

IWK Health Centre
Province of Nova Scotia

SPRING 2006

Cultural Competence for Primary Health Care in Nova Scotia: A DVD and Discussion Guide





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“Cultural competence in health care describes the ability of systems to care for patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs” (Betancourt et al.,2002).

I. About this DVD and Discussion Guide

Cultural Competence in Primary Health Care: A DVD and Discussion Guide for Nova Scotia is a resource for health care providers. This resource has several goals:

- to define cultural competence in primary health care
- to describe how cultural competence relates to the health of Nova Scotia's ethnically diverse communities
- to identify strategies for building cultural competence in Nova Scotia's Primary Health care system
- to provide a starting point for discussion, assessment and action

II. Ways to Use the DVD and Discussion Guide

1. Get started

Watch the DVD on your computer or DVD player. Read through this Discussion Guide. Complete your own Self-Assessment and/or Organizational Assessment. Commit to increasing your own cultural competence and make a plan for action.

2. Share and plan for action with others

Use the posters included to promote a sharing of these concepts among your co-workers. Watch the DVD as a group. Discuss the concepts highlighted in the video. Copy the assessments and then complete them as a group. Strategize and commit to increasing cultural competence. Make a plan for action.

Consider the following points for discussion:

- What stood out for you from the DVD presentation?
- What did you learn about cultural competence?
- How could increasing your cultural competence better serve the diverse minority communities with whom you work?
- What would it take for you and/or your organization to become more culturally competent?
- What opportunities can you and/or your organization take advantage of to increase cultural competence?

III. Cultural Competence and Primary Health Care in Nova Scotia

Nova Scotia is a diverse province, with citizens representing our First Nations and cultures from around the world. These cultures mostly include people from Acadian, African Canadian, Francophone, First Nations, Asian and Arabic communities. Four percent of Nova Scotians identify themselves as belonging to a diverse community, 7% within the Halifax Regional Municipality.

Unfortunately, some Nova Scotians are excluded from fully taking part in the health care system because of poverty, ill health, gender, sexual orientation, ethnicity or lack of education. For some, this can be because the health care workforce does not reflect nor understand racial, cultural or ethnic diversity. There are also statistical and research gaps related to diverse minority populations in Nova Scotia. This complicates efforts to understand the interaction of the determinants of health, which have a great impact on these diverse communities.

Working towards more culturally competent primary health care can help.





"Cultural competence is the process of becoming; not a state of being."
Josepha Campinha-Bacote

What is cultural competence?

There are many definitions of cultural competence and a general lack of agreement on terms and definitions. Often-cited definitions include the following:

"Cultural competence in health care describes the ability of systems to care for patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs" (Betancourt et al 2002).

"...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 1989).

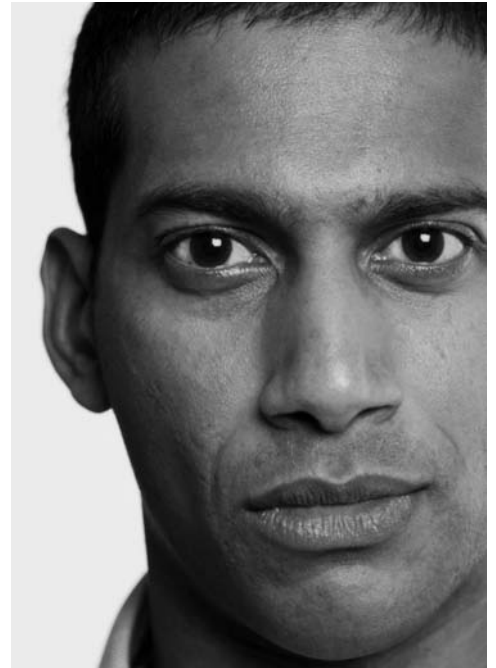
Essentially, cultural competence is a process in which healthcare providers continually strive to work effectively within the cultural context of a patient.

- Cultural competence is not only
- something that can be learned in a classroom
 - a technical skill to be mastered
 - a problem solving or conflict resolution approach to develop
 - a communication technique to refine

Instead, cultural competence requires a fundamental change in the way people think about, understand and interact with the world around them. As with the definition of culture itself, cultural competence is shared, learned and integrated. It is a continuous, dynamic process, not simply an end to be reached (Dunn 2002, 106-107).

Cultural competence requires that healthcare providers have effective skills, knowledge and attitudes; that organizations have inclusive procedures and guidelines; and that health systems have adequate funding, sound policies and supportive leaders and champions.

Our goal is for individuals, agencies, institutions and systems to become more culturally competent across a continuum of services.



“Care is a state in which something does matter; it is the source of human tenderness” Rollo May



Why do culture, race and ethnicity matter to health?

Cultural bias and lack of understanding contribute to inadequate care. The cultural and racial blinders of a health care provider may prevent identification and treatment of illnesses and disease and may lead to interventions that deny the integrity and value of patients. Language barriers lead to lack of understanding, heighten risk levels and increase the likelihood of patient relapse into the system. As a result, patients underutilize health services, providers believe that patients are non-compliant, and both end up frustrated or angry (Fadiman, 1997)

In the end, inequities exist in the health status of a patient based on poverty, ill health, gender, sexual orientation, race and ethnicity or lack of education. Cultural competence is important because it reduces disparities in health services and increases detection of culture-specific diseases; it addresses

inequitable access to primary health care; and it improves the health status of culturally diverse communities. Without cultural competence, these inequities will only worsen as demographic trends towards diversity continue.

The needs and barriers facing Nova Scotia's ethnically diverse communities in accessing primary health care have been identified through a process of engagement with the Department of Health and each District Health Authority.

These include:

- discrimination: twenty percent of visibly diverse first generation Canadians report unfair treatment compared to 5% of first generation Canadians who are not visibly diverse
- lack of health data collection and analysis for ethnically, culturally and linguistically diverse groups
- limited outreach to Nova Scotia's culturally diverse communities
- a need for cultural health interpretation and services in other languages in primary health care settings
- a need for Increased representation of diverse primary health care providers
- few health services are provided in plain language
- written health related material is not always provided in plain language or in the language of need
- a need to recognize and respect the prominent role of spirituality and faith in many culturally diverse populations
- a need for culturally competent primary health care





"It is more important to know what kind of patient has a disease than what kind of disease a patient has." William Osler

How can we build cultural competence in Primary Health Care?

Brach and Fraser (2000) propose the following strategies to improve cultural competence:

- Interpreter services
- Recruitment and retention policies for minority staff
- Ongoing orientation and training
- Coordinating with traditional healers
- Use of community health workers
- Culturally competent health promotion
- Including family and/or community members in care giving
- Immersion into another culture
- Administrative/organizational accommodations

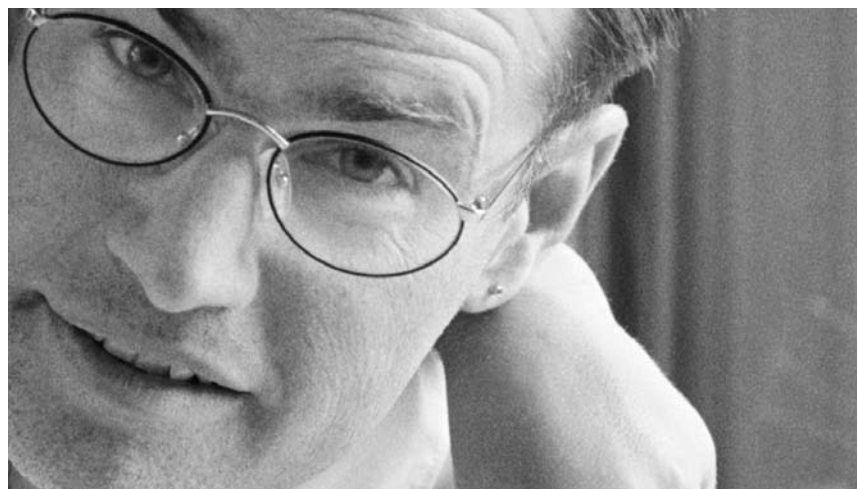
In moving forward, challenges to consider include a lack of agreement on terms and core approaches; limited research on the impact and effectiveness of these approaches; and a misperception that cultural competence initiatives are focused on people of specific ethnic backgrounds, versus on diverse cultural populations. This, for example, may include, but not be limited to, diverse religions, class, ages or sexual orientation (Rees and Ruiz/Kaiser Family Foundation 2003, 5).

Strategies for health care providers

For health care providers, becoming more culturally competent involves assessing your attitudes and values, knowledge and skills. What's important?

- Work on changing your view of the world
- Become familiar with core cultural issues, especially those that relate to health and illness
- Learn more about the groups with whom you work
- Develop a relationship of trust with others
- Negotiate for mutually acceptable and understandable interventions of care (Dunn 2002)

Complete the **Self-Assessment Tool for Primary Health Care Providers** included in this discussion guide to find your starting point.



"Everyone needs a cultural assessment; not just people who 'look like' they need one." Josepha Campinha-Bacote



Strategies for health care organizations and systems

Without institutional change, even competent individuals will be limited in their ability to practice in a culturally competent manner. Culturally competent systems of primary health care involve:

- Institutionalization of culturally competent approaches to care
- Ongoing commitment to provision of appropriate care
- Integration of cultural competence into every facet of the organization

A culturally competent organization understands, accepts and respects diversity and includes and actively involves people who are reflective of the diverse groups represented within its community

Staff who can interact appropriately in a culturally diverse work environment will be better prepared to assist clients from diverse communities.

Improve understanding

- Learn more about the diverse communities and individuals you care for
- Enhance patient-provider communication and trust
- Involve the community and patients in meetings and assessments
- Examine your staffing policies, mission statement to ensure they reflect the diversity of those you serve

Target staffing and staff training

- Maximize diversity within your health care leadership and your workforce. Increase and retain the proportion of under-represented racial and ethnic minorities among health professionals
- Integrate cross-cultural education in the training of all current and future health care providers and staff, including those at the first points of patient contact. Start by increasing awareness of the need for cultural competence.

Focus on language and literacy

- Support the use of interpretation services and community health workers
- Consider health literacy in communicating with clients and in health promotion
- Ensure culturally and linguistically appropriate health education materials and health promotion and disease prevention interventions



Complete the **Organizational Assessment Tool** included in this discussion guide to discover areas needing improvement.

Nova Scotia's response to cultural competence in Primary Health Care

Nova Scotia's vision for Primary Health Care includes supporting communities in their efforts to improve the health and well-being of their members. The pillars of this approach include health care that is

Community-based, family focused and person-centered—the uniqueness and diversity of individuals, families and communities are valued and responded to appropriately.

Responsive and flexible—services are offered in ways that value and respond to the cultural, ethnic and spiritual experiences of individuals, families and communities.

Accessible—there is equity of access for those who have historically faced barriers, including but not limited to barriers related to illness, disability, poverty, culture, ethnicity, language, geography, sexual orientation and gender.

The Primary Health Care section of Nova Scotia's Department of Health has implemented a "Diversity and Social Inclusion in Primary Health Care Initiative" to effectively address the needs of ethnically diverse populations. The three-year initiative, which concluded in March 2006, had two goals:

1. To lead in raising awareness of diversity and social inclusion issues in Primary Health Care
2. To consult with stakeholders including culturally diverse populations to develop guidelines and policies for the Primary Health Care system

Outcomes of this initiative are reported in three key documents

1. *Diversity and Social Inclusion in Primary Health Care: From Dialogue to Action* (2003)
2. *Diversity and Social Inclusion in Primary Health Care: Cultural Competence Workshop* (2005)
3. *A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia* (2005)

To read more about diversity and social inclusion in Nova Scotia's Primary Health Care system and to access these documents, visit <http://gov.ns.ca/heal/primaryhealthcare/diversity.htm>

The Diversity and Social Inclusion initiative resulted in recommendations for culturally inclusive policies and the first provincial guidelines for cultural competence in Primary Health Care in Canada.

"You must be the change you wish to see in the world." Mahatma Gandhi

Appendix 1: Self-Assessment Tool for Primary Health Care Providers

For each item listed, enter A for “things I do frequently,” B for “things I do occasionally” and C for “things I rarely or never do.”

Statement	Score
<hr/> <i>Physical Environment, Materials and Resources</i> <hr/>	
1. I display pictures, posters, artwork and other decor that reflect the cultures and ethnic backgrounds of individuals or families to whom I provide service.	_____
2. I ensure that, brochures, magazines and other printed materials in reception areas are of interest to and reflect the diversity of the community in which I provide service.	_____
3. When using brochures, posters, videos, or other media resources for health education, treatment or other interventions, I ensure that they reflect the cultures and ethnic background of individuals and families to whom I provide service.	_____
4. I ensure the printed information I provide takes into account the literacy levels of individuals or families to whom I provide service.	_____
<hr/> <i>Communication Styles</i> <hr/>	
1. When interacting with individuals and families who do not have spoken English proficiency, I always keep in mind that: <input type="checkbox"/> Spoken English proficiency does not reflect literate English proficiency or language of origin proficiency or literacy. <input type="checkbox"/> Limited ability to speak the language of the dominant culture has no bearing on ability to communicate effectively in one’s mother tongue. <input type="checkbox"/> Limitations in English proficiency do not reflect mental ability.	_____
2. I use bilingual and/or bicultural staff trained in medical interpretation when required or requested.	_____
3. For individuals and families who speak languages other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.	_____
4. I understand cultural context for naming disease and try to be respectful of this in my interactions. (In some cultures, there is stigma associated with terminal disease, sexually transmitted disease and/or communicable diseases. In some cultures, this stigma is avoided by naming the disease by its attributes, rather than its medical name, i.e. AIDS is sometimes named “the sleeping sickness.”)	_____
5. I can provide alternatives to written communication if required or preferred.	_____

Social Interaction

1. I understand and accept that family is defined in a variety of different ways by different cultures (e.g., extended family members, kin, godparents). _____
2. Even though my professional or moral point of view may differ, I accept individuals and families as the ultimate decision makers for services and supports impacting their lives. _____
3. I understand that age, sex and life cycle factors need to be considered in interactions with individuals and families. For instance, a high value may be placed on the decision of elders, the role of eldest male or female in families, or roles and expectation of children within the family. _____
4. I accept and respect that male-female gender roles may vary among different cultures and ethnic groups (e.g., which family member makes major decisions for the family). _____

Health, Illness and End of Life Issues

1. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups. _____
2. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures. _____
3. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death. _____
4. I understand that grief and bereavement differ by culture. _____
5. I seek information from individuals, families or other key community informants that will respond to the needs and preferences of culturally and ethnically diverse communities served by my program or agency. _____
6. I keep abreast of the major health concerns and issues for ethnically and racially diverse client populations residing in the geographic locale served by my program or agency. _____
7. I am well versed in the most current and proven practices, treatments and interventions for major health problems among ethnically and racially diverse groups within the geographic locale served by my agency or program. _____

Assumptions, Attitudes and Values

1. I recognize and accept that individuals from diverse cultural backgrounds may desire varying degrees of acculturation into dominant culture. _____

2. I avoid imposing my values. _____

3. I intervene in an appropriate manner when I observe other staff or clients within my program or agency engaging in behaviors that are not culturally competent. _____

4. I screen resources for cultural, ethnic or racial stereotypes and/or inclusion before sharing them with individuals and families served by my program or agency. _____

5. I am aware of the socioeconomic and environmental risk factors that contribute to the major health problems of culturally, ethnically and racially diverse populations served by my program or agency. _____

6. I avail myself to professional development and training to enhance my knowledge and skills in the provision of services and supports to culturally, ethnically, racially and linguistically diverse groups. _____

7. I advocate for the review of my program or agency's mission statement, goals, policies and procedures to ensure that they incorporate principles and practices that promote cultural and linguistic competence. _____

Note: There is no answer key with correct responses. However, if you frequently responded "C," you may not necessarily demonstrate beliefs, attitudes, values and practices that promote cultural competence within health. Use these areas as a starting point for your own learning.

Appendix 2: Organizational Assessment Tool

Adapted from a tool created by the Ontario Healthy Communities Coalition, 2004

	Yes	No	Need to work on
<i>Organizational Policies and Practices</i>			
1. Anti-discrimination and workplace harassment policies are in place	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Existing policies have been examined in order to identify barriers to inclusion	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Issues of diversity and social inclusion have been addressed in a strategic action plan	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Informed Leadership in Policy Implementation</i>			
1. A strategic action plan to reduce barriers to social inclusion has been established.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. This plan addresses issues of diversity, inclusion and equity as well as workplace discrimination/ harassment.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Steps to monitor, review and evaluate the plan are in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Resources have been explicitly allocated for effective implementation of the plan.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Communication and Decision-Making</i>			
1. The organization has compiled an updated regional profile of the community including demographics, socio-economic issues and environmental issues relevant to health status	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. A list of community, regional and provincial organizations that work directly with diverse and/or marginalized populations has been developed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. A list of other points of access to diverse communities (places of worship or social clubs etc.) has been developed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. A comprehensive list of community and ethnic media has been developed.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Communication strategies have been developed to provide necessary information to the various communities within a service area. Strategies include key informants, community leaders, community newsletters and audio-visual media.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<i>Progress in Reduction of Barriers</i>			
1. A policy for monitoring and evaluating progress in elimination of barriers to inclusion is in place.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. All staff have opportunities for involvement in evaluation and providing input in areas related to diversity and social inclusion.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Service Planning

- | | | | |
|---|--------------------------|--------------------------|--------------------------|
| 1. Consultation with representatives from the diverse communities has been undertaken to inform organizational planning. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Information about the health care needs and information needs of diverse communities has been obtained. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Outreach strategies have been developed and resources have been allocated equitably. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Programs and services are adapted to respond to expressed [or identified] needs and issues of diverse communities within the service area. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Resources have been allocated to provide appropriate linguistic services. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Staff Recruitment and Retention

- | | | | |
|--|--------------------------|--------------------------|--------------------------|
| 1. Possible barriers to recruitment, hiring, promotion and retention of members of diverse cultural groups as staff, volunteers and partners have been explored. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Employment opportunities (paid and volunteer) have been advertised in non-mainstream media outlets e.g. at social clubs or places of worship. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Employment opportunities (paid and volunteer) have been advertised using appropriate language based on the demographics of the service area. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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Details of our event





NOVA SCOTIA

Health