



Nova Scotia Department of Health and Wellness, Primary Health Care

An Introduction to Cultural Competence in Health Care

Session 2: Bridging Gaps in Health and Care Participant Materials

Building a Better Tomorrow Together:

Team Development for Primary Health Care Collaboration

2011

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Building a Better Tomorrow Together

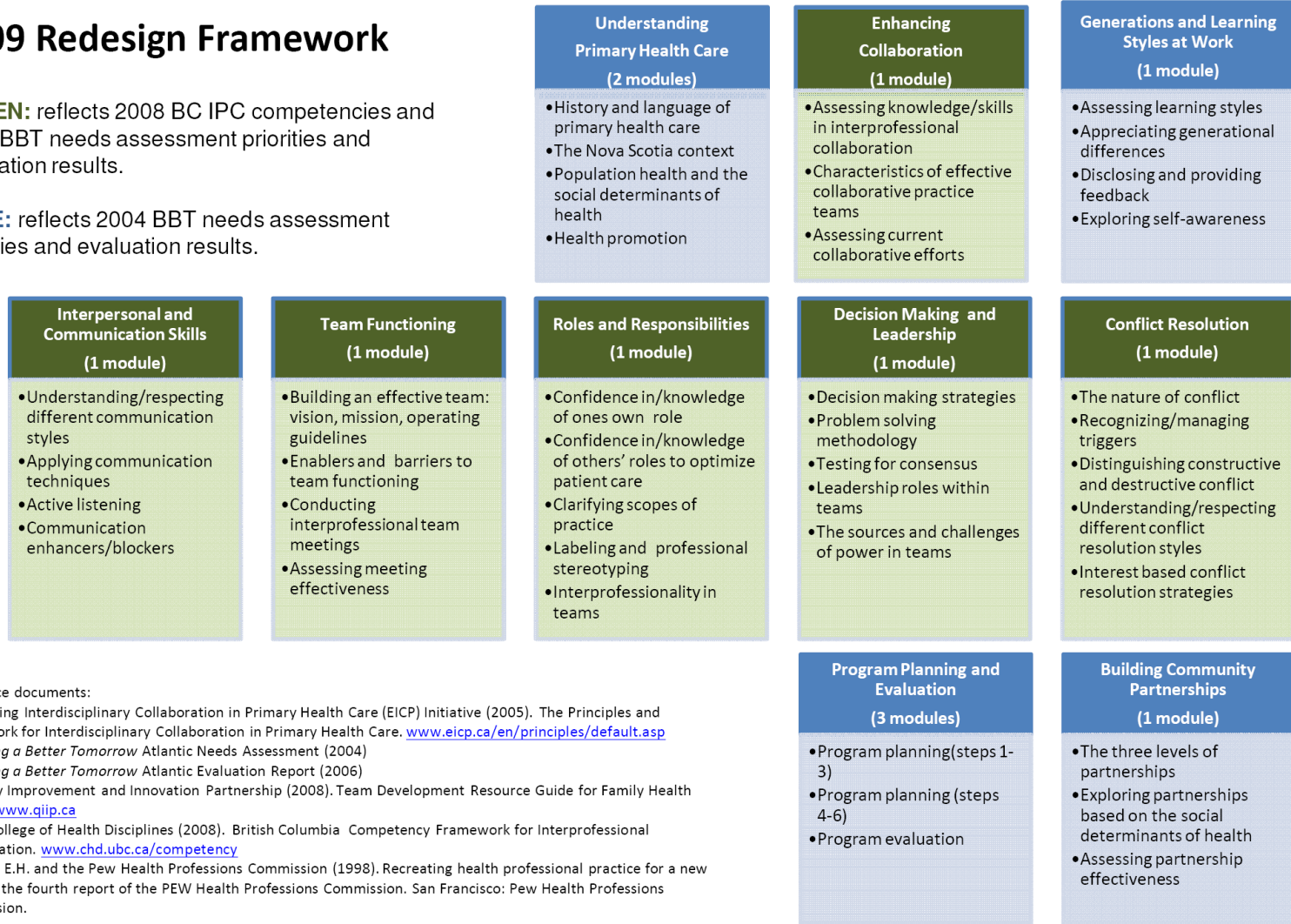
Team Development for Primary Health Care Collaboration



2009 Redesign Framework

GREEN: reflects 2008 BC IPC competencies and 2004 BBT needs assessment priorities and evaluation results.

BLUE: reflects 2004 BBT needs assessment priorities and evaluation results.



Reference documents:

- Enhancing Interdisciplinary Collaboration in Primary Health Care (EICP) Initiative (2005). The Principles and Framework for Interdisciplinary Collaboration in Primary Health Care. www.eicp.ca/en/principles/default.asp
- *Building a Better Tomorrow* Atlantic Needs Assessment (2004)
- *Building a Better Tomorrow* Atlantic Evaluation Report (2006)
- Quality Improvement and Innovation Partnership (2008). Team Development Resource Guide for Family Health Teams. www.qiip.ca
- UBC College of Health Disciplines (2008). British Columbia Competency Framework for Interprofessional Collaboration. www.chd.ubc.ca/competency
- O'Neil, E.H. and the Pew Health Professions Commission (1998). Recreating health professional practice for a new century: the fourth report of the PEW Health Professions Commission. San Francisco: Pew Health Professions Commission.

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Session 2: Bridging Gaps in Health and Care Agenda

Welcome and Introductions

Understanding Cultural Competence: Power and Privilege

Cultural Knowledge

BREAK

Cultural Competence in Clinical Care

Tools and Resources

Next Steps and Closure

Introduction to Cultural Competence, Session 2

Learning Objectives

Upon completion of this session, participants will be able to:

- Explore reflections from Session 1
- Review ground rules
- Identify elements of power and privilege
- Share actions that build equity in health systems
- Define cultural knowledge
- Identify the need for cultural knowledge
- State sources of cultural knowledge
- Share approaches for clinical cultural competence
- Identify DHA and province-wide initiatives and resources that support cultural competence
- Refer to individual and/or organizational assessment tools
- Identify individual and organizational next steps
- Reflect on learnings

Quotable Quotes

"The minute we become an integrated whole, we look through the same eyes and we see a whole different world together."
- Azizah Al-Hibri

"Of all the forms of inequality, injustice in health is the most shocking and the most inhuman."
- Rev. Martin Luther King Jr.

There are as many paths as there are people.
Traditional Sufi saying

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

To learn about other people is science; to learn to know yourself is intelligence.
- Chinese Proverb

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

The only constant is change.
Traditional Sufi saying

A fish is the last to acknowledge the existence of water.
- Proverb

There is no greater agony than bearing an untold story inside you.
- Maya Angelou

I've learned that people will forget what you said, people will forget what you did, but people will never forget how you made them feel.
- Maya Angelou

If you judge people, you have no time to love them.
- Mother Teresa

With the gift of listening comes the gift of healing.
-Catherine De Hueck Doherty

It is more important to know what type of patient has a disease than what type of disease a patient has.
- William Ostler

The Invisible Backpack

"...privilege is an "invisible package of unearned assets which I can count on cashing in every day, but about which I was 'meant' to remain oblivious."

Sources: The backpack concept was originally explored by Peggy McIntosh in *White Privilege and Male Privilege: A Personal Account of Coming to See Correspondences through Work in Women's Studies*, Working Paper Number 189 (1988). For a copy of the article, search www.eric.ed.gov.

This backpack example has been revised to include a definition of culture beyond race and ethnicity. Some backpack questions are from *Everyone Belongs: A Toolkit for Applying Intersectionality*, Canadian Research Institute for the Advancement of Women (CRIAOW)

Consider the following questions. Answer yes, no (or sometimes) to each.

- ___ ___ 1. I can talk freely about my sexual orientation or gender identity to others at home, work and in the community.
- ___ ___ 2. I can be confident that I will not be harassed for using a washroom of my choice.
- ___ ___ 3. I am never asked to speak on behalf of all the people of my racial or ethnic group.
- ___ ___ 4. I can carry out my daily routine without worrying about physical access (ramps, elevators.)
- ___ ___ 5. When my loved one is unwell, I know that I will be welcomed as part of the health team without question.
- ___ ___ 6. I can be pretty sure that if I ask to talk to the "person in charge", I will be facing a person that looks like me and understands me.
- ___ ___ 7. If I move out of my current residence, I am fairly sure that I can rent or buy a home that I can afford in a neighborhood where I might want to live.
- ___ ___ 8. When I see a hospital direction sign, I can read it confidently.
- ___ ___ 9. I can be pretty sure that if I need legal or medical help, my race, religion or sexual orientation will not be used against me.

___ ___ 10. I know that I will not be judged on my parenting ability because of my financial status.

___ ___ 11. I can work in a job without being underestimated because of my age or perceived age.

___ ___ 12. I can go to work, take public transit or do errands at any time of the day or night, without worrying about my personal safety.

___ ___ 13. I can walk into a store, bank or restaurant and communicate with people in my own language.

___ ___ 14. People don't often ask me, "Where are you from" or "What country are you from" without knowing my citizenship status.

___ ___ 15. I can be sure that my children and grandchildren will be exposed to a school curriculum that testifies the existence of their history, culture, language etc.

Reflection questions

What stands out for you about power and privilege after completing this activity?

What backpack questions would you like to add? Why?

What issues of power and privilege do you think are most important, given your role in health care?

Feeling overwhelmed by your own privilege? Consider becoming an ally for diversity and inclusion in your workplace or community. Work in solidarity with others to support social justice and effective change.

Bridging Gaps in Care: Case Studies

Sources:

Case 1 from Srivastava, R. (2007). *The Healthcare Professional's Guide to Clinical Cultural Competence*. Mosby, Elsevier, Canada.

Cases 2, 3 and 4 from College of Nurses of Ontario (2009) *Culturally Sensitive Care Practice Guideline*. Online, available at:
www.cno.org/docs/prac/41040_CulturallySens.pdf, pages 9 and 10.

Case 1: Nancy

Nancy is nurse in a women's health clinic that serves many immigrants and refugees. She often treats women whose male partners attend appointments, answer questions on her behalf and essentially do not allow the woman to interact directly with the provider.

Nancy finds this frustrating. She believes women should have equal status within the healthcare system in Canada. She also finds it hard to assess health and personal risk when unable to communicate alone with the patient.

Case 2: Ear Infection

A family comes to a walk-in clinic with a young child who is crying and tugging at his ears. The family has recently come to Canada, but understands English well enough that the nurse feels language is not an issue. An assessment reveals that the child has an infection in both ears, and the parents are given a prescription for an antibiotic and Tylenol drops for fever and pain. The situation is fairly routine and an interpreter is not considered necessary. The parents are informed of the diagnosis and treatment, and nod in understanding.

The next day the family returns with the child whose condition seems to have worsened. There is now pink discharge from both ears, and the entire family is in distress. An interpreter is called to assist. Through the interpreter, the nurse learns that the parents had the prescription filled promptly, and understood the child was to be given the medicine every four hours. They had been administering the antibiotic orally, but since they had treated previous ear infections with ear drops, had administered the Tylenol drops in the child's ears.

Case 3: 35-year old

A woman, 35, is admitted to the general medical unit. While in the hospital, she expresses concern about her partner's ability to care for her children. She also appears worried about how she will manage at home after she is discharged.

The nurse suggests that perhaps a family meeting is necessary and offers to contact her husband. The nurse further suggests that maybe the client's mother, who has called often to inquire about her daughter, should be involved in the meeting.

Case 4: St Francis

A home care client has lost sensation and mobility in her legs. On a home visit to provide wound care for a severe burn on the sole of his left foot, the nurse discovers a picture of St. Francis of Assisi covered in plastic and carefully placed between the layers of bandage around the foot.

The client describes the picture as a relic that can prevent or positively influence life's problems, and that St. Francis is known for healing animals and people. He believes that placing the picture in the dressings will help the wound to heal.

Case 1: Nancy

- Trust is important. Forcing the issue may increase distrust.
- Nancy's cultural perspectives are surfacing
- Nancy needs more data/information
- Developing a relationship and building trust are critical.

Case 2: Ear Infection

- Verbal and non-verbal communication are important
- Confirm impressions with the client
- Appear open and receptive
- Confirm accurate communication.
- Demonstrate and provide translated follow-up material

Case 3: 35-Year Old

- Assess your language for bias, judgment, and assumptions. For example, don't assume sexual orientation or family status
- Ask the client open-ended questions
- Engage in active listening. Suspend judgment
- Sample open-ended questions follow

Case 4: St Francis

- Whenever possible, preserve the culture of the client
- Find ways to honour client choice
- accommodate elements of the request
- negotiate with the client to carry out the interventions you think are necessary for positive outcomes
- See cross-cultural assessment models that follow

Culturally Competent Approaches to Care

1. RESPECT

Source: Bigby J. and Ashley, S. (2008). Disparities in Surgical Care: Strategies for Enhancing Provider–Patient Communication, *World Journal of Surgery*: Vol. 32, No 4.

R: RESPECT: A demonstrable attitude involving both verbal and non-verbal communication.

E: EXPLANATORY MODEL: What is the patient’s point of view?

S: SOCIOCULTURAL CONTEXT: What about class, race, ethnicity, education, sexual norms and orientation, family and gender roles for example?

P: POWER: What is the power differential between the patient and provider?

E: EMPATHY: Put into words the significance of the patient’s concerns so the patient feels understood.

C: CONCERNS AND FEARS: Elicit the patient’s emotions and underlying concerns of her or his symptoms.

T: THERAPEUTIC ALLIANCE/TRUST: A measurable outcome that will enhance adherence and compliance.

2. LEARN

Source: Berlin E. and W. Fowkes (1983). A Teaching Framework for Cross-cultural Health Care. *The Western Journal of Medicine*; 139: 934-938.

L: LISTEN with empathy and understanding to the person’s perception of the situation.

E: ELICIT culturally relevant information and EXPLAIN your perception of the situation.

A: ACKNOWLEDGE the similarities and differences between your perception and theirs
bold

R: RECOMMEND options / alternatives and RESPECT the person and their choices.

N: NEGOTIATE agreement

3. ETHNIC RN

Source: Levin S., Like R. AND J. Gottlieb (2000). ETHNIC: a framework for culturally competent clinical practice. In: Appendix: Useful clinical interviewing mnemonics. *Patient Care*; 34(9) 188-9.

E: EXPLANATION	of the problem/condition by the client
T: TREATMENT	or home remedies used and treatment sought
H: HEALERS	and other “non-professionals” from whom client seeks advice
N: NEGOTIATION	of mutually acceptable options
I: INTERVENTION	that includes client’s beliefs and practices

C: COLLABORATION with client, family healers and community resources

R Recommend treatment

N Negotiate agreement

Patient's Health Beliefs Assessment Guide

Source: Kleinman A. (1980). *Patients and Healers in the Context of Culture*. Berkeley, California: University of California Press.

- What do you think caused your problem?
- Why do you think it started when it did?
- What do you think your sickness does to you?
- How severe is your sickness? Do you think it will last a long time, or will it be better soon in your opinion?
- What are the chief problems your sickness has caused for you?
- What do you fear most about your sickness?
- What kind of treatment do you think you should receive?
- What are the most important results you hope to get from treatment?

Individual Cultural Competence Assessments

Option 1

Source: Adapted from Ring, J et al. (2008). *Curriculum for Culturally Responsive Health Care: The Step-By-Step Guide for Cultural Competence Training*. Radcliffe Publishing Ltd., p200.

For each of the following items, check how often you have performed each. Use the following key to identify the best option. Never (1) Almost never (2) Monthly (3) Frequently (4) Daily (5)	
	Rating
1. I recognize personal bias when working with patients or co-workers.	
2. I have examined/discussed national data on health, health equity and health care disparities.	
3. I have examined/discussed local data on health, health equity and health care disparities.	
4. I have discussed the underlying causes of health inequities, disparities and the barriers to eliminating them.	
5. I have worked with a community agency that serves to enhance health and eliminate health disparities.	
6. I have referred to the <i>Cultural Competence Guidelines for the Delivery of Primary Care in Nova Scotia</i> .	
For each of the following, state you level of agreement using the following key. Strongly Disagree (SD) Disagree (D) Slightly Disagree (SLD) Slightly Agree (SLA) Agree (A) Strongly Agree (SA)	
7. I have reflected on my own cultural context (gender, age, ability, class, ethno-racial identity, spirituality, sexual orientation, gender identity) as it relates to my role in health care.	
8. I am committed to addressing challenges and opportunities posed by diversity in health care.	
9. I am able to discuss how access, historical, political, environmental and institutional factors (including racism and discrimination) impact health and underlie health and health disparities.	
10. I can discuss the social determinants of health including the impact of education, culture, socioeconomic status, housing and employment.	
11. I am interested in working to address the social determinants and community factors affecting health and health care disparities.	
12. I can describe health beliefs and practices of individuals that live in my work area.	
13. I know which diverse patients may be at risk of health disparities in	

my region.	
14. There are many power imbalances in health care and the health workforce.	

Option 2

Source: Ontario Healthy Communities Coalition.

For each item listed, write A for “things I do frequently,” B for “things I do occasionally” and C for “things I rarely or never do.” Ensure that you can provide concrete examples to justify your score.

	Rating
Physical Environment, Materials and Resources (skip this section if you do not work out of an office or public space)	
1. I display pictures, posters, artwork and other decor that reflect the diverse cultures 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 diverse cultures 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	
1. When interacting with individuals and families who Low English Proficiency (LEP) proficiency, I always keep in mind that: - Spoken English proficiency does not reflect reading 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.	
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 the cultural context for naming diseases 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, same sex relationships).	
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 (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 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 diverse communities served by my program or agency.	
6. I keep abreast of the major health concerns and issues for 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 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 behaviours that are not culturally	

competent.	
4. I screen resources for 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 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 and change.

Sample Organizational Assessments

Option 1

Source: Adapted from the Ontario Healthy Communities Coalition

Please rank the status of each of the following items based on your opinion.

- Not Yet Started
- Beginning Phase
- Well Under-way
- Fully Developed (including monitoring/review procedures)
- Not Applicable
- Do Not Know

You are welcome to add your comments to explain or illustrate your status.

Measures	Status
A. Governance: Policy and Leadership	
1. The Board and the organization have publicly stated their commitment to being an inclusive organization, through a position or policy statement.	
2. The Board has clearly outlined its expectations for management on the implementation of the diversity and inclusion strategy.	
3. The organization has addressed issues of diversity and inclusion in its strategic plan.	
4. Anti-discrimination and workplace harassment policies are in place.	
5. An action plan to reduce barriers experienced by diverse patients and families within the organization has been established.	
6. Resources have been explicitly allocated for effective implementation of a diversity and inclusion strategy.	
7. The organization demonstrates its commitment to diversity and inclusion by celebrating the diverse cultural and religious needs of its patients, families and community. (e.g. observing religious holidays, incorporating religious, including different cultural foods)	
8. The organization has a process in place to assess existing and new policies, guidelines and practices to determine if they contain barriers to inclusion.	
9. The organization actively monitors and evaluates progress in eliminating barriers to inclusion for patients, volunteers and staff.	
10. The organization expects all employees, volunteers and physicians to be respectful of all persons.	

B. Communication, Collaboration and Decision-Making	
1. The organization has compiled and updated a regional profile of the community including demographics and socio-economic issues relevant to health status.	
2. The organization has developed a comprehensive list of community and ethnic media channels.	
3. A list of community, regional and provincial organizations that work directly with diverse and/or marginalized populations has been developed.	
4. Communication strategies have been developed to provide necessary information to and to encourage dialogue with the various communities and organizations within a service area. (Strategies could include key informants, community leaders, community newsletters and audio-visual media).	
5. The organization has developed effective and inclusive formal and informal working relationships with diverse community groups and organizations.	
6. Partnerships are actively sought with organizations representing diverse populations.	
C. Service Planning and Delivery	
1. Members of diverse communities are invited to participate in the planning of the organization's programs and services.	
2. Programs and services are adapted to respond to expressed [or identified] needs of diverse communities within the service area.	
3. Resources have been allocated to provide appropriate interpretation/linguistic services.	
4. Programs and services are planned with consideration of the financial barriers of families within the region.	
5. An evaluation process has been established to monitor the accessibility, appropriateness and effectiveness of programs and services with diverse communities.	
D. Recruitment and Retention	
1. The organization has explored and removed possible barriers in the recruitment, hiring, promotion and retention of diverse staff, physicians and volunteers.	
2. Employment and volunteer opportunities have been advertised in non-mainstream media outlets e.g. community organizations or places of worship.	

3. Employment and volunteer opportunities have been advertised using appropriate language based on the demographics of the service area.	
4. The organization makes a consistent effort to recruit potential staff/physicians/volunteers/Board members who reflect the diverse communities it serves.	
5. The organization makes a consistent effort to accommodate the diverse cultural and religious needs of staff, patients and families (e.g. observing religious holidays, flexible work hours).	
6. There is an existing process for staff and volunteers to report discriminating or harassing behaviour.	
7. Indicators of inclusive practice are included in the performance appraisal of staff.	
E. Awareness and Learning	
1. The organization displays pictures, posters and other materials that reflect the diversity of the patients and families served.	
2. The organization ensures that magazines, brochures, toys and other materials in reception areas are of interest to and reflect the different cultures of patients and families utilizing those areas.	
3. The organization provides a relevant session on cultural competency that is mandatory for all new staff, physicians and volunteers.	
4. The organization provides opportunities for on-going learning in cultural competency.	
5. The organization provides continuous opportunities for staff to engage in first voice panels of diverse patients and families.	
6. The organization is aware of and embraces the diverse ways in which a family is defined (e.g. same-sex parents, grandparents, extended family members).	

Option 2

Source: Andrulis, Denis et al. Conducting a Cultural Competence Self-Assessment (Dennis Andrulis, SUNY/Downstate Medical Center, Brooklyn, NY, in collaboration with Thomas Delbanco, Beth Israel Deaconess Medical Center, Boston, MA, Laura Avakian, Massachusetts Institute of Technology, Boston, MA, Yoku Shaw-Taylor, Public Health Foundation, Washington, DC). Full document with guidelines for interpretation and use can be found at: <http://erc.msh.org/provider/andrulis.pdf>.

1. When you hear the term “cultural competence,” what comes to mind?
2. What are the most challenging priorities of the multi-ethnic and cultural nature of the healthcare organization?
3. What are the major organizational obstacles (policies, organizational characteristics) inhibiting ethnic and cultural understanding among staff, patients, providers, etc.? What are the major organizational characteristics that enhance the multi-ethnic and cultural nature of the healthcare organization?
4. As the healthcare organization has attempted to meet the needs of ethnic and cultural diversity, what issues have arisen (need for resources, conflict, etc.)?
5. What mechanisms, if any, are in place that promote communication among different levels and departments of the healthcare organization in regard to issues of cultural competence?
6. What has the healthcare organization done to provide the best care for the multi-ethnic and cultural patient population (e.g. educating providers in regard to different ethnic/cultural beliefs and practices; use of specific services—interpreters, community liaisons, etc.)?

7. In what ways have you addressed the ethnic and cultural needs of patients as they receive care throughout the continuum (home health, social services, etc.)?

8. What services, programs, etc. are available to staff regarding ethnic/cultural related issues?

9. In what ways are providers trained and helped to deal with ethnic and cultural issues (e.g. trained to recognize diseases common in certain populations, mechanisms and protocols by which providers can request assistance in dealing with ethnic/cultural patient issues and needs)?

10. What relationships does the healthcare organization have with particular community groups and how have these relationships affected the ethnic/cultural competency effort (community businesses under contract, initiatives with neighborhood health centers, etc.)?

11. What community outreach actions have been taken by the healthcare organization (e.g. health education programs, materials and forums for various ethnic/cultural groups, community support for patients of various ethnic/cultural backgrounds)?

12. In what ways are ethnic and cultural differences recognized throughout the healthcare organization (e.g. celebration of certain days, programs focused on specific health needs of a particular group)?

13. What, if any, ethnic/cultural professional programs are there to develop, as well as attract staff? Are internships targeted toward ethnic professionals? Mentoring programs? What are the challenges in developing and delivering these programs?

14. What government guidelines or regulations guide or influence your programs and initiatives regarding ethnic/cultural diversity and cultural competence?

15. What are the greatest strengths and the biggest concerns of the healthcare organization in regard to the delivery of care to and interactions with the multiethnic/cultural populations of its community?

16. What have you seen or would you like to see in terms of actual effects of ethnic/cultural initiatives on the work environment and on patient care?

17. What are your concerns about any of the ethnic/cultural activities undertaken by your organization?

Self-Reflection and Next Steps

Take this opportunity to reflect on this session by responding to the following questions.

1. *What are my key learnings from this session?*
2. *What might I do differently as a result of this session?*
3. *What are my individual next steps for action?*
4. *What next steps do I see for my workplace or department?*

Appendix 1: Language and Interpretation Resources

Mi'kmaq Hospital Interpreter Liaison Program, Halifax and Sydney, call 453-9358 or 567-8000.

Deaf: ASL interpreters are available through the Society of Deaf and Hard of Hearing Nova Scotians (see www.sdhns.org). The cost of ASL interpreters is free for patients and is covered by MSI. Interpreters are available for all primary care settings. In Cape Breton, call 1-888-770-8555 and in mainland Nova Scotia call 1-800-516-5551.

Deaf-blind: To ensure access to health-care services, deaf-blind people may require the services of both a Sign Language (ASL) interpreter and an intervenor (enables communication for the deaf-blind).

Cultural health interpretation: Call the answering service of Nova Scotia Interpreting Services (902) 425-5532. Leave your name and department information (mainly based in Metro Halifax). Cost centre is required. For an account, call 425-6604.

For information on cultural health interpretation within Capital Health, including posters promoting health interpretation, contact: Karima Bushra, Consultant, Cultural Health Interpretation (language services), 473-1909

The IWK Health Centre has a Coordinator of Bilingual Services who provides interpretive services for patients, families, and care providers throughout the IWK.

Telephone health interpretation: Telephone language services provide over-the-phone interpretation using certified medical interpreters who listen, analyse the message, and accurately convey its original meaning. Private companies include Access Alliance (www.aais.ca), Language Line (www.language.com), Telanguage (www.telanguage.com) and CanTalk (www.cantalk.com)

Video health interpretation: *In Demand Interpreting* and others provide instant access to certified medical interpreters through video technology. For more information, contact: www.theculturalink.com

Appendix 2: Other Resources

Implicit Bias Test

See: <http://projectimplicit.net>

Choose tests such as Race, Arab-Muslim, Gender and/or Sexuality. You will have to register, but the tests are free of charge.

Unnatural Causes: Is Inequality Making Us Sick? A seven-part documentary series exploring racial and socio-economic inequalities in health in the United States. Website includes video clips, case studies, fact sheets and more.

See: <http://www.unnaturalcauses.org>

Cultural Competence Assessment Tool for Clinical Guideline Development and accompanying Reporting Tool, NS Health and Wellness

<http://www.gov.ns.ca/health/primaryhealthcare/diversity.asp>

Messages for All Voices: Integrating cultural Competence and Health Literacy in Health Materials, Forms and Signage (2010)

www.gov.ns.ca/health/primaryhealthcare/healthLiteracy.asp

Quick reference guide and full version both available

Ouch! That Stereotype Hurts

www.ouchthatstereoypehurts.com

An easy-to-use video training program that teaches staff simple approaches for dealing with stereotyping and bias in the workplace.

Calgary Health Region, Alberta

www.calgaryhealthregion.ca/programs/diversity/diversity_resources/research_publications/directional_document.pdf

A wealth of useful tools including standards, assessment tools and so on.

Annapolis Valley Health

www.changingourpictureofhealth.ca

A series of three local videos segments of real people sharing their health care stories. The concepts of equity, health literacy, looking at people from a holistic perspective, and not passing judgment come through these stories. There are also helpful facilitation tools on the website.

Readings: Cultural Competence

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Readings: Cultural Safety

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Ramsden I (2002). *Cultural Safety and Nursing Education in Aotearoa and Te Waipounamu*. On-line, available at: culturalsafety.massey.ac.nz/RAMSDEN%20THESIS.pdf. Accessed February 2008.

Resources: Social Exclusion

See the work of Dr Grace-Edward Galabuzi
www.ryerson.ca/politics/facultyandstaff/bio_GraceGalabuzi.htm

An Inclusion Lens: Workbook for Looking at Social and Economic Exclusion and Inclusion (2002). Produced by Malcolm Shookner, Population Health Research Unit, Dalhousie University, for the Population and Public Health Branch, Atlantic Regional Office, Health Canada
www.phac-aspc.gc.ca/canada/regions/atlantic/Publications/Inclusion_lens/inclusion_2002_e.pdf

Closing the Distance: Social and Economic Inclusion Initiative (2004) Social Planning Network of Ontario
http://closingthedistance.spno.ca/tb_deep.php

Resources: Social Determinants of Health/Income Inequality

Social Determinants of Health: The Canadians Facts (2010). Mikkonen, J and Raphael, D. Toronto: York University School of Health Policy and management.
<http://www.thecanadianfacts.org/>

Social Determinants of Health: Canadian Perspectives, Second Edition (2008). D. Raphael (ed).

The Spirit Level: Why Equality is Better for Everyone (2010). Wilkinson R, Pickett K. Penguin.

Wilkinson R, Pickett K. (2006). Income inequality and health: a review and explanation of the evidence. *Social Science and Medicine*; 62: 1768-84.

Wilkinson R (2005). *The Impact of Inequality: how to make sick societies healthier*. New Press, New York

Canadian Population Health Initiative: Free online courses

All materials have Canadian content and examples and each uses a social determinants of health approach to explore the content, using well known physical and mental health outcomes.

Course topics include an introduction to population health, mental health and homelessness, criminal activity and delinquency, youth, and healthy weights, as well as recorded panel discussions on positive mental health and socio-economic status in urban Canada.

See: <http://secure.cihi.ca>

Other Web Resources

CultureGrams: CultureGrams are summaries of cultural information regarding ethnic and geographic groups. They include language spoken, communication styles, religious beliefs, diet and so on. Keep in mind that these are generalizations—a CultureGram does not represent all members of a cultural group. CultureGrams are usually available in libraries/health libraries. You need a user name and password from the library to use it.

See: online.culturegrams.com//index.php

Health Literacy

Literacy Nova Scotia: www.ns.literacy.ca

Canadian Council on Learning: www.ccl-cca.ca/CCL/Reports/HealthLiteracy

Acadian and Francophone

NS Office of Acadian Affairs: www.gov.ns.ca/acadian/fr/index.htm

Le Réseau Santé – Nouvelle-Écosse : www.reseausantene.ca/English.htm

Fédération acadienne de la Nouvelle-Écosse: www.fane.ns.ca

Nova Scotia Department of Health, French Language Services:

www.gov.ns.ca/health/fls/default_en.asp

African Nova Scotian

Office of African Nova Scotian Affairs: www.gov.ns.ca/ansa/default.asp

Health Association of African Canadians: www.haac.ca

African Diaspora Association of the Maritimes (ADAM): www.adamns.ca

Black Cultural Centre for Nova Scotia: www.bccns.com

First Nations, Métis, and Inuit

Nova Scotia Office of Aboriginal Affairs: www.gov.ns.ca/abor/office

Confederacy of Mainland Mi'kmaq: www.cmmns.com

Union of Nova Scotia Indians: www.unsi.ns.ca

Native Council of Nova Scotia: <http://ncns.ca>

Atlantic Policy Congress of First Nations Chiefs Secretariat: www.apcfnc.ca

Recent Immigrant and Refugee

Multicultural Association of Nova Scotia: www.mans.ns.ca

Immigrant Settlement and Integration Services: www.isisns.ca

Metropolis: atlantic.metropolis.net/index_e.html

YMCA Centre for Immigrant Programs: See: www.ymcahrm.ns.ca

Sex and Gender

Atlantic Centre for Excellence in Women's Health, www.acewh.dal.ca

Canadian Women's Health Network, www.cwhn.ca

Sexual Orientation and Gender Identity

Nova Scotia Rainbow Action Project: www.nsrp.ca

Canadian Rainbow Health Coalition: www.rainbowhealth.ca/english/index.html

Levels of Ability

CNIB: www.cnib.ca

CNIB, Nova Scotia and PEI: www.cnib.ca/en/ns-pei

Society of Deaf and Hard of Hearing Nova Scotians (SDHHNS): www.sdhhs.org

Nova Scotia Disabled Persons Commission: www.gov.ns.ca/disa

Nova Scotia Hearing and Speech Centres: www.nshsc.ns.ca

Appendix 3: Definitions

Cultural competence: A set of congruent behaviours, 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.)

Cultural competence embraces the importance of culture, the assessment of cross cultural relations, vigilance towards the dynamics that result from cultural differences, including issues of power, privilege and oppression, the expansion of cultural knowledge, and the enabling and empowering of clients to improve their lives and their communities by building on the strengths of individuals and communities, and adapting services to meet culturally unique needs (Bernard and Moriah, 2007: 87.)

Cultural sensitivity: Awareness that cultural similarities and differences exist and they affect values, learning and behaviour (Stafford *et al*, 1997.)

Valuing diversity through cultural competence is more than just being sensitive or *nice* to people. Cultural competence goes beyond sensitivity to respond appropriately and effectively to diversity in health promotion, health care, health workplaces and health systems.

Cultural safety: an environment, which is safe for people; where there is no assault, challenge or denial of their identity, of who they are and what, they need. It is about shared respect, shared meaning, shared knowledge and experience, of learning together with dignity, and truly listening (Nursing Council of New Zealand, 2002.)

Cultural safety supports self-determination, where safety is determined by the user of the health system, not the system itself. Cultural safety moves beyond cultural sensitivity to analyzing power imbalances, institutional discrimination, colonization and relationships with colonizers, as they apply to health care. Given that this has been the lived experience of Aboriginal Canadians, self-determination and cultural safety, as defined and determined by Aboriginal Canadians, is critically important.

Culture: Integrated patterns of human behaviour—thoughts, communications, languages, practices, beliefs, values, skills, customs, courtesies, rituals, manners or interacting and roles, relationships, and expected behaviours—of a group of people at a given point in time. (National Centre for Cultural Competence 2004)

Diversity: A broad term with multiple meanings...[for some] it refers to differences or variations across individuals and social groups while for others it represents differences that make a difference...In health care, then, diversity...implies difference from the

majority, which is assumed to be the norm...Diversity can be both visible and invisible (Srivastava, 2007:13.)

Diversity: the ways in which we differ.

- Goes beyond race and ethnicity. Dimensions of diversity include age, income, location, sexual orientation, communication style, personality etc
- From a health context, diversity is difference that matter to health.
- Diversity is an asset to groups and society. As with a garden, diversity brings strength and resilience to the whole.

Health equity: The absence of systematic disparities in health, or the major determinants of health between groups. Equity has an ethical dimension and is related to human rights. Equity supports the right to the highest attainable standard of health, as indicated by the health status of the most socially advantaged group (Braveman and Gurskin 2003.)

Health literacy: the ability to find, understand, use and share information, services and supports that promote, maintain and improve health throughout life. Health literacy is more complex than basic literacy. Health literacy requires

- the use of multiple skills at the same time, such as communication, math and reading.
- the ability to navigate forms and complex health systems
- feeling empowered to seek health information and take action to improve health

Literacy: the state of being literate—able to read and write, do basic math calculations and to understand and use printed information in daily activities. Literacy can also refer to Sign Language and other forms of communication.

About 42% of adults across Canada have problems using the written word. This number is even higher in Atlantic Canada.

- However health is defined or measured, people with limited literacy skills are worse off than others. Low literacy is also generally associated with greater use of health care resources.
- Literacy also affects social determinants of health, such as social status, employment and education (IALS 2000.)

Social exclusion: An expression of unequal relations of power among groups in society which then determine unequal access to economic, social, political and cultural resources (Galabuzi (2009) as cited in Mikkonen, J. and Raphael, D. 2010: 32.)

Aspects of exclusion include:

- Laws, regulations and discrimination
- Denial of social goods such as health care, language services, education and housing

- Lack of opportunity to take part in social and cultural activities, often due to lack of money
- Inability to access economic resources and opportunities such as paid work

Exclusion is one of 14 Social Determinants of Health. Aboriginal Canadians, African Canadians, recent immigrants, women and people with disabilities are most likely to experience social exclusion (Mikkonen, J. and D. Raphael 2010.)

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Building a Better Tomorrow Together Evaluation Questionnaire

Module Title: _____

Training Location: _____ Date: _____

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree
1. This module addressed my learning needs in this area.	1	2	3	4	5
2. The information which was provided was applicable to my practice/work.	1	2	3	4	5
3. My participation in this module has enhanced my knowledge and skills in this area.	1	2	3	4	5
4. My participation in this module will influence my practice/work in the future.	1	2	3	4	5
5. The facilitator was knowledgeable of the subject matter being presented.	1	2	3	4	5
6. The facilitator presented the information in a clear and concise manner.	1	2	3	4	5
7. The facilitator was enthusiastic and responsive to participant's learning needs.	1	2	3	4	5
8. There was opportunity to interact with other participants.	1	2	3	4	5
9. There was opportunity to interact with the facilitator.	1	2	3	4	5
10. The facilities were comfortable and conducive for learning.	1	2	3	4	5
11. The module was well organized.	1	2	3	4	5
12. I would recommend this module to others.	1	2	3	4	5

13. What did you like about this module?

14. What changes or improvements could be made?

15. What aspects of your practice/work do you intend to change as a result of participating in this module?

Notes