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Health competence from a transcultural perspective. Knowing how to approach transcultural care

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Abstract

Intercultural health, including intercultural competence, is a field of study which is generating a great deal of interest in the scientific community, indeed the focus on cultural competence in the curriculum, is becoming a priority. The importance of establishing political relationships with other countries, and more especially development cooperation agreements – redefined by the current recession –together with the global movement of populations, pose new challenges for health providers. This study aims to understand the social and cultural dynamics at work, essential for the acceptance and adoption of the cultural competence programmes, which are being proposed. The fieldwork was carried out in the Ecuadorian Amazon, among the Achuar people, researching an applied health promotion programme, based on the principles of development cooperation and western biomedicine. The main data collection methods were participative observation and in-depth interviews. The main findings reveal a lack of continuity in healthcare where use of indigenous methods of diagnosis and therapeutic resources coexist alongside the biomedical model, and where development agencies and healthcare professionals need to acquire cultural skills combined with specific local knowledge in order to be able to work with greater efficacy within their clients' cultural context. There is a clear necessity to reinforce relationships, communications, and dialogue between governments and cooperation agencies, with specific regard to the health of indigenous peoples and perceptions thereof.

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1. Introduction

Intercultural health, including intercultural competence, is a field of study which is generating a great deal of interest in the scientific community. Cultural competence is now becoming a priority for inclusion in the curriculum and training syllabuses of health professionals. Current research and the concepts developed, in this field, can be used to provide input for the content to be included in such training programmes.

Concerns about studying intercultural health have been growing for a long time. In Europe the migration of various population groups and communities means the problem has become more visible and widespread, nevertheless, it is important that intercultural health concerns are not solely limited to these contexts and to minority and indigenous groups (Knipper, 2010). Given its current relevance, it is surprising, that it has not been paid more attention nor generated greater and more forceful debate (unlike in Latin America), as there is a clear need for intercultural dialogue across all areas of social, cultural and political life, starting at an institutional level, but as Fernández (2006, p. 317) says it is only 'fashionable' among certain programmes, movements and collectives.

This is a delicate area of debate and the common perceptions in the findings of studies addressing this issue – especially those conducted among indigenous populations (Clifford et al, 2015) – all speak of the difficulty and complexities in finding valid responses. Thus, work needs to continue along these lines, in order to be able to put into practice the recommendations of the great number of academic papers in this field.

As mentioned above, applying reductionism to the intercultural health concept, by focussing solely on minorities, foreigners and 'problematic' groups, means that the socio-political and economic dynamics which also come into play, get ignored or neglected. The term 'intercultural' is complex and it also includes those population groups likely to be subject to cultural competence care, while biomedical health culture fails incorporate intercultural competence into its educational and training programmes. While the terms "transcultural", "intercultural" or "interculturality", are not new, it is impossible as Guilherme and Dietz (2015) state "to establish fixed and stable lines between them, as they form a complex web of meanings that to some extent may cross each other". According to Kleinman and Benson (2006), Kruse (2014), the same thing happens with 'cultural competence' which is a new ideological term, coined in response to the economic, political and sociocultural rationale of the inter-cultural discourse, expressed in different ways in different situations.

Cultural competence means taking into account all the cultural factors that come into play when anyone is involved in any interactive process (whether in the field of health or other contexts) where there is a relationship of inter-subjectivity and reflexivity in which ethical considerations are involved. Interculturality envisages the co-existence, interaction and exchange between diverse cultures (Soler, 2014, p. 31). However, Gimeno et al (2010, p. 207) consider that interculturality – not only means the acceptance of otherness or the harmonious co-existence between different groups – but that it also has a political component, based on access to power, such as that demonstrated in the relationship of 'power – knowledge' meaning shared knowledge applied to health, in this case. In this way, we find proposals that health professional educational programmes should include aspects and content referred to as 'transcultural competence', a term coined by Pratt in 1952 and which means capturing the "cultural translation of one worldview to another assuming there are only two at stake and that their borders are perceptible" (Guilherme & Dietz, 2015, p. 23). The authors brilliantly continue that "reconciling differences is the aim of the development of this set of skills described above as 'transcultural competence', not building upon conflicting relations, although terms such as multiculturalism, interculturality, and the transcultural, among others, are currently so widely used that they have become too elastic."

The different tools which are being developed to assess cultural competence, particularly those related to the sphere of health, demonstrate the interest, concern and relevance that this issue holds for health professionals, researchers and academics today. The design of assessment tools to evaluate cultural competence training and the development of guides on cultural competence for educating medical students, nurses and other healthcare staff, plus the assessment and analysis of this part of the curriculum is very striking in North American. Under the slogan 'Better communication for Better care' the American Medical Association (AAA, 2005) offered a series of tools designed to help health organisations and institutions in general – but more particularly Health workers – to respond to the needs of diverse patient populations by enabling both health professionals and organisations to offer improved communication and relationships.

Kumas-Tan's (2007) systematic review and analysis, of approximately 20 years of literature, identified 54 tools, including the 10 most frequently used cultural competence measuring tools. Generally, these instruments equate culture with race and ethnicity, and conceptualise culture as an attribute possessed by the 'other' race or ethnic group. In this area, there remains much to do, as Knipper (2006, p. 427) states the challenge for putting a system of intercultural medical strategies into place, lies in the conscious and instructive use of basic categories such as 'culture' and 'ethnicity', because, as long as such categories are perceived as 'exotic', by the parallel academic medical systems and institutions, there will be no advance.

To cite some of the tools used, the *Intercultural Development Inventory* (IDI®) is a method to assess cultural sensitivity and cultural competence by measuring the levels of intercultural competence in order to identify the specific orientation of participants (Kruse, 2014). The *Inventory of Cultural Competence* (ICC) (Castro, 2012), evaluates the dimensions relating to intercultural contact and divides them into 5 categories: openness to new experiences, autonomy and independence, acceptance of cultural diversity, emotional instability and relationships. These findings demonstrate convergent validity with other scales, such as the *Big Five Factory* (BFF), the *Questionnaire of Openness to Others* (QOO) and the *Satisfaction with Life Study* (SWLS). Another tool is the *Multicultural Competence Scale in Helping-Profession Students* (MCSHPS) (Hladik, 2014), a scale which does not yet exist in Europe and is inspired by another 4 tools: the *California Brief Multicultural Competence Scale* (CBMCS), the *Multicultural Awareness, Knowledge* (MAKSS), the *Multicultural School Psychology Counseling Competency Scale* (MSPCCS) and the *Individual Importance of Multicultural Competence Scale* (IIMCS). It consists of a questionnaire with 20 items, which measures 5 factors: multicultural knowledge, pluricultural activity, multicultural awareness, understanding of terms and multicultural communication skills. Another measurement tool is the *Cultural Competence Assessment Instrument* (CCAI), which measures cultural competence along the dimensions of: facts, awareness, attitude and behaviour.

A widely used inventory for assessing cultural competence processes among Health and Nursing professionals is the *Inventory for Assessing the Process of Cultural Competence Among Healthcare Professionals* (IAPCC) (Campinha-Bacote, 1998, 2002). This is a 20-item inventory which measures such cultural competence constructs as: cultural awareness, cultural knowledge, cultural skills, cultural encounters and 'cultural desire' which was later added as an additional construct. Campinha-Bacote's cultural construct model for Healthcare services (*The Process of Cultural Competence in the Delivery of Healthcare Services),* considers that cultural competence is "the process in which the healthcare professional continually strives to achieve the ability and availability to effectively work within the cultural context of a client (family, individual or community)". This continuous process implies integrating these 5 constructs, considering variations within groups, along with the direct relationship between the health professionals' the health professionals' competence levels and their capacity to deliver culturally sensitive care which is the essential component for providing effective care services.

The cultural competence process combines the fields of transcultural nursing, medical anthropology and multicultural orientation. The works of Leininger (1980) in transcultural nursing were used for the development of the constructs used in the Campinh-Bacote model. Madeleine Leininger's theoretical framework on Nursing "Culture care: diversity and universality" emphasises the need to take into account a patient's social and cultural structure, in order to provide responsible care in line with that culture and to thus meet each patient's needs, values, beliefs, cultural reality and way of life. Leininger reasons that the culture shock and impositions which come from nurses' own ethno-centrism have a negative impact on the quality of human care given to patients from different cultures, and that, nursing and medical diagnoses, when they are not based on cultural foundations, lead to unfavourable outcomes and potentially serious health problems, as patients may abandon treatment. Dressler, González-Faraco, Murphy & Dos Santos (2015) also talk of the negative influence of low cultural consonance – understood as the capacity for cognitive openness by a person from an alien culture – which can become a source of stress, confusion and uncertainty.

The aim of this study is to understand and give our interpretation of the social and cultural dynamics which arise when different health models encounter each other, and more specifically when health staff take with them and apply the biomedical model to care in the Amazon region, and the corresponding feedback from, and fit with, local models and local health staff. In order to meet these objectives different cultural competence assessment tools were employed – and specifically the Campinha-Bacote (1998) model for Nursing Professionals.

2. Methodology

Our aim was to try and understand the intercultural –and transcultural in the context of this study – nature of the

social and cultural dynamics at work around health processes which are critical to the acceptance, implementation and integration of the premises put forward by cultural competence programmes. Our approach was to analyse the different models of intercultural competence and the different tools aimed at guiding those health professionals who, like ourselves, question the quality of the care we offer.

A qualitative methodology was selected with a strongly ethnographic approach, given the particular characteristics of the study, in accordance with Willis and Trondman (2000). The ethnographic research design was based on data collection carried out during fieldwork trips among the Achuar population (Ecuadorean Amazon) which took place periodically over the years 2008 to 2010. These inhabitants are recipients of a health promotion project, which is based on the principles of western medicine and development cooperation. One of the main objectives of this project is to improve the epidemiological health indicators in the area by setting up and training a network of health promoters together with the distribution of community first aid kits – located where primary care takes place in the community.

The ethnographic approach adopted, included various information gathering techniques, ie participant observation data collection, qualitative interviews, fieldwork diaries, consideration from both *emic* and *etic* perspectives. This combination was considered to offer the most appropriate research methodology to explore more deeply and illuminate an area which tends to remain hidden in the shadows and which cannot be easily approached from more neutral attitudes and perspectives. Various studies (Knipper, 2013; Willen 2013; Carpenter-Song, & Whitley 2013; Hannah & Carpenter-Song, 2013) endorse ethnography as the best approach for evaluating the social and cultural dynamics explored in transcultural studies. In this case, all the above ethnographic research tools were employed in order to provide the most powerful set of data collection techniques possible.

The sample was made up of medical and nursing professionals, caring for the health of the Achuar population. These professionals were either of ecuadorian origin and thus dependent on their National Ministry of Health, or health professionals from spanish development cooperation organisations with specific health programmes and profiles – colonist health personnel-, and finally local healthcare personnel of Achuar origin. Two focus groups and 11 in-depth interviews were carried out among 28 participants (this is part of a wider study), with systematic and supervised participant observation in place. The gender distribution of the sample was predominantly female – with just 2 male physicians – this proportion being usual for studies among healthcare professionals.

In the qualitative analysis and data interpretation, the search for meaning and significance was given priority. A system of selective coding was established, giving rise to categories, which were systematically and constantly compared one to another. In addition to the sources cited, further desk research was undertaken relating to the field of Achuar medicine, relevant current legislation, and training literature, such as that used by nurses who participated in the project. Additional training materials developed for use by local health staff in training sessions and courses were also studied. At the same time the cultural practices of the Achuar people and their relationship with political practice were researched and analysed. From an ethical standpoint, the Helsinki Declaration was adhered to, and a paper has already been published on this subject (Pulido, 2016).

3. Results

The main findings reveal a 'lack of continuity' or a 'discontinuity' in care, where the use of indigenous methods of diagnosis and therapeutic resources coexist alongside the biomedical model. The latter being incorporated via periodic interventions of colonist healthcare personnel, attached to the Ecuadorian Health Ministry and/or international organisations. Colonist personnel – with the exception of one Doctor who had worked for more than 15 years among the Achuar people – find the work difficult. Only very occasionally, and even then only for short periods, has it been possible to get nurses and a doctor to work at a health point, as they tend to leave in order to further their professional career. Additionally, they can't get used to the way of life, they aren't ready to work with 'savages' nor with people who have very deeply rooted customs. Given the enormous difficulties in finding health workers who want to work with the Achuar people, the Health Ministry is attempting to find a way to reinforce the healthcare practitioners who cover these posts (after having removed the economic incentive which had been implemented for a while).

The lack of biomedical staff – attached to the Health Ministry – who want to stay in these areas, leads to healthcare being carried out by the health brigades – which carry out limited healthcare activities on a sporadic and intermittent basis. In this way, these communities occasionally receive at least some of the most basic necessities of Primary Health Care, such as vaccination and delivery of medicines. International organisations attempt to make good this situation, and design projects to be carried out by development agents and health staff – who are distant from the cultural context.

Nurses who participate in the health promotion projects are volunteers, which suggest that a priori they are open to

intercultural exchange, and one might imagine that getting to know and learn about different cultural realities could be sufficient to motivate for them. However, this affective component does not always translate into a cultural awareness of their own systems of values, biases, beliefs and professional prejudices which they bring with them, and which inevitably come into play, due to their inexperience in working in contexts far removed from their own healthcare culture and because they have not received cultural awareness training or information in this regard. They are unaware of the significance of cultural dominance in the way they carry out their work and this impedes cultural consonance, as there is a tendency to impose their own cultural system of beliefs, values and behaviour patterns: "They have to be vaccinated, so their children won't die, with this vaccine they won't get sick" IN –Informant Nurse- 56.

Other more bureaucratic activities, such as attempts to formalise health records or include clinical histories become an arduous task, difficult to impose on a society without a written language where the principles of writing have only recently been introduced. As a nurse explained, complaining about the diversity of healthcare professionals involved; the lack of systematic recording of care received or treatment prescribed: "We tried to organise the vaccinations as it was bloody chaos!" IN 6.

The institutions tend to generalise about the indigenous populations and provide only very unspecific materials. There are further difficulties, which make it even harder to carry out competent care. The healthcare professionals knowledge of the Achuar people is minimal while their training does not cover this subject; healthcare professionals do not speak the local language and are ignorant of the Achuar people's approach and understanding of the process of being sick, their therapeutic journeys, or belief systems relating to health or their cultural values. In some of their assessments and reporting, the strong need for Healthcare professionals to be able to understand the local language via an interpreter was confirmed, which implies a lot more than simply translating the symptoms, as the population plays back terminology they believe appropriate in order to gain access to the desired health services. As can be seen by the case of a male patient who demanded an air ambulance for his 'ovarian' pain. The colonist doctor faced with this demand, complained that: "The Achuar just want a light aircraft to go and see their shaman. And, if that happens with Fernando (a mestizo name) who I think speaks good Spanish and understands me well, imagine what happens with all the others!" MI -Medical Informant- 40.

The health professionals put their heart and soul into it, but they experience a lot of anxiety and sometimes even a sense of failure, as a doctor, who had been working there for 3 months, said: "I don't provide good care. Here things aren't done well, they aren't done as they should be. Nor do they take their medication, nor can I make myself understood. I don't feel comfortable as a professional giving this type of care. I feel rather 'disabled', I feel rather useless … (silence) 'Frustrated', that's the word. I can't reach them and I don't know how to, however hard I try … I have never encountered their culture before, I respect it, but they should respect mine too!" MI 40

Acquiring cultural knowledge of the beliefs and values relating to health, implies attempting to understand the Achuar people's world vision, how they interpret illness and how this in turn guides their thoughts and practices. The lack of rigorous data on the incidence and prevalence of disease, among the Achuar people, according to biomedical categories, is eclipsed by the categories of illnesses recognised by this group but which are not included in any biomedical statistics. To this end, local health staff are trained in the diagnosis and application of treatment according to biomedical definitions, in order to attempt to gather epidemiological information and achieve more successful results, nevertheless bias and poorly defined medical categories are still found. For the Achuar people, treatment efficacy not only defines the disease category but it also brings into question the capabilities of the healthcare staff. Health professionals continue to dispense a worryingly high level of pharmaceutical drugs even though they know that they will not be taken by the Achuar people. "Here a lot more drugs are administered than outside, because you know that outside they know about them, they know how to [take them]… Once I told a patient that he didn't need any treatment or vitamins, and he asked if I was going to keep them for myself, because these drugs were theirs, and that they had been sent for the Achuar people. Since then I don't confront anyone, I don't oppose them, if they want them I give them to them" MI 5.

It was noted that greater work experience and contact with other cultural groups brought greater cultural sensitivity, knowledge and competence, but even so, this was very far from the required minimum standards.

Indigenous medicine has its own diagnostic methods and therapeutic resources, the most notable being ritual ceremonies and the use of medicinal plants. A third tier in Achuar medicine includes the equipment, drugs, furniture, tools, remedies and language that western medicine, with the best of intentions, has brought with it. Thus, the indigenous medical landscape would be incomplete if we did not include biomedicine. Indeed, not only would it be incomplete, but, as this is the most visible and the least hidden element, it becomes very difficult to exclude biomedicine from what purists may understand Achuar medicine to be, even if we wanted to.

4. Discussion

The inclusion of cultural competence as part of the syllabus in health training courses is uneven throughout Latin-America, where although it is quite often included in nursing studies, it rarely figures in medical degrees. And, while there are many studies, which assess cultural competence among students, there are far less among working healthcare professionals. Nevertheless, studies (Plaza del Pino & Soriano, 2009) indicate that the lack of cultural competence among working professionals is extremely worrying because healthcare professionals who do not acquire cultural competence in training, do not acquire such tools in their later working lives. Thus paternalist care patterns and attitudes from the developed world, persist, exacerbated by the gender variables present in healthcare professions and often with religious overtones (Pulido, 2013).

It is crucial to improve healthcare professionals training programmes by including, in the syllabus, the appropriate sociological and anthropological content to promote the understanding of illness from the patient's socio-cultural context (Seguín, 1964). This needs to be implemented for all healthcare students across the board: starting from the lower tiers, so specifically among nursing studies for the purposes of this study, and also more broadly to include all university healthcare science degrees.

Flores Martos (2011) points out that interculturality, and thus cultural competence, has become a 'magic' word, used arbitrarily for anything and everything, regardless of its original meaning. It is now a 'politically correct' concept accepted widely, and almost mechanically, as something positive. Under the umbrella of interculturalism or cultural competence, there is the risk of implementing politically integrationist and unifying policy strategies which would modify the existing health models.

This language has been adopted by development cooperation agencies, indicating that the agencies themselves play a dominant role in validating and establishing the concept via their activities and funding (Hita, 2011, p. 64). The importance of establishing political relationships with other countries –based on development cooperation agreements which have been redefined by the recession (Grasiot, 2015)– and the consequences of the global movement of populations, present new challenges for healthcare providers, not only in destination countries but also when these migrants arrive at our own health centres – irrespective of whether the healthcare professionals migrate or if they receive migrating citizens from other countries.

The cultural competence demanded of healthcare professionals, is also an essential requirement for development cooperation agency staff, as it is the agencies which design, develop and execute biomedical health projects in areas which are culturally different. In order to improve communication between the people engaged in the process and so that institutions' activities can be appropriate and effective, it is necessary to foment the complex integration of knowledge, awareness, attitude and skills. (Pulido 2010, Abad 2005).

At the same time, quality control measures of intercultural competence levels in healthcare, need to be put in place, using instruments and tools which can clearly establish the minimum required criteria.

5. Conclusions

Ethnography is the tool, par excellence, for the study of cultural competence in complex health contexts, as it enables us to identify the socio-cultural dynamics which contribute to the acquisition of intercultural competence. It is recommended that the demarcation between disciplines be set aside to allow anthropology to bring to medical science a more holistic and integrated understanding of the process of what being ill means to the local populations.

Health and educational institutions, development agencies and healthcare professionals all need to acquire the appropriate cultural skills in order to offer greater efficacy to the diverse users of established health systems. They need to be able to take into account both the local dimensions and the individual patient's needs. On the one hand, this implies educational and training programmes which includes sensitization to, and awareness training in, cultural diversity, and, on the other hand, the ability to measure levels of cultural competence by using appropriate tools (which are currently being developed). There is a clear need to reinforce relationships, communications, and exchanges between countries, their governments and the cooperation agencies, in order to collect all the relevant information about citizens' health, as well as citizens' own perceptions of their health and healthcare.

The absence of cultural awareness in the educational programmes' syllabus for healthcare staff, combined with the lack of coordination between the different institutions, significantly reduces the degree of patient compliance, the

quality of health services provided and the attainment of Primary Health Care objectives. Furthermore, the communication competence demanded of patients themselves is an indication of the asymmetrical relationship which continues to exist between healthcare providers and their patients.

For all the actors involved, interculturality including cultural competence, implies moving away from the dual and divided (dichotomic) thought model which persists in the humanitarian landscape: donor vs receptor, expatriate vs local, NGO vs state, giver vs receiver, biomedical vs traditional (Abramowitz et al, 2015). This applies to the understanding of all healthcare processes (including illness and perceptions of illness) and means developing common objectives born of participant processes and new instruments for validating the healthcare received by patients. A close relationship between the State and all the institutions and organisations involved is necessary more than ever.

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