DELIVERING CULTURAL-SENSITIVE HEALTH SERVICES

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Sommario

La competenza culturale è un insieme di attitudini, capacità, comportamenti e strategie che permettono di lavorare con efficienza in situazioni di incrocio culturale.
I servizi sanitari si trovano a dover garantire adeguata assistenza ai pazienti immigrati, che rappresentano quasi il 10% della popolazione e sono portatori di culture differenti.
Dal 2011 il CCM organizza un Corso di Salute Globale per operatori sanitari con un modulo volto a migliorare le competenze culturali e le conoscenze sul fenomeno migratorio.
La "competenza culturale" è un percorso pensato per gli operatori sanitari che vogliano prendersi in carico la salute di tutti i pazienti.

Abstract

Cultural competence consists in attitudes, skills, behaviors and strategies allowing organizations and individuals to behave in situations of cultural diversity.
Health systems are requested to assist an increasingly varied population, composed also of migrants (in Italy, they represent approximately 10% of the overall population).
Since 2011, CCM has been organizing a Course in Global Health for health professionals. The course includes a module specifically meant to enhance participants' cultural skills, providing them with knowledge and competences helpful to deal with migrant patients.
All health workers committed to offer high quality assistance to each patient should attain "cultural competence".

Keywords
Migration, education and training, cultural competence

Introduction

Culture, though variously defined, can be deemed as a composite system of shared beliefs, values and behaviors, that individuals acquire both consciously and unconsciously throughout life. Cultures are multiples, layered and dynamic, and include language, styles of communication, practices, customs and views on roles and relationships. Each individual can be part of multiple and even contradictory cultures, which may attain to different spheres (e.g. profession, religious group, gender, age-groups). Culture goes beyond race, ethnic background and country of origin. Culture

shapes the way we approach our world and affects interactions between patients and clinicians (Betancourt, 2004).

Anthropologists use it as a heuristic (abstraction) useful to understand societies/communities, but warn against the risk of reification (e.g. African culture, Muslim culture, etc.).

Perceptions of physical and psychological wellbeing differ substantially across and within societies. Although cultures often merge and change, human diversity entails persistence of different lifestyles and beliefs, connected with different systems of values. Therefore, culture should be acknowledged as immanent to societies, shaped by and in turn shaping the political, economic, legal and moral context and practices.

On the one hand, if biomedicine ignores the pivotal role of culture, biological wellbeing may end up as the only measure for health. On the other hand, when 'culture' is reified and considered a main cause of good or ill-health, structural conditions affecting peoples' health status could be overlooked. Especially under conditions of constrained resources to health systems and biomedical ethnocentrism, patients – commonly the most vulnerable ones – could be themselves blamed for ill health.

In the three overlapping domains of **cultural competence**, health inequalities and communities of care, the deep connection between health and culturally-affected perceptions of wellbeing can be understood (Napier, 2014).

Cultural competence

Background

At the beginning of the XX century, with the advent of anthropological fieldwork in colonial settings, research attention started being paid to how different cultural concepts affect health-related behaviours (Frenk, 2010).

Medical anthropology is a branch of anthropology, studying people, health and healing within ecological, social, political and economic contexts.

Ways of thinking that at first seem foreign and exotic might seem less so once one understands how complex beliefs and practices overlap to produce coherent and consistent forms of meaning (Fadiman, 1997). In many societies—especially those in which malnutrition is ubiquitous—obesity is often mistaken for health (Popenoe, 2003), whereas in other cultures (Brazil, for instance) the right to be beautiful (as it is culturally defined) might extend to plastic surgery for poor people (Edmonds 2007; Napier, 2014).

Beliefs about the body that might baffle physicians— for example, the idea that diseases are the consequences of ancestral actions—might parallel new and emerging ideas in science about epigenetics, symbiosis, disease vectors, or evolutionary principles (Napier, 2012).

Clinical adherence

Although cultural competence training was initially developed in the 1960s, it has been formally integrated into biomedical education only recently, arguably in response to the need for health systems to address the rapidly changing demographic patterns and health priorities, following globalization and dramatic increase in the movement of persons, goods and services (Engel, 1997) (Betancourt, 2002). In most trainings, however, it is not present (as in Italian Medical Schools), even if the view prevails that cultural competence can improve clinical outcomes by addressing the needs of those who are different from whatever dominant socio-cultural groups provide care.

Even today, cultural competence and diversity are poorly valued within biomedical education, scarcely understood and subject to political rather than educational priorities (Dogra, 2007). Conventional understanding of cultural competence that emphasizes recognition of racial, ethnic and linguistic identities shifts clinical meaning away from socioeconomic determinants of health and standard clinical diagnoses. Cultural competence is surely much more than a vague umbrella term that encompasses training in cultural sensitivity, multi-culturalism, and cross-culturalism (Wear, 2003; Napier, 2014).

Competence as Mindfulness

Stella Ting-Tomey – in a broader reflection on "Identity Negotiation Theory" – summarizes the "Mindfulness Component" in competent intercultural communication as follows:

> "Langer's (1989, 1997) concept of mindfulness encourages individuals to tune in conscientiously to their habituated mental scripts and preconceived expectations. Mindfulness means the readiness to shift one's frame of reference, the motivation to use new categories to understand cultural or ethnic differences, and the preparedness to experiment with creative avenues of decision-making and problem solving. Mindlessness, on the other hand, is the heavy reliance on familiar frames of reference, old routinized designs or categories, and customary ways of doing things. It means we are operating on "automatic pilot", without conscious thinking or reflection. It means we are at the "reactive" stage rather than the intentional "proactive" stage. To engage in a state of mindfulness in transformative intercultural communication, individuals need to be aware that both differences and similarities exist between the membership groups and the communicators as unique human individuals" (Ting-Tomey, 2005).

In discussing Anxiety, Uncertainty, Mindfulness and Effective Communication, William Gudykunst states:

> "To communicate effectively with strangers, we must be able to understand strangers' perspectives. This requires mindfulness. As indicated earlier, Langer (1998) argues that

> mindfulness involves creating new categories, being open to new information, and recognizing strangers' perspectives. Communicating effectively with strangers requires that we develop mindful ways of learning about strangers….These processes are all interrelated and lead us to be 'receptive to changes in an ongoing situation" (Praxmarer, 2010).

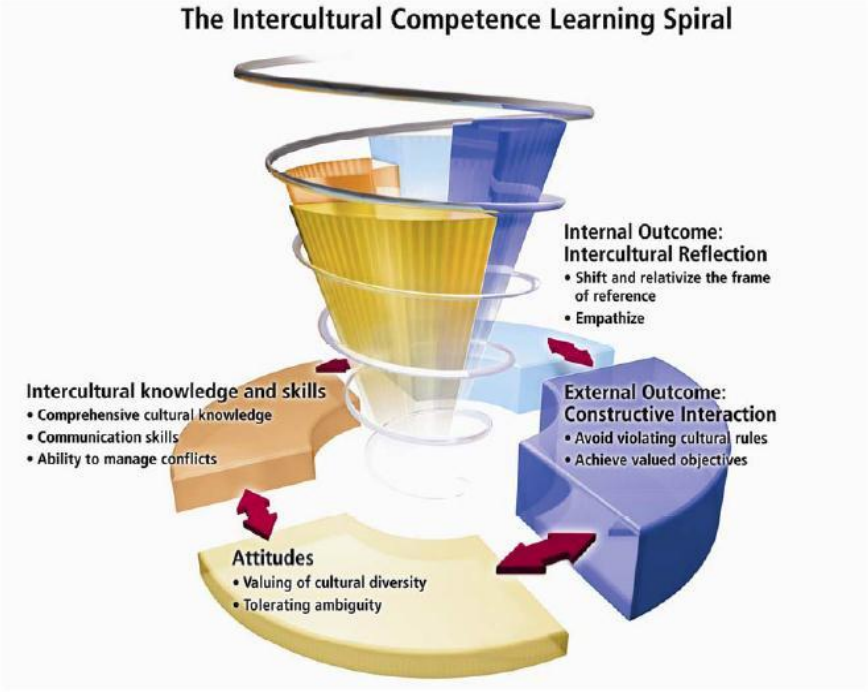
Profiling The Intercultural Effective Person (Fig.1)

The profile of skills and knowledge identifies nine major competence areas for a person, to be acknowledged as being intercultural competent:

- adaptation skills
- an attitude of modesty and respect
- an understanding of the concept of culture
- knowledge of the host country and culture
- relationship-building
- self-knowledge
- intercultural communication
- organizational skills
- personal and professional commitment"

(Praxmarer, 2010), (Kealey, 2004), (Slavik, 2004), (Vulpe, 2000)

Fig.1 - Development of Competence as Learning Process



Source: *Intercultural competence – The key competence for the 21st century?* Theses by the Bertelsmann Stiftung (2006) based on the models of intercultural competence by Dr. Darla K. Deardoff: http://www.bertelsmann- stiftung.de/bst/de/media/xcms_bst_dms_18255_18256_2.pdf)

Cultural competence consists in a set of attitudes, skills, behaviors and strategies enabling organizations and workers to effectively deal with situations of cultural diversity.

As mentioned above, over the years it evolved from theories on how to behave with patients of different cultural backgrounds to principles of patient-centered care, granting all individuals empathy, understanding and satisfaction of their needs, values and preferences.

In each doctor-patient relationship both communication skills and the cultural background of patient and doctor play a key role in the outcome of care (e.g. patient's compliance, appropriate use of the health services, health-seeking behavior).

Globalization and the related expansion in the movement of people, goods and services have deeply affected national health systems and health professionals' practice. On the one hand, patterns of transmission and distribution of infectious and chronic diseases have deeply transformed, while on the other hand biological, social, economic and cultural features in each person are more and more diverse. Therefore, health systems struggle to provide adequate assistance to migrants, failing to adjust to rapidly changing patients' needs and features.

Migrant status and ethnicity interact with many other factors (e.g. age, gender, socio-economic status) and shape unique human beings, with unique needs and resources. Health care organizations and professionals need to take into account this complexity. Therefore, attention to diversity should be a main pillar of health care planning, including health care staffs' education/training and recruitment and organization of health care provision (Seeleman, 2015; The Migrant Friendly Hospital project: the Amsterdam Declaration, 2015).

In this frame, valuing cultural competence in biomedical profession is pivotal. Medical schools should be the primary agents of change by taking the necessary steps in their institutional setup, curriculum development and delivery of medical education (Sorensen, 2017).

Ccm activity

Comitato Collaborazione Medica (Ccm) considers the right to health for all a guiding principle and main target. Since 2008, Ccm has been partnering Piedmont local and regional health authorities to enhance the access and use of health care services by most vulnerable groups, including migrants. To this aim, Ccm has developed a series of training modules on cultural competences targeting health professionals, medical and nursing students, cultural mediators, educators and social workers. Moreover, since 2012, together with some non-governmental organization (Ngo) of Consorzio Ong Piemontesi (Cop) and the University Piemonte Orientale, Ccm has been rolling out a Course in Global Health for health professionals. The course includes a specific module meant to

improve participants' cultural skills and knowledge about migrants' health related vulnerabilities and relational and communicational skills helpful in dealing with migrant patients .The total number of students from 2012 to 2017 was 66 of which 34 medical Doctors (MD) (Fig.2). The teachers were MD, Anthropologists, Experts in social sciences and cultural mediators (Fig.3).

Fig.2: Participants to Global Health Courses

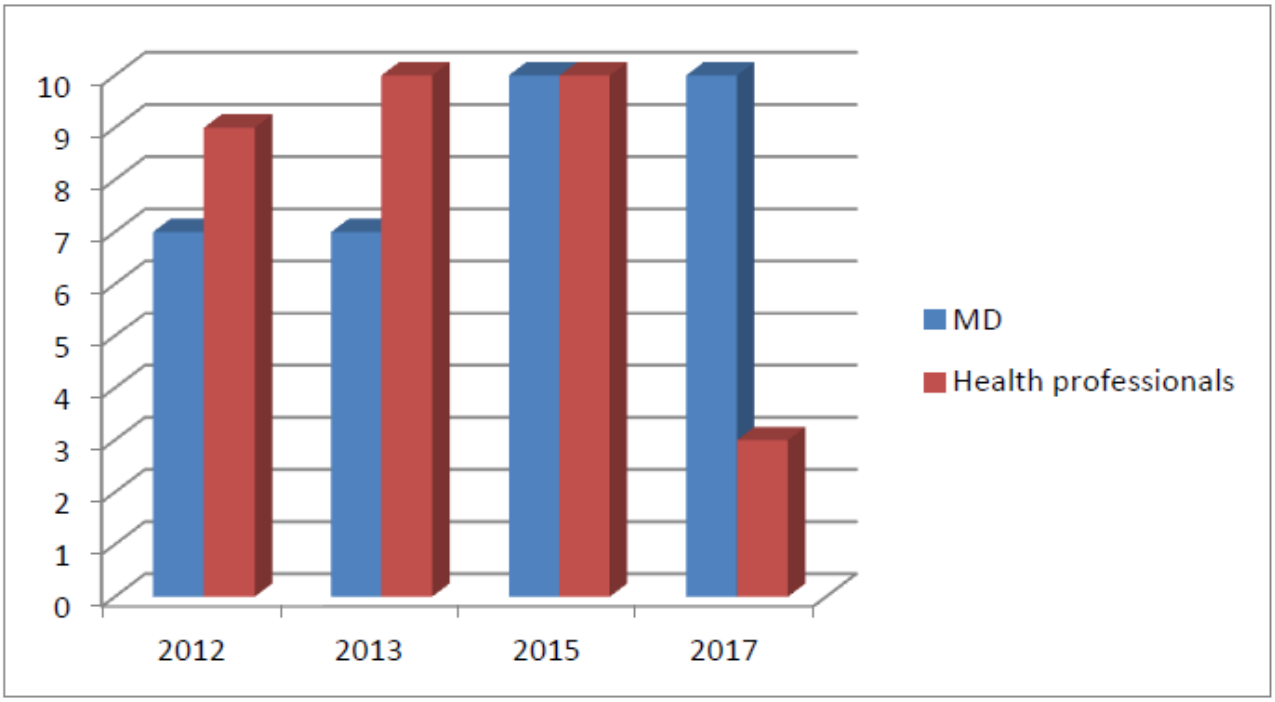
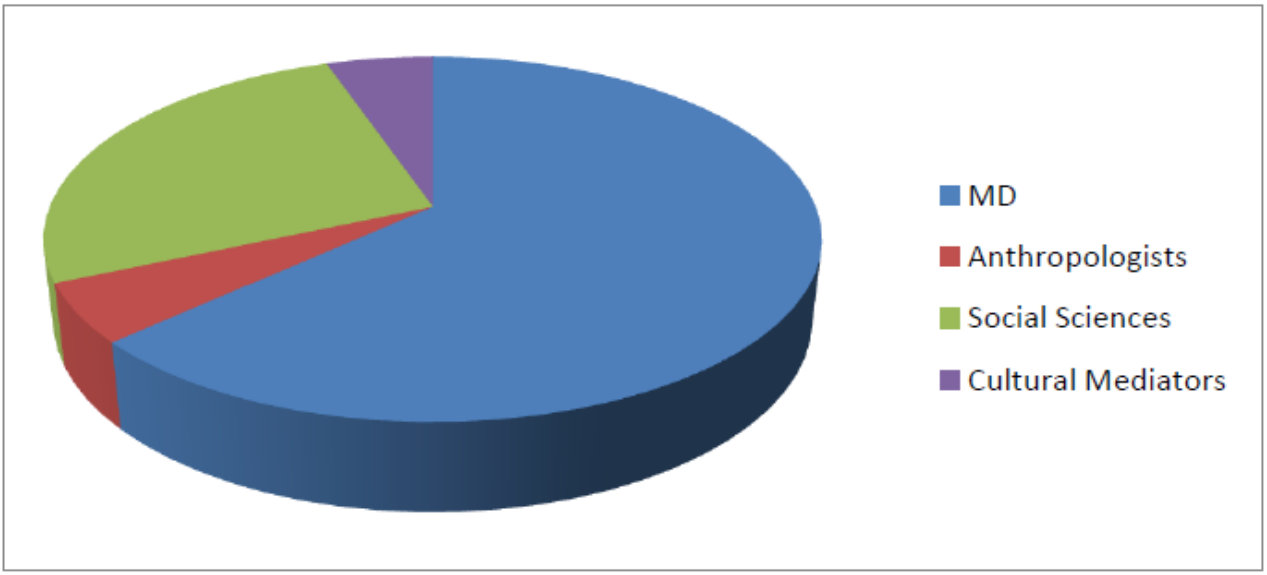


Fig.3 Teachers profession



According to the objectives of Dublin Descriptors (December 2004) and the indications of the Association of American Medical Colleges (Aamc), medical students should attain the following:

- Knowledge and understanding about how people from different cultures and beliefs perceive health and illness and how they react to symptoms, diseases and therapies;
- Applied knowledge and capacities to recognize and adequately face gender and cultural prejudices, putting patient's health at the centre;
- Autonomy of judgment, in order to give the right importance to the relationship between effective communication and quality of care;
- Communication skills, demonstrating the ability to ask questions unveiling patient's preferences and to answer patient's needs from a cross-cultural perspective;
- Learning skills, being able to acknowledging socio-cultural factors and the impact of ethnic, cultural and socio-economic factors on decision-making and clinical processes.

CCM courses cover the following subjects:

- migration in Italy (social and legal aspects), health inequalities and social determinants of health;
- principles and objectives of health promotion and Information, Education and Communication (IEC);
- linguistic and communication challenges in contest of intercultural service provision;
- health policies in globalized contexts and 'health in all policies' approach;
- cultural competences in health organizations, structure of the Migrant Sensitive Health Systems;
- Health inequalities between and within countries: focus on mother-and-child health, infectious and chronic diseases, traumas, primary health care.

As a good communication between doctor and patient is likely to result into positive therapeutic outcomes, integrating "cultural competence" into health staffs' educational and professional background aims to significantly contribute to individual, public and global health. In this frame, CCM training programmes and related initiatives mean to provide an answer to the urging educational needs of health professionals.

Cultural competence is not a panacea that will single-handedly improve health outcomes and eliminate disparities, but a necessary set of skills for physicians who wish to deliver high-quality care to all patients. If we accept this premise, we will see cultural competence as a movement that is not marginal, but mainstream (Betancourt, 2004).

Acronyms

Ccm	Comitato Collaborazione Medica
Ngo	Non Governmental Organization
Cop	Consorzio Ong Piemontesi
Aamc	Association of American Medical Colleges
Iec	Information, Education and Communication

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