

Nutrition, Breastfeeding, and Ethnicity:  
Cultural Considerations for Preventing and Reducing  
Infant Mortality Among Recent Immigrants to Boston

OVERVIEW OF THE PROBLEM

Meeting the special health needs of recent immigrants and refugees, and of other minorities, presents new demands and poses new challenges to the American health system. If the system is to respond to meet these needs, it must remove institutional barriers by becoming culturally literate about the ethnic diversity and variations of newcomer consumers through knowledge, information, and education. And, it must willingly take culture and ethnicity into account by translating established treatment protocols and strategies into appropriate, culturally syntonic practices, services, and policies. To do otherwise, either by design or default, severely compromises the ultimate effectiveness and efficacy of the delivery system, diminishes the quality of care to consumers, and jeopardizes the well-being of the immediate as well as the larger community.

There is much documentation to support the imperative to translate cultural considerations into clinical practice. Ample evidence teaches us that culture can affect the health of patients in ways that are not always easy to understand. Beliefs about causes of illness, ways to cure illness, family dynamics, religious beliefs, the use of non-Western methods of relief and cure, patient expectations of roles in the therapeutic process--are just some of the factors that enter into the alliance between the patient, the

provider, and the system (Kristal, et. al., 1983; Griffith, 1982; Kaplan, et. al., 1977). Therefore, it is both desirable and appropriate to institute special programs and services targeted to recent immigrants. And, indeed, there is historical precedence for such efforts. In the past, large influxes of immigrants into this country have led to major changes in the health care delivery system (Yankhauer, 1983)

Historically, immigrant populations have constituted a highly susceptible, highly vulnerable, high risk group for adverse health and social consequences and attendant problems. Women, as the primary agents of socialization, and children, as the primary recipients of the socialization process, bear a disproportionate share of the burden of assimilation and integration into the new society and surrounding. Similarly, they are disproportionately exposed to serious health hazards, as evidenced in the substantial disparities between the health status of immigrant women and children and the general population.

Yet, despite wide differentials and inordinate needs, these highly vulnerable groups receive less effective, less efficacious health care than majority groups. Although considerable progress has been made in recent years to lessen disparities and correct differentials, children who are born to mothers who are poor, non-white, non-English-speaking or who are minorities, minority immigrants or refugees, are at greatest risk for health deficits (Binkin, et.al., 1985; Egbuonu, et. al., 1982; Gortmaker, 1979).

Studies show that immigrant and minority mothers are more likely to exhibit higher, disproportionate maternal risk factors such as: poor