have a large field ahead of us in which to work. To define only the involvement of a medical anthropologist in the most classical cultural aspects is again an over-reductive approach. It is necessary to look more deeply at the migration process itself, which includes needs, family and local experiences. All this supports a project with objectives, which are always subject to revision. All these items must be considered if we are to understand the value assigned to health at each moment in the migration process and in the adaptation and settling in the receiving society. And, last but not least, research into how autochthonous people, including health professionals, respond to migrations must be considered as important as the knowledge related to migrants themselves.

The four contributions presented here adopt approaches which consider migrants as a part of the societies in which they have settled and take into account the facts of social inequality and lack of rights. They avoid approaches with hard culturalist and differential biases. In this section all the papers deal with Southern Europe. This means that there are no contributions from countries in which specific communities of foreign origin have been constituted as part of immigration policy, as happens in the United Kingdom.

Alejandro Goldberg's paper is a research project that provides an outlook on current migration processes from a well-defined radical political position. He draws the frame within which topics related to health must be considered. The paper presented by César Zúniga and Paolo Bartoli focuses on the health-seeking behaviour of migrants in Umbria (Italy). This text links the process of adaptation of migrants with their practices related to illness and health, and with their use of the health services. This services underline the important role of limiting the effects of inequality and social exclusion. The contributions by Xavier Allué and Maya Pellicciari emphasise the cultural gap between health professionals and patients, both migrants and autochthonous. In this respect, Allué asks if cultural competency in hospitals is only related to others coming from abroad, while Pellicciari points out how prejudices and contradictions rooted in medical training rise up more dramatically when patients are migrants. As Maya Pellicciari shows, migrants are a good mirror to study us.