A Cultural Competence Guide for Primary Health Care Professionals in Nova Scotia

"Adding wings to caterpillars does not create butterflies--it creates awkward and dysfunctional caterpillars. Butterflies are created through transformation..."
Stephanie Marshal

2005

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Your comments, questions and feedback on this guide, and the Diversity and Social Inclusion Initiative are welcome, and can be directed to the Initiative Lead, Sharon Davis-Murdoch, via:

Email: murdocsd@gov.ns.ca

Fax: (902) 424 0506

Mail: Primary Health Care Section,
Nova Scotia Department of Health
PO Box 488, 1690 Hollis Street
Halifax, Nova Scotia, B3J 2R8

Purpose of this Guide

This guide includes tools and resources to assist primary health care professionals in providing culturally competent health care. Culture is a broad term used in reference to a wide variety of groups. In order to respectfully and effectively address health needs and issues related to race, ethnicity and language, the focus of this guide is on these elements of culture.

Who is this Guide For?

This guide is for professionals working within the primary health care system, including:

- Management and Administrative Staff
- Front-Line Staff
- Primary Health Care Providers, including *but not limited to*:

Doctors	Dentists	Occupational Therapists
Pharmacists	Social Workers	Physiotherapists
Midwives	Nurse Practitioners	Public Health Nurses
Nutritionists	Family Practice Nurses	Mental Health Professionals

Structure of this Guide

The guide is divided into five self-contained sections, each applicable to different groups of professionals working in the primary health care system.

Section I is applicable to all primary health care professionals, provides general information about cultural competence, followed by key concepts that come up in relation to cultural competence. The section concludes with brief demographic, historical and health barriers synopses of Nova Scotia's four most prominent diverse communities: First Nations, African Canadians, Immigrant Canadians as well as Acadians and Francophone Canadians.

Section II contains information and tools most relevant to primary health care providers, including self-assessment questionnaires and useful patient / client encounter questions.

Section III focuses on the role management and administrative staff play in developing cultural competence within primary health care, and includes organizational assessments and the role of Human Resources divisions.

Section IV recognizes the integral role front-line staff play in client/patient – organization interaction, and provides tools for front-line staff to use in assessing their cultural competence.

Section V concludes the guide with additional resources, such as community contacts, online resources and definitions of terms.

Section I

Cultural Competence in Primary Health Care

Cultural Competence
Key Concepts
- ✧ Culture
- ✧ Principles and Assumptions
- ✧ Power and Privilege
- ✧ Exploring Differences
- ✧ Equitable Access
- ✧ Racism & Oppression

Diverse Communities in Nova Scotia

Please Note:

Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

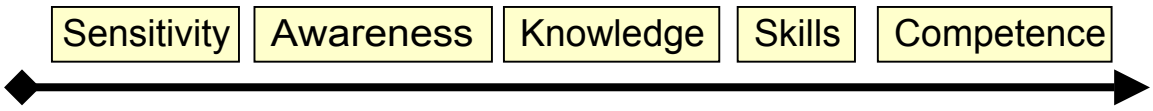
While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people.

What is Cultural Competence?

Cultural competence:

- Is a set of "congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables the system or professionals to work effectively in cross–cultural situations".[1]

Cultural Competence can be viewed as a process:



Why is Cultural Competence Important?

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
- It impacts health status of culturally diverse communities
- It responds to Nova Scotia's changing demographics – an increasingly diverse population.

A Culturally Competent Primary Health Care System:

- Provides health care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs.
- Requires an understanding of the communities being served as well as the cultural influences on individual health beliefs and behaviors.
- Devises strategies to identify and address cultural barriers to accessing primary health care

1 Cross et al., 1989; Isaacs & Benjamin, 1991

Key Concepts

Culture is…

- Dynamic, ever evolving and changing, created through individuals' interactions with the world, resulting in ways of naming and understanding reality.
- Shared when individuals agree on the way they name and understand reality.
- Symbolic, often identified through symbols such as language, dress, music and behaviors.
- Learned and passed on through generations, changing in response to a generation or individual's experiences and environment.
- Integrated to span all aspects of an individual's life.

Principles and Assumptions

As individuals we often consciously or unconsciously make 2 key assumptions:

1. Everyone who looks or sounds the same IS the same
2. Everyone who looks or sounds like us IS like us

We need to pay attention to how we think or feel about other people and how these beliefs will influence our actions towards them.

It is important to be aware of our biases, which are part of our own cultural backgrounds, so that we can reduce the barriers that keep us from understanding each other.

Power and Privilege

In the process of enhancing our cultural competence it is important to recognize the type of power that surrounds our privilege [whether or not we feel powerful]. In society, the **privileged group** has the power to:

- ✧ Act and define reality
- ✧ Determine what is normal and correct
- ✧ Institutionalize and systematize discrimination

Ways the Privileged Culture Uses Power:		
Structures and Organizations	Decision-making	Unfair distribution of capacity to make and enforce decisions
	Resources	Provision of unequal access to money, education, information and opportunity
Cultural values	Standards	Parameters for appropriate behavior are set such that they reflect and give privilege to the norms and values of the dominant culture
Ideology	Naming reality	Involves defining 'reality' by naming 'the problem', 'the solution', 'the institution' incorrectly or too narrowly. Having a set of beliefs, with a bias.

<u>Comparing Power and Privilege</u>

Power is about the possibility of deciding on resource allocation.
Privilege is about reaping the benefits.

Power is involved in deciding that universal health care is 'too expensive' or will 'limit my choices'.
Privilege is reflected in the fact that being born white gives one a far greater chance of survival than most people in the world.

Power involves defining the parameters of the discussion.
Privilege is about not needing to know that the parameters have been set.

Exploring Differences

Generally, people with invisible differences have a greater ability to blend in with the dominant culture than people with visible differences.

Visible differences can be seen or heard and are often noticed upon initial encounters.

Invisible differences *cannot be seen or heard* and may never be detected.

Both visible and invisible differences can have an impact on health.

Equitable Access

Access is the ability or right to approach, enter, exit, communicate with, or make use of health services.

Equitable access recognizes that things like geographic location, communication styles, language of service; signage, physical design and service-delivery style influence a person's access to health services and strives to address these issues.

For instance, language barriers to access in health promotion, prevention and screening result in inequitable access leading to the use of more expensive services as health deteriorates.

When we treat people EQUALLY we ignore differences.

When we treat people EQUITABLY we recognize and respect differences.

Racism and Oppression

The concepts of power, privilege, race and equity are linked.

It is at the intersection of power and privilege; namely, in the capacity of one group to make and enforce decisions that racism, is most clearly revealed.

Power and privilege influence the degree of access to resources, which may not be equitably allocated to all.

There are different types of racism, some conscious and some unconscious. All types of racism can impact a person's ability to obtain health services, thereby impacting health status.

Racism	The belief that race accounts for differences in human character or ability and that a particular race is superior to others.
Overt Racism	Attitudes, actions, policies and practices that openly embody the assumption that one's ethnoracial group is superior to other(s). This form of racism includes hate propaganda and hate crimes.
Systemic Racism	This form of racism may be introduced consciously or unconsciously. Policies and practices that adversely affect ethno-racial and ethno-cultural policies are a dominant part of the fabric of society.
Internalized Racism	The perception among those from outside the dominant culture that racists' ideology is true/inevitable. It is racism turned inward. The process occurs when society as a whole rewards the attitudes, values and behaviors of the dominant group or culture.
Oppression	A system of domination of one group over another.

Cultural competence is a process with emphasis on adapting one's attitudes, behaviors, knowledge and skills as opposed to "cookbook" responses to staff development, which could do more harm than good and may lead to stereotyping.

EIGHT STEPS TO CULTURAL COMPETENCE FOR PRIMARY HEALTH CARE PROFESSIONALS

1. Examine your values, behaviors, beliefs and assumptions.
2. Recognize racism and the institutions or behaviors that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve, including: physical and biological variations, concepts of time, space and physical contact, styles and patters of communication, physical and social expectations, social structures and gender roles.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements. Unique experiences and histories will result in differences in behaviors, values and needs.
6. Learn how different cultures define, name and understand disease and treatment. Engage your clients to share with you how they define, name and understand their ailments.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

Cultural Diversity in Nova Scotia

Nova Scotia has a very diverse population that includes people from all over the world. Acadian, Francophone, African Canadian, First Nations, Asian and Arabic people are the dominant diverse groups in Nova Scotia. Provincially, 4% of Nova Scotians reported they were members of a diverse community, while 7% of Halifax's population reported the same (2001 census).

Diverse Communities in Nova Scotia by District Health Authority✦

DHA	First Nations	Francophone Canadians~	Black○	Chinese	South Asian	Arabic
1 SSDHA	980	585	420	95	40	75
2 SWNDHA	2,095	**13,085***	**1,755***	80	105	85
3 AVDHA	985	1635	1,125	160	25	105
4 CEHHA	1,390	835	700	78	**192***	116
5 CHA	165	400	345	25	35	-
6 PCHA	665	475	520	95	25	35
7 GASHA	1,070	3960	640	75	40	25
8 CBDHA	**5,310***	4235	970	**185***	90	**125***
9 CDHA	3,570	11,290	13,365	2,485	2,345	3,030

Source: Statistics Canada Census 2001

✦ This table includes the 6 most populous groups in Nova Scotia.
*The largest population outside of Halifax is shaded.
~ Francophone Canadians includes anyone who identifies any combination of French and English as first language still understood or current language.
○ Statistics Canada Census uses the terminology Black, in this document we use African Canadian.

Religious faith and spirituality of Nova Scotians is also diverse. The dominant religion in Nova Scotia is Christianity, however, Judaism, Islam, Hinduism, Sikh, Buddhism, Baha'i and many other faiths are also celebrated by Nova Scotians.

Religious Communities in Nova Scotia

Christian	**780,530**
Muslim	**3,545**
Jewish	**2,120**
Buddhist	**1,735**
Hindu	**1,235**
Sikh	**270**
Eastern religions	**565**
Other religions	**1,155**

Common Issues Impacting Access to Primary Health Care Raised by Nova Scotia's Culturally Diverse Communities

1. Discrimination: 20% of first generation Canadians who are visibly diverse report unfair treatment compared to 5% of first generation Canadians who are not visibly diverse
2. There is a lack of race, ethnic, and language specific health data
3. There is limited outreach to culturally diverse communities
4. There is a need for cultural health interpretation and bilingual services in primary health care settings
5. There is a need for more representation of culturally diverse communities among primary health care professions
6. There are too few health services provided in plain language
7. Written health material are not always provided in plain language or different languages
8. There is need for recognition and respect of the prominent role of spirituality in many culturally diverse populations
9. There is a need for delivery of culturally competent primary health care

Culturally Diverse Communities in Nova Scotia

Acadian and Francophone Canadians

Demographics

Acadians and Francophone Canadians can be found across the province, however members of these communities are largely concentrated in Halifax, Digby and Yarmouth. These communities account for 65.8% of Nova Scotia's francophone population. In some communities, Acadians represent the majority of the population: Argyle, 55%; Clare, 68.3%; Isle Madame, 51.6%; Inverness North, 44%.

Background

Acadians speak French as their first language. They are descendants of the Acadians who came from France and first settled in Nova Scotia 400 years ago.

In the 2001 census, 3.65% of Nova Scotians identified French as their first official language. The ability to receive services in French and the preservation of the French language is an important concern among Nova Scotia's Acadian population.

Francophone Canadians are those who speak French as their first language. They may have originally arrived in Nova Scotia from other locations within Canada and/or other countries. All Acadians are Francophones *but not all francophones are necessarily Acadians.*

Issues Identified in Consultation with Community Representatives

Through consultations with representatives from the Acadian and Francophone Canadian communities the following issues were identified as having an impact on health:

1. Language barriers- medical records and prescriptions as well as any forms and written material provided in the health care setting are not yet provided in both French and English
2. Geographical barriers sometimes hinder access to health services
3. There is a need for more bilingual primary health care professionals including physicians, nurses, nurse practitioners, pharmacists and specialists
4. Signage and posters promoting the availability of services in French are not currently provided
5. Available written information in French should be provided in plain language

African Canadians

Demographics

There are 48 African Canadian communities across Nova Scotia. 66% of the African Canadians living in Nova Scotia live in Halifax. Southwestern Nova Scotia (Kings, Annapolis, Digby, Yarmouth, Shelburne, Queens and Lunenburg counties) has the largest community of African Canadians outside Halifax.

Halifax has the highest proportion of Canadian-born African Canadians among major urban areas in Canada - 91% of African Canadians living in Halifax were born in Canada.

Background

Many African Canadians have a history in the Atlantic Provinces dating back 400 years. African Canadian heritage in Nova Scotia is largely reflected in three distinct groups:

- Indigenous (have no country of ethnic origin other than Canada)
- Caribbean immigrants (citizens of countries outside the African continent)
- African immigrants (from countries in Africa)

The vast majority of people of African descent who have lived outside of Africa over generations (historic migrants) have a shared history of slavery and segregation.

Many African Canadian populations have strong faith-based belief systems that include Christian (Baptist, Catholic, Presbyterian), Muslim, Jewish, Baha'i and Buddhist faiths among others.

Issues Identified in Consultation with Community Representatives

Through consultations with representatives from African Canadian communities the following issues were identified as having an impact on health:

1. Difficulties in communication with primary health care providers
2. Under-representation of African Canadians among health professionals
3. Assumptions about racial/ethnic background
4. Discrimination, systemic racism, stereotypes and bias
5. Racial profiling in everyday situations such as; driving, shopping, school and neighborhood interactions
6. Geographical isolation for those in rural communities
7. Lack of control over access and availability of health services
8. Insufficient research-based health information and virtually no African Canadian health data
9. No universal screening for sickle cell anemia, and suspected high rates of undiagnosed sickle cell anemia
10. Stigma around issues of homosexuality and mental illness
11. Anecdotal evidence of higher (than general population) prevalence of: sarcoidosis, diabetes, hypertension, anemia, cancers, stress, physical inactivity, poor diet, obesity, heart disease, alcoholism, violence and abuse

Immigrant Canadian Community

Demographics

Most immigrants reside in Halifax although small populations of immigrants are present in every region of the province. The proportion of immigrants coming to Nova Scotia from Europe is on the decline, while that from Asia, Central America, Africa and the Middle East is on the rise. There are three ways people can immigrate to Nova Scotia:

i. Family-sponsored: citizens or permanent residents can sponsor family members living abroad.
ii. Refugees: have no new country of habitual residence
iii. Nova Scotia Nominee program (NSNP);
   a. Economic – to support growth/ development of small business
   b. Skilled workers - employer-driven, designed to meet skill shortages
   c. Community identified – community recommended nominees who will add social or economic value to their community

Two new streams have also been suggested: international post-secondary students, and family business, which allows immigrants who own businesses in Nova Scotia to nominate a family member.

Background

Immigrants to Nova Scotia are generally risk-takers; willing to give up what they know in hopes of a better life, they face many challenges. Most immigrants are healthy upon entry into Canada but many experience deteriorating health over time. Culture shock, loneliness, and homesickness often lead to mental health issues. Immigrants who come to Canada as refugees are particularly vulnerable to the impact of post-traumatic stress.

Immigrants in all categories are often unemployed or underemployed. Stress related to difficulty in getting credentials recognized and/or finding employment significantly impacts the health of this population.

Issues Identified in Consultation with Community Representatives

Through consultations with representatives from Immigrant Communities the following issues were identified as having an impact on health:

1. Support groups are needed
2. Language barriers
3. Limited access to paid and trained cultural health interpreters
4. Health outreach is required
5. Refugees have health needs that may be different from other categories of immigrants
6. Health issues include depression and effects of diet change
7. Racial profiling: people of the Muslim faith and Nova Scotians of Middle Eastern origin have stated this as an issue after the September 11th attack in the US
8. Credential assessment and recognition: Immigrants face barriers in having their qualifications and international work experience recognized and for some, professional licenses validated

First Nations Peoples

Demographics

The vast majority of Nova Scotia's First Nations people are members of the Mi'kmaq Nation. Inuit and Métis people also call Nova Scotia home. There are 13 First Nations communities living across the province of Nova Scotia. However, most of the First Nations population resides in Cape Breton: Victoria County (6.3%) and Richmond County (4.4%).

Background

First Nations is a term used to recognize the indigenous Nations, communities, and peoples whose families have occupied this land for several thousands of years. The Union of Nova Scotia Indians and the Confederacy of Mainland Mi'kmaq govern First Nations people in Nova Scotia.

Many First Nations people are Roman Catholic but may also have traditional beliefs, partake in traditional ceremonies and use traditional medicines to treat common ailments. A pan-Aboriginal approach to cultural competence is not appropriate. Although First Nations, Inuit, and Métis people share some cultural traits, each Nation has its own laws, customs, and traditions complete with local variations.

★More on Jurisdictional Barriers: The lack of definition of roles and responsibilities of the various stakeholders providing health care to First Nations peoples can create problems. There is a fragmentation of program planning and delivery, which is compounded by jurisdictional divisions. Options for integration of services involving the federal, government, provincial government and First Nations communities are thus currently being explored.

Issues Identified in Consultation with Community Representatives

Through consultations with representatives from the First Nations peoples the following issues were identified as having an impact on health:

1. Jurisdictional barriers which prevent access to health care (e.g. post-operative VON care may be inaccessible)
2. Social isolation and geographical isolation
3. Historical bi-cultural tension
4. Residential school system resulting in the loss of culture, language, traditions, and history
5. Transportation challenges
6. Stereotypes and bias
7. Interactions with primary health care providers who appear disrespectful
8. Misconceptions around compliance issues
9. Poor knowledge or understanding among providers regarding First Nations culture e.g. traditional healing methods
10. Difficulties in recruitment and retention of on-reserve physicians
11. Poor working relationships with off-reserve health professionals
12. Health issues include: poor nutrition, diabetes, high blood pressure, heart disease, addiction, stress and depression.

Section II

Tools for Primary Health Care Providers

- ✧ Providing Health Care in a Multicultural Society
- ✧ Patient and Client Encounter Questions
- ✧ LIAASE: A General Cultural Competence Tool
- ✧ Health Professional Self-Assessment Tool

8 Elements of Cultural Competence for Primary Health Care Providers

1. Examine your values, behaviors, beliefs and assumptions.
2. Recognize racism and the institutions or behaviors that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements.
6. Learn, and engage your clients to share, how they define, name and understand disease and treatment.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

Please Note:

Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people.

Providing Health Care in a Multicultural Society

Organizations recognized as leaders in culturally competent health services delivery recommended the following guidelines when providing health care in a multicultural society.

> ***"It is more important to know what sort of a patient has a disease, than what sort of disease a patient has."***
> William Osler

- ✧ Avoid using family members as interpreters or translators
- ✧ Become familiar with expressions of distress. Patients may not show or acknowledge pain; be respectful of the patient's desire to maintain emotional control [or express emotion] when asked about upsetting subject matter
- ✧ Consider the patient's background rather than making assumptions; get to know the patient, ask questions
- ✧ Learn about and avoid religious and/or social taboos. Respect culture-specific rituals e.g. after death or during religious festivals
- ✧ Remember potential prescribing pitfalls - people from different backgrounds metabolize certain drugs differently
- ✧ Find out if a patient is using traditional or alternative treatments and remedies. Many of these remedies interact with drugs and may affect drug absorptionLearn about cultural and religious beliefs, especially as these relate to perceptions of illness Explain reasons for certain questions and/or tests - this allays fears of discrimination or insensitivity to one's history with the health care system
- ✧ Offer options for treatment
- ✧ To address fears of discrimination, based on historical experiences with the system, it is important to provide information on screening for culture-specific diseases

Cytochrome P450 isoenzymes are involved in the oxidation of many drugs. Some patients (e.g. Hispanics and Nigerians) are more likely to have low levels of these enzymes leading to poor metabolism of drugs.

Sometimes generalizations about culture-specific issues may be of value.

Information about the language, culture, history and experience of people can be useful without being stereotypic.

However, it will not be possible to learn all you need to know about each patient solely by reading information about their culture.

PATIENT & CLIENT ENCOUNTER QUESTIONS

When	Question	Rationale
Before the consultation	When possible: Would you prefer one of my female/male colleagues to examine you for this?	Some may prefer a same gender health service provider.
	When possible: Would you like a cultural health interpreter?	Patients may prefer to have an interpreter present during an examination. Even if they can speak English, they may be better able to articulate their condition with the help of an interpreter.
Before and/or during the consultation	Would you like to include/ involve anyone else in this process? 1) Consultation during diagnosis 2) Decision-making on treatment options	Determine the most appropriate mode of communication for news related to the patient's medical condition. In some cultures, the family is informed before the patient about a terminal condition. Sometimes, due to the belief that telling the patient would only worsen their condition and disrespect their value to the family, the family may shield bad news from the patient.
During the consultation	Are you treating this condition yourself in any way?	Patients may assume that questions about other medications they are taking relates only to prescription or over-the counter medications, so may not inform you of herbal remedies they may be using that interact with prescription drugs. They may also be reluctant to inform you of any other practices or treatment methods they are using.
	Tell me about how you are feeling?	Listening respectfully. When you speak, try to use plain language.

When	Question	Rationale
During the consultation	Do you have treatment preferences you would like me to include in your care plan?	Some may want to incorporate traditional healing and health practices with conventional medicine.
	May I examine you?	Understand cultural norms about modesty. Explain what will be done and why.
	Do you mind removing [an item of jewelry, ornament, regalia]?	These items may have significant spiritual or other meaning to the individual. If it is necessary to remove an object from a patient's body have the patient or family member remove it and if possible keep it close to the patient.
	Would you like me to explain or go over anything again? (Tell me what you heard me say about…)	This gives the patient an opportunity to relate their understanding of the information about the condition and/or instructions that you have provided.
	Do you have a special diet right now that is different from what you would normally eat?	Some patients may prefer certain foods and or drinks when they are ill. In addition during fasting and religious seasons diets may be different and need to be considered during the process of determining the appropriate course of treatment.
	What do you think caused your illness?	Some may have a different idea of what the cause of illness. Spirituality, culture and experience may have a significant role in the patient's understanding and treatment of the illness.
During and/or After the consultation	Do you need some time to make your decision?	Some may be reluctant to proceed with treatment and may want to consult a family member, community elder, religious leader, alternative health practitioners or wait for the illness to progress while coping using available remedies in the home.
	Would you like for me to explain the next steps / process? [E.g. for getting a referral to a specialist]	Patients new to the system may not understand the processes involved

LIAASE: A General Cultural Competence Tool

Adapted from Ontario Healthy Communities coalition October 2004

Learn

◇ Read literature from other cultures
◇ Identify your own biases and stereotypes

Inquire

◇ Ask questions to clarify and understand information
◇ Dig deeper to find reasons for behaviors or attitudes
◇ Frame inquires as searches for answers, show a willingness to learn
◇ Do not judge or interpret actions or speech, verify that what you understand is correct
◇ Speak clearly; avoid slang, colloquial expressions and large, complex words

Avoid Polarization

◇ Solicit other options or points of view
◇ Ask what perspective a person from a different background would have

Avoid Arguing and Defending

◇ Curb the impulse to defend your point of view or opinion
◇ Agree to disagree on differences in values

Show Empathy

◇ Listen not just to the words, but to the feelings behind the words
◇ Acknowledge and validate powerful emotions when expressed

And finally…

State your needs and expectations

It is important to set a respectful tone for the interaction. Let people know what you want and what you consider unacceptable behavior. In this way, assumptions, conflict, and/or resentment can be avoided.

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."

Physical Environment, Materials & Resources	
1. I ensure the printed & posted information in my work environment reflects the diversity and literacy of individuals or families to whom I provide service.	___
Communication Styles	
2. When interacting with individuals and families who do not have spoken English proficiency, I always keep in mind that:	
◆ Spoken English proficiency does not reflect literate English proficiency or language of origin proficiency or literacy.	___
◆ Limited ability to speak the language of the dominant culture has no bearing on ability to communicate effectively in one's mother tongue.	___
◆ Limitations in English proficiency do not reflect mental ability.	___
3. I use bilingual and/or bicultural staff trained in medical interpretation when required or requested.	___
4. 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.	___
5. 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".)	___
6. I can provide alternatives to written communication if required or preferred.	___
Social Interaction	
7. I understand and accept that family is defined in a variety of different ways by different cultures (e.g., extended family members, kin, godparents).	___
8. 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.	___
9. 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.	___
10. 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

11. I understand that the perception of health, wellness and preventive health services have different meanings to different cultural or ethnic groups. ___

12. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures. ___

13. I accept that religion and other beliefs may influence how individuals and families respond to illnesses, disease and death. ___

14. I understand that grief and bereavement differ by culture. ___

15. I seek information from individuals, families or other key community informants that will to respond to the needs and preferences of culturally and ethnically diverse communities served by my program or agency. ___

16. 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. ___

17. 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

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

19. I avoid imposing my values. ___

20. 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. ___

21. 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. ___

22. 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. ___

23. 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. ___

24. 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. ___

NB: 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 care delivery programs.

Section III

Tools for Management & Administrative Staff in Primary Health Care Settings

- ✧ An Organizational Change Strategy
- ✧ Organizational Assessment tool
- ✧ LIAASE: A General Cultural Competence Tool
- ✧ Health Professional Self-Assessment Tool

8 Elements of Cultural Competence for Primary Health Care Providers

1. Examine your values, behaviors, beliefs and assumptions.
2. Recognize racism and the institutions or behaviors that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements.
6. Learn, and engage your clients to share, how they define, name and understand disease and treatment.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

Please Note:

Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people.

An Organizational Change Strategy

Culturally competent primary health care recognizes that the needs of patient's and their families are impacted by racial, cultural, linguistic, educational and socio-economic backgrounds.

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

"An inclusive organization not only recognizes diversity but also embodies it."

(Ontario Healthy Communities Coalition, 2004)

A culturally competent organization:

- ✧ Understands, accepts and respects diversity
- ✧ 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.

Cultural insensitivity leads to interventions that deny the integrity & value of clients. As a result, patients underutilize health services, providers believe that patients are non-compliant, and both end up frustrated or angry. Fadiman, 1997

Role of Management in Cultural Competence

A multi-sectoral approach to enhancing cultural competence is necessary to addressing the key issues identified by the diverse communities in the province.

Communication:
Clear, reliable communication between all levels of the organization and between the organization and its clients is paramount to an organization's success. Consistent messages and behaviors modeled by senior leadership, directors, and managers reflect a clear commitment to the organization's culture, vision, mission and values.

Often information is provided in a generic form that is applicable only to the "mainstream" culture.

Effective communication can mean the difference between being understood or misunderstood.

◇ Communication varies from one culture to the next. The type of media, technology and other tools used to convey information should be appropriate and effective for the target audience in each instance.

◇ Consideration of appropriate methods of conveying messages to specific groups in a diverse community is beneficial. Some may prefer oral communication to written communication and/or both.

Leadership
Leadership facilitates change from above and within. Inspiring leadership, which models desirable behaviors, has the power to change individuals and organizational culture.

◇ Do you measure the level of cultural competence of your staff?

◇ Does your staff have a clear understanding of the needs and interests of the community it serves?

◇ Do you evaluate organizational cultural competence?

◇ Is the organization promoting, supporting and educating staff about differences in needs of diverse communities served?

◇ Does your organization provide services and programs to develop staff cultural competence so that they may work respectfully and effectively with each other as well as the communities they serve?

Training

Organizations must set their staff up for success. This occurs through training, mentorship, and behavior modeling. Providing training to staff in cultural competence reflects the organization's commitment to establish a culturally competent work environment and services.

◇ Cultural competence training should focus on empathic listening and development of communication skills that work across cultures.

◇ Internal staff development should occur before training on provider-patient interaction in the health care setting.

◇ Staff with direct patient interaction may require more culture-specific information and training than others.

Having a diverse looking staff does not mean having a cultural competent staff.

'Diverse staff' and 'culturally competent staff' are distinct concepts – one addresses appearance, the other addresses behavior.

Why HR?

Human resource staff are change managers.

HR professionals are often involved in the development of services and programs for staff in primary care facilities and thus should be aware that culturally appropriate services and programs are required.

Recommendations for action on enhancing cultural competence include recruitment of HR and other professionals from members of diverse cultural groups into the workplace so that culturally representative providers are visible within the primary health care system

HR professionals may be responsible for orientation of staff and should:

- ◇ Provide information on 'organizational culture'
- ◇ Provide information on opportunities for career development
- ◇ Define expectations of role in the workplace

LIAASE: A General Cultural Competence Tool

From Ontario Healthy Communities coalition

Learn

◇ Read literature from other cultures

◇ Identify your own biases and stereotypes

Inquire

◇ Ask questions to clarify and understand information

◇ Dig deeper to find reasons for behaviors or attitudes

◇ Frame inquires as searches for answers, show a willingness to learn

◇ Do not judge or interpret actions or speech, verify that what you understand is correct

◇ Speak clearly; avoid slang, colloquial expressions and large, complex words

Avoid Polarization

◇ Solicit other options or points of view

◇ Ask what perspective a person from a different background would have

Avoid Arguing and Defending

◇ Curb the impulse to defend your point of view or opinion

◇ Agree to disagree on differences in values

Show Empathy

◇ Listen not just to the words, but to the feelings behind the words

◇ Acknowledge and validate powerful emotions when expressed

And finally…

State your needs and expectations

It is important to set a respectful tone for the interaction. Let people know what you want and what you consider unacceptable behavior. In this way, assumptions, conflict, and/or resentment can be avoided.

Organizational Assessment Tool

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

Organizational Policies and Practices

	Yes	No	Need to work on
1. Anti-discrimination and workplace harassment policies are in place 2. Existing policies have been examined in order to identify barriers to inclusion 3. Issues of diversity and social inclusion have been addressed in a strategic action plan			

Informed Leadership in Policy Implementation

	Yes	No	Need to work on
1. A strategic action plan to reduce barriers to social inclusion has been established. 2. This plan addresses issues of diversity, inclusion and equity as well as workplace discrimination/ harassment. 3. Steps to monitor, review and evaluate the plan are in place. 4. Resources have been explicitly allocated for effective implementation of the plan.			

Communications & Decision-Making

	Yes	No	Need to work on
1. The organization has compiled an updated regional profile of the community including demographics, socio-economic issues and environmental issues relevant to health status 2. A list of community, regional and provincial organizations that work directly with diverse and/or marginalized populations has been developed. 3. A list of other points of access to diverse communities (places of worship or social clubs etc.) has been developed. 4. A comprehensive list of community and ethnic media has been developed. 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.			

Progress in Reduction of Barriers

	Yes	No	Need to work on
1. A policy for monitoring and evaluating progress in elimination of barriers to inclusion is in place. 2. All staff have opportunities for involvement in evaluation and providing input in areas related to diversity and social inclusion.			

Service Planning

	Yes	No	Need to work on
1. Consultation with representatives from the diverse communities has been undertaken to inform organizational planning. 2. Information about the health care needs and information needs of diverse communities has been obtained. 3. Outreach strategies have been developed and resources have been allocated equitably. 4. Programs and services are adapted to respond to expressed [or identified] needs and issues of diverse communities within the service area. 5. Resources have been allocated to provide appropriate linguistic services.			

Staff Recruitment and Retention

	Yes	No	Need to work on
1. Possible barriers to recruitment, hiring, promotion and retention of members of diverse cultural groups as staff, volunteers and partners have been explored. 2. Employment opportunities (paid and volunteer) have been advertised in non-mainstream media outlets e.g. at social clubs or places of worship. 3. Employment opportunities (paid and volunteer) have been advertised using appropriate language based on the demographics of the service area.			

Self-Assessment Tool for Primary Health Care Professionals

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."

Physical Environment, Materials & Resources	
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.	___
Communication Styles	
5. When interacting with individuals and families who do not have spoken English proficiency, I always keep in mind that:	
◆ Spoken English proficiency does not reflect literate English proficiency or language of origin proficiency or literacy.	___
◆ Limited ability to speak the language of the dominant culture has no bearing on ability to communicate effectively in one's mother tongue.	___
◆ Limitations in English proficiency do not reflect mental ability.	___
6. I use bilingual and/or bicultural staff trained in medical interpretation when required or requested.	___
7. 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.	___
8. I can provide alternatives to written communication if required or preferred.	___

NB: 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 care delivery programs.

Section IV
Tools for Front-Line Staff in Primary Health Care Settings

- ✧ **Addressing Conflict**
- ✧ **LIAASE: A General Cultural Competence Tool**
- ✧ **Health Professional Self-Assessment Tool**

8 Elements of Cultural Competence for Primary Health Care Providers

1. Examine your values, behaviors, beliefs and assumptions.
2. Recognize racism and the institutions or behaviors that breed racism.
3. Engage in activities that help you to reframe your thinking, allowing you to hear and understand other world views and perspectives.
4. Familiarize yourself with core cultural elements of the communities you serve.
5. Engage clients and patients to share how their reality is similar to, or different from, what you have learned about their core cultural elements.
6. Learn, and engage your clients to share, how they define, name and understand disease and treatment.
7. Develop a relationship of trust with clients and co-workers by interacting with openness, understanding, and a willingness to hear different perceptions.
8. Create a welcoming environment that reflects the diverse communities you serve.

Please Note:

Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people.

Why Front-Line Staff?

Front-line staff are the gateway to care; your role may require taking more time to assist patients even before the primary care providers have a chance to see them. For instance, people from diverse communities who are new to Canada may not understand the process for seeing a physician, or for physician payment. They may not understand the information required in the forms that must be filled out or may not have a health card yet but need to see a physician.

Front-Line staff includes anyone with initial patient contact, e.g.: receptionists, clerks, billing departments, clergy and volunteers.

Staff should be trained in cultural competence to facilitate positive and appropriate interactions with clients. Staff who can interact appropriately in the culturally diverse work environment will be better prepared to assist clients from diverse communities.

Addressing conflict

As gateways to care, front-line staff may be faced with situations in which misunderstandings have led to client-discomfort or feelings of inappropriate treatment.

- ✧ There can be no "over–reaction". Any reaction is a clear indication that something has happened [or is still going on] that has made an individual respond in the way that they have. This event may or may not have anything to do with you.

- ✧ In resolving the conflict, ask if you have done something to offend the other person; if you have then apologize and ask what they think should be done about the situation.

- ✧ Even if a client says that you have not caused offense, work with them to find a solution that is fair and on which you can both agree in order to relieve the tension.

Much of the process of developing cultural competence involves a re-examination of our values and the influence of these values on our beliefs, which affect our attitudes and actions.

LIAASE: A General Cultural Competence Tool

From Ontario Healthy Communities coalition

Learn

◇ Read literature from other cultures

◇ Identify your own biases and stereotypes

Inquire

◇ Ask questions to clarify and understand information

◇ Dig deeper to find reasons for behaviors or attitudes

◇ Frame inquires as searches for answers, show a willingness to learn

◇ Do not judge or interpret actions or speech, verify that what you understand is correct

◇ Speak clearly; avoid slang, colloquial expressions and large, complex words

Avoid Polarization

◇ Solicit other options or points of view

◇ Ask what perspective a person from a different background would have

Avoid Arguing and Defending

◇ Curb the impulse to defend your point of view or opinion

◇ Agree to disagree on differences in values

Show Empathy

◇ Listen not just to the words, but to the feelings behind the words

◇ Acknowledge and validate powerful emotions when expressed

And finally…

State your needs and expectations

It is important to set a respectful tone for the interaction. Let people know what you want and what you consider unacceptable behavior. In this way, assumptions, conflict, and/or resentment can be avoided.

Self-Assessment Tool for Primary Health Care Professionals

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."

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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. ___

Communication Styles

5. When interacting with individuals and families who do not have spoken English proficiency, I always keep in mind that:

- Spoken English proficiency does not reflect literate English proficiency or language of origin proficiency or literacy. ___
- Limited ability to speak the language of the dominant culture has no bearing on ability to communicate effectively in one's mother tongue. ___
- Limitations in English proficiency do not reflect mental ability. ___

6. I use bilingual and/or bicultural staff trained in medical interpretation when required or requested. ___

7. 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. ___

8. I can provide alternatives to written communication if required or preferred. ___

NB: 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 care delivery programs.

Section V

Additional Resources

- ✧ Contact Information
- ✧ Online Resources
- ✧ Definition of Terms

Please Note:

Like all people, individuals from culturally diverse populations have differing skills, knowledge, and values. It is important to understand people as individuals within the context of cultural competence.

While culturally diverse populations often experience barriers in accessing primary health care or feelings of exclusion in general, it cannot be assumed that all people within these groups experience the same reality. The form of exclusion experienced may not be the same across groups of people.

Contact Information

For information on First Nations Peoples contact:	
Office of Aboriginal Affairs http://www.gov.ns.ca/abor/default.htm	Tel: (902) 424-7409 Fax: (902) 424-4225 E-mail abor_off@gov.ns.ca Suite 910-Centennial Building, 1660 Hollis Street PO Box 1617, Halifax, NS B3J 2Y3
Native Council of Nova Scotia http://www.ncns.ca/	Tel: (902) 895-1523 Toll free in N.S. 1-800-565-4372 Fax: (902) 895-0024 E-mail: info@ncns.ca P.O. Box 1320, Truro, NS, B2N 5N2
Union of Nova Scotia Indians http://www.unsi.ns.ca/contact.html	Email: rec@unsi.ns.ca Phone: (902) 539-4107 Fax: (902) 564-2137 P.O. Box 961, Sydney, NS, B1P 6J4
Confederacy of Mainland Mi'kmaq http://www.cmmns.com/	Tel: (902) 895-6385 Fax: (902) 893-1520 PO Box 1590, 57 Martin Crescent, Truro, NS, B2N 5V3

For information on the African Canadian Community contact:	
Office of African Nova Scotian Affairs	Tel: (902) 424 5555 Fax: 424- 7189 P.O. Box 2691 Halifax, NS, B3J 3P7
Health Association of African Canadians http://www.haac.ca/	E-mail: haac@chebucto.ns.ca Tel: (902) 494 3116 P.O. Box 31154, Halifax, NS, B3K 5Y1

For information on the Immigrant Community contact	
Office of Immigration http://www.novascotiaimmigration.com	Email: immigration@gov.ns.ca Telephone: (902) 424-5230 Toll Free in N S: 1-877-292-9597 Fax: (902) 424-7936 1505 Barrington Str., 15th Floor Maritime Centre, Suite 1501 PO Box 2311,Halifax NS B3J 3C8
Multicultural Association of Nova Scotia (**MANS**) http://www.mans.ns.ca.	Email: admin@mans.ns.ca Tel: (902) 423 6534 Fax: (902) 422 0881 1113 Marginal road, Halifax NS B3H 4P7
Metropolitan Immigrant Settlement Association (MISA) http://www.misa.ns.ca	Email: info@misa.ns.ca Tel: (902) 423-3607 Fax: (902) 423-3154 7105 Chebucto Road, Suite 201, Halifax, NS B3L 4W8
YMCA Newcomers Services http://www.ymcahrm.ns.ca/newcome.html	Tel: (902) 457-9622 Fax: (902) 457-0386 3663 Dutch Village Road, Halifax NS B3N 2T1

For information on Acadians and Francophone Canadians contact:	
Office of Acadian Affairs http://www.gov.ns.ca/acadian/home.htm	Tel: (902) 424-0497 Fax (902) 428-0124 7th floor, Dennis Building, 1740 Granville Street PO Box 682, Halifax, NS, B3J 2T3
Réseau Santé	Email: reseau@reseausanteNE.ca Tel: (902) 762 2074 Fax: (902) 762 0119 West Pubnico, Nouvelle Écosse B0W 3S0
La Fédération Acadien de la Nouvelle-Écosse FANE http://www.federationacadienne.ca/fane/index.cfm	Télé: (902) 433 –0065 Fax: (902) 433-0066 54, Queen Street, Dartmouth (N. -É.) B2Y 1G3
For information on Cultural Interpreters contact	
Cultural Health Information and Interpretation Services (CHI-IS) culturalhealthinfo@ns.sympatico.ca	Tel: (902) 425 5532 Fax: (902) 425 6604 24 hr cell: (902) 488 0888 2786 Agricola Street. Suite 200, Halifax N.S. B3K 4E1
For information on training in Cultural Competence contact	
MANS http://www.mans.ns.ca/competence.html	Email: admin@mans.ns.ca Tel: (902) 423 6534 Fax: (902) 422 0881 1113 Marginal road, Halifax, N.S B3H 4P7

Online resources

ORGANIZATIONAL CULTURAL COMPETENCE

- National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care, Office of Minority Health Resource Center, http://www.omhrc.gov/CLAS

- Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile, Prepared for: The Health Resources and Services Administration U.S. Department of Health and Human Services, April 2002. http://www.hrsa.gov/omh/cultural1.htm

- National Center for Cultural Competence, Georgetown University: A Guide to Planning and Implementing Cultural Competence http://gucchd.georgetown.edu/nccc/products.html

- I. Providing Oral Linguistic Services and II. Planning Culturally and Linguistically Appropriate Services: A Guide for Managed Care Plans, http://www.cms.gov/healthplans/quality/project03.asp

- National Satellite Broadcast: Cross-Cultural Communication in Health Care: Building Organizational Capacity, June 4, 2003, Co-sponsored by the HRSA Center for Health Services Financing and Managed Care and the DHHS Office of Minority Health, http://www.hrsa.gov/financeMC/broadcast

- "Cultural Competence Works: Using Cultural Competence to Improve the Quality of Health Care for Diverse Populations and Add Value to Managed Care Arrangements" http://www.hrsa.gov/financeMC/ftp/cultural-competence.pdf

CULTURALLY COMPETENT COMMUNITY AND PUBLIC HEALTH

- "Improving the Health of Diverse Populations…": Assessing Health Communication Strategies for Diverse Populations, Institute of Medicine, 2002, http://www.nap.edu/books/0309072719/html

- DeBlois H, Evans A. Asset Mapping: Locating the Gifts in Your Community. Empowering Communities Through Access to Information and Training, Module 4 (April 2003). http://www.nhhealthpolicyinstitute.unh.edu/asset.pdf

- National Center for Cultural Competence, -Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs and Sharing a Legacy of Caring: Partnerships Between Health Care & Faith-Based Organizations http://gucchd.georgetown.edu/nccc/products.html

CLINICAL CULTURAL COMPETENCE

- Betancourt JR, Like RC, Gottlieb BR, Eds. Caring for Diverse Populations: Breaking Down Barriers. Special Issue of Patient Care: The Practical Journal for Primary Care Physicians, 2000; 34(9), May 15, 2000 www.patientcareonline.com

- A Medical Mosaic: Achieving Cultural Competency in Primary Care. The American Journal of Multicultural Medicine, Special Edition, Winter 2001/2002 (http://www.medicalcrossfire.com/multicultural.html)

- Recommended Core Curriculum Guidelines on Culturally Sensitive and Competent Health Care. Family Medicine 1996; 28:291-297 (http://www.stfm.org/corep.html)

- American Institutes for Research/Office of Minority Health -Cultural Competency Curriculum Modules Project http://www.air.org/cccm/

- Ethno Med http://www.ethnomed.org

- Perspectives of Difference: A Diversity and Cross-Cultural Teaching Module for the Internet http://dgim.ucsf.edu/pods/html/main.html

- Yeo G et al. Core Curriculum in Ethnogeriatrics Developed by the Members of the Collaborative on Ethnogeriatric Education, Supported by the Bureau of Health Professions, Health Resources and Services Administration, USDHHS, October 2000 http://www.stanford.edu/dept/medfm/ebooks/intro.pdf

Definition of Terms

Access	The right, opportunity or ability to reach, enter or use a facility, program or materials
Bias	A point of view about persons that may manifest through favoritism, dislike, prejudice and even fear based on looks, behavior, lifestyle or circumstances.
Culture	Composed of language, concepts, beliefs, values, symbols, structures, institutions and patterns of behavior etc. A person's culture may or may not be the same as his or her ethnic origin or identity. In society, a person may have encountered a variety of cultural influences.
Cultural awareness	Appreciating and accepting differences between individuals as well as cultures.
Cultural blindness	Differences are ignored and one proceeds as though differences do not exist. "*There's no need to worry about a person's culture -- if you're sensitive you'll do OK*."
Cultural imposition	A belief that everyone should conform to the majority; "We know what's best for you. If you don't like it you can go elsewhere."
Cultural knowledge	Deliberately seeking out a variety of world views and explanatory models of a situation in addition to viewing the event through one's own cultural lens.
Cultural sensitivity	Reducing resistance and defensiveness during interactions, acknowledging bias that may influence one's behavior
Cultural skills	Practicing different ways to explain a particular issue from other perspectives, learning how to culturally assess a person to avoid relying solely on written or preconceived "facts"
Discrimination	Differential treatment of an individual due to actual and perceived visible or invisible differences, "We just aren't equipped to serve people like that."
Diversity	Differences among people, as individuals or groups. Diversity includes difference in age, abilities, culture, ethnicity, gender, physical characteristics, religion, sexual orientation, values etc.
Ethnic Group	A group of people who share a common ancestry or history.
Ethnicity	An ethnic group, character, background, or affiliation.
Ethnocentrism	Inability to accept another culture's world view; "My way is best."

Equitable access	Access to health care is equitable if there are no barriers (information, financial, etc) that prevent access to health care services
Internalized Racism	Conscious or subconscious incorporation and acceptance of negative stereotypes and images from media, folklore, of historical accounts, etc, that define and portray persons of color as inferior.
Multicultural Health Care	Culturally, racially and linguistically sensitive and responsive health care; it includes concepts of ethnic and race relations, cross-cultural care, human rights and equity.
Oppression	Use of political power and domination to maintain an unjust system against an identified group of people Commonly felt and expressed by a widespread, if unconscious, assumption that a certain class of people are inferior.
Primary Health Care	Primary health care is at the centre of a community-based health care system. It focuses on a person's health and well-being. It brings individuals, families, and health and community organizations together to take an active role in identifying and delivering health services in their communities.
Race	A social category used to classify humankind according to common ancestry or descent and reliant upon differentiation by general physical characteristics such as color of skin and eyes, hair type, stature and facial features
Racial Profiling	The use of race as a consideration in suspect profiling, or other law enforcement practices.
Racially Visible People	A term defined by race or color only and not by citizenship, place of birth, religion, language or cultural background. The term applies to people who are Black, First Nations, Chinese, South Asian, South East Asian, Filipino and Latin American Canadians among others. These terms are generally regarded as positive identities as opposed to "Non-whites", "minorities", "visible minorities", or "ethnics".
Racism	Discrimination based on race, which systematically treats an individual or group of individuals differently because of their race.
Stereotyping	Generalizing about a person while ignoring the presence of individual differences "s/he's like that because s/he's Asian - all Asians are nonverbal."
Systemic racism	The process of exclusion of individuals whose lived reality has not been acknowledge by the system. It is propagated by the dominant culture which chooses/cannot acknowledge alternate realities.

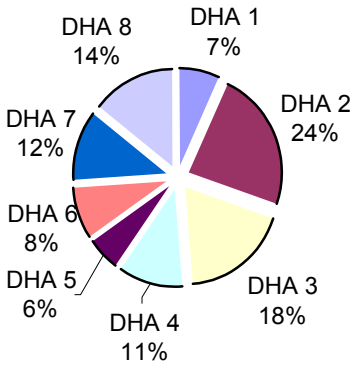
Appendices &

References

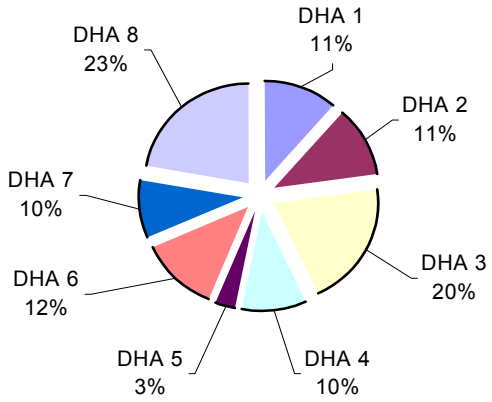
Appendix A

Distribution of Diverse Communities in Nova Scotia by District Health Authority (outside of Capital Health)

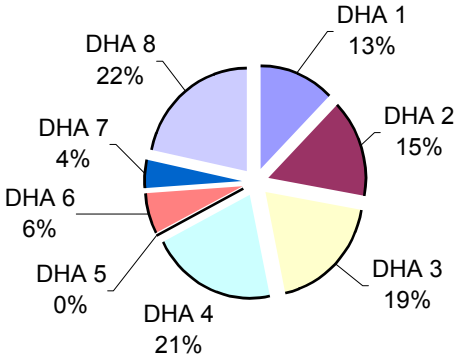
Distribution of African Canadian population Nova Scotia outside Capital Health



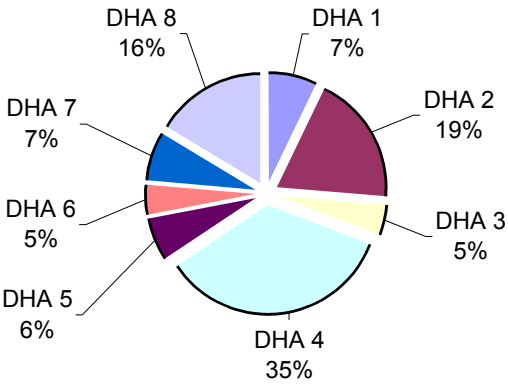
Distribution of the Chinese population in Nova Scotia outside Capital Health



Distribution of Arabic population in Nova Scotia outside Capital Health



Distribution of the South Asian population in Nova Scotia outside Capital Health



Appendix B

The Diversity and Social Inclusion in Primary Health Care Initiative

In response to various recommendations made to the Department of Health, the Primary Health Care Section developed a **Diversity and Social Inclusion in Primary Health Care Initiative** to begin to effectively address needs of culturally diverse populations.

A three-year plan has been carried out to:

- Lead in raising awareness of diversity and social inclusion issues in Primary Health Care.

- Consult with stakeholders including culturally diverse populations to develop guidelines and policies for the Primary Health Care system and provincial guidelines for the delivery of Primary Health Care.

Appendix C **"Bridging the Gap: Bringing Together Culture and Health Care"**
An Account of the Task Force on Newcomer Access to Health Care

Providing culturally competent health care requires a commitment from health care providers and organizations to understand and respond effectively to the different attitudes, values, verbal cues and body language brought by clients to the health care setting.

- On April 28th, 2005, Metropolitan Immigrant Settlement Association (MISA) and Task Force on Newcomer Access to Health Care organized a community forum for organizations and individuals interested in immigrant health issues, to engage in a meaningful dialogue around the challenges and opportunities to providing holistic, accessible and equitable health care services to newcomers to Nova Scotia.
- Two years ago, with funding from Health Canada's Population Health Fund, MISA facilitated the development of a Task Force to explore ways to enhance the responsiveness of the health and social service sectors for newcomers.
- Representatives from a broad range of sectors met over six months to share information, discuss issues and identify policies that impact on newcomers' health. Extensive consultations were conducted through formal interviews, focus groups and working groups.
- The Task Force compiled 7 Policy Goals from the consultations with community members and advisors. These Goals reflect the themes that emerged from the gaps and needs that were identified by both community members and health providers[2].

Key themes raised in discussions in the 2005 community forum include:

- Cultural competency training is a must; we need to understand the cultural context of where people are coming from.
- The issues go far beyond health care; we must address all of the determinants of health affecting newcomers in our policies, programs and services.
- Lack of interpretation services is a current barrier to equitable health care; MSI needs to incorporate interpretation into their service.
- Policies need to reflect the cultural diversity of Nova Scotia's population, in order to attract and retain more immigrants to the province.
- Welcoming newcomers to our community is everyone's responsibility; we need to work together, by sharing resources and best practices in order to do this most effectively.
- Ongoing opportunities to come together and collaborating, motivated action; a formal network of communication would help to bridge some of the gaps.

What Next?

- Health services need to acknowledge and respect the cultural environment of each client. This is especially essential because the initial adjustment to a new social and physical environment can create additional stresses. During the initial settlement period, many newcomers find themselves unemployed, living on fixed incomes and with no social support from families or friends in their new country.
- A greater inter-sectoral effort is required to improve access and health services for newcomers. We need to continue to review current health policies as they apply to newcomers and encourage health decision-makers to implement changes suggested through the Task Force. We need to evaluate our own programs and services to ensure they reflect the cultural diversity of Nova Scotia's population.
- We must recognize that is our own responsibility to make our communities more welcoming to newcomers, and therefore the first step to changing the system is our own.

[2] The Task Force Policy Platform, the complete document of the 7 Policy Goals, available at www.misa.ns.ca

Appendix D

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