



Enhancing Cultural Competency

A Resource Kit for Health Care Professionals

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Acknowledgments

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1.0 INTRODUCTION



“Diversity is the one true thing we all have in common. Celebrate it every day.”

Anonymous





Calgary at a Glance – Changing Demographics

The face of the Canadian nation continues to change, as Canada now welcomes approximately 250,000 immigrants* to the country every year. The 2006 Census found that 19.8% of the total Canadian population was foreign born, the highest percentage in 75 years. Between 2001 and 2006, 1,109,980 individuals immigrated to Canada. While multiculturalism has always been a prominent feature in Canadian history, there has been a shift in immigration demographics within the past two decades. No longer are the source countries of immigration Europe and the Americas, but are now predominantly those of non-western countries, particularly those in Asia. As a result of this trend, Canada's visible minority population has significantly increased. According to the 2006 Census, 70.2% of foreign born population, reported a mother tongue other than English or French. Canada also welcomes many refugees*.

The thriving economy of Western Canada

continues to attract people from around the world, as seen in the 15,849 newcomers who moved to Alberta in 2003, accounting for 7.2% of Canada's total number of immigrants. The top ten source countries of Alberta immigrants are as follows: India (12%), China (11%), the Philippines (9%), Pakistan (6%), the United Kingdom (5%), Korea (4%), the United States (3%), Iran (3%), Afghanistan (2%), and Vietnam (2%) (Statistics Canada, 2002). According to Citizenship and Immigration Canada, there was a shift, identifying the top 5 source areas to Alberta as: Asia and Pacific (70%), Europe and United Kingdom (11.3%), Africa and Middle East (9.3%), United States (5.8%) and South and Central America (3.6%).

Calgary is rated as one of the cleanest, safest and friendliest cities in North America and provides an ideal option for new residents from around the world and the rest of Canada. Classified as the fastest growing city in Canada, 59% of people who immigrated to

Alberta in 2003 chose Calgary as their home. As a result, Calgary continues to become increasingly diverse with regards to culture and ethnicity. According to the 2001 Census of Canada, 197,410 Calgarians, or one fifth of the population, are foreign born and 17.5% of the population are classified as visible minorities.

In 2006, the estimated number of foreign born individuals in Calgary increased 28% (from 2001) to 252,800 people. Between 2001 and 2006, 57,940 or 5.2% of new immigrants called Calgary home (2006 Census). These newcomers accounted for 5.4% of Calgary's 2006 population.



***Immigrant** is a person who has moved themselves (and often their families) to take up permanent residence and often citizenship in the new country. Immigrants are classified as skilled workers, provincial nominees or business immigrants, or may fall into the “Family Class” of immigrants.

***Refugee** is a person who has a well-founded fear of persecution because of race, religion, nationality, membership in a social group, or political opinion. Refugees are of every race and religion and can be found in every part of the world. Refugees are often forced to give up everything, including their homes, belongings, families and countries in fear for their lives and liberty. The United Nations High Commissioner for Refugees (UNHCR) works to protect and assist the world's refugees. At the end of 2003, the number of refugees and others of concern to the UNHCR reached 22.4 million.

Global Greetings

How many languages would you have to learn to be able to say hello to everybody in the world? You would have to learn at least 2,796 languages! Here are just a few of those languages and greetings:



Thai:
"Swasdee!"

Persian:
"Salam!"

Hindi: "Namaste"

Kiswahili:
"Jambo!"

Norwegian: "Hei!"

German:
"Guten tag!"

English:
"Hello!"

Irish:
"Dia Dut!"

Polish: "Dzien Dobry!"

Portugese: "Bom dia!"
Serbo-Croatian: "Zdravo!"

Korean: "Annyong ha shimnkikka!"

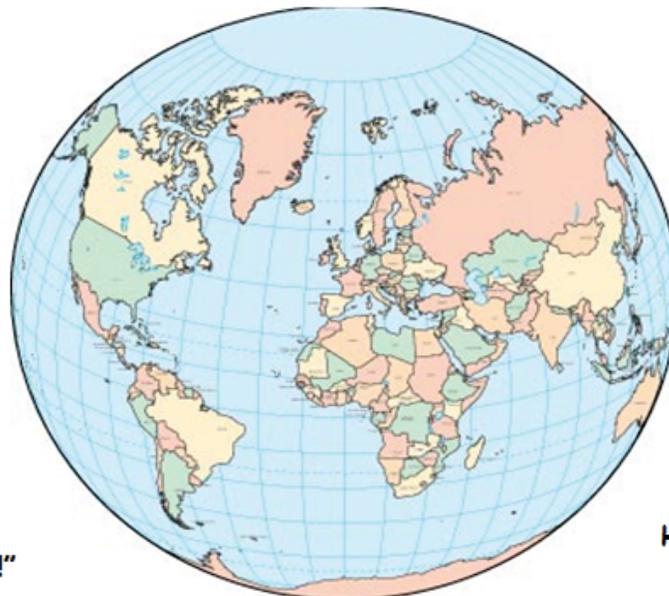
Fijian: "Bula!"

Mandarin:
"Ni hao!"

Japanese:
"Konichiwa!"

Russian:
"Zdravstvuite!"

Hungarian: "szervusz!"



Within Calgary, more than 70 non-official languages are spoken. The top 5 most represented languages spoken are: Chinese (Mandarin, Hakka and Cantonese), German, Punjabi, Tagalog, and Spanish (Census 2001). The most common languages spoken among new immigrants to Calgary in 2001 and their corresponding greetings are:

- ▶ **Mandarin:** “*Ni hao!*”
- ▶ **Punjabi:** “*Satsriakal*”
- ▶ **Tagalog:** “*Magandang tanghali po!*”
- ▶ **Korean:** “*Annyong ha shimnkikka!*”
- ▶ **Spanish:** “*Hola!*”
- ▶ **Urdu:** “*Aadaab*”
- ▶ **Arabic:** “*Al salaam a’alaykum!*”

(Citizenship and Immigration Canada, 2002).





Purpose and Overview of Resource Kit

This resource kit was produced in response to a need identified by the diversity program coordinators within the Alberta Health Services that health care professionals need easy access to information in order to enhance their skills in providing culturally competent care to individuals and families from diverse cultural backgrounds.

The resource kit provides an overview of the following topic areas:

- ▶ Changing demographics in Calgary, focusing on the increase in visible minority and immigrant populations within the city and its consequence on health practices.
- ▶ The need for cultural competency in health care.
- ▶ Culture as a determinant of health, illustrating how economic, political and social backgrounds affect health conditions of newcomers.
- ▶ Addressing communication barriers that exist within the health care system.
- ▶ World views on health issues, including ethno-specific information as well as general suggestions for enhancing culturally competent practice.
- ▶ Culturally sensitive assessment and information gathering, including assessment tools and models specialized for diverse populations.

- ▶ Culturally sensitive care and service provision for ethnic groups.
- ▶ Community resources aimed at ethno-cultural issues, including current contact information and brief descriptions of each organization.
- ▶ Alberta Health Services Diversity Programs, and
- ▶ Other resources for learning.

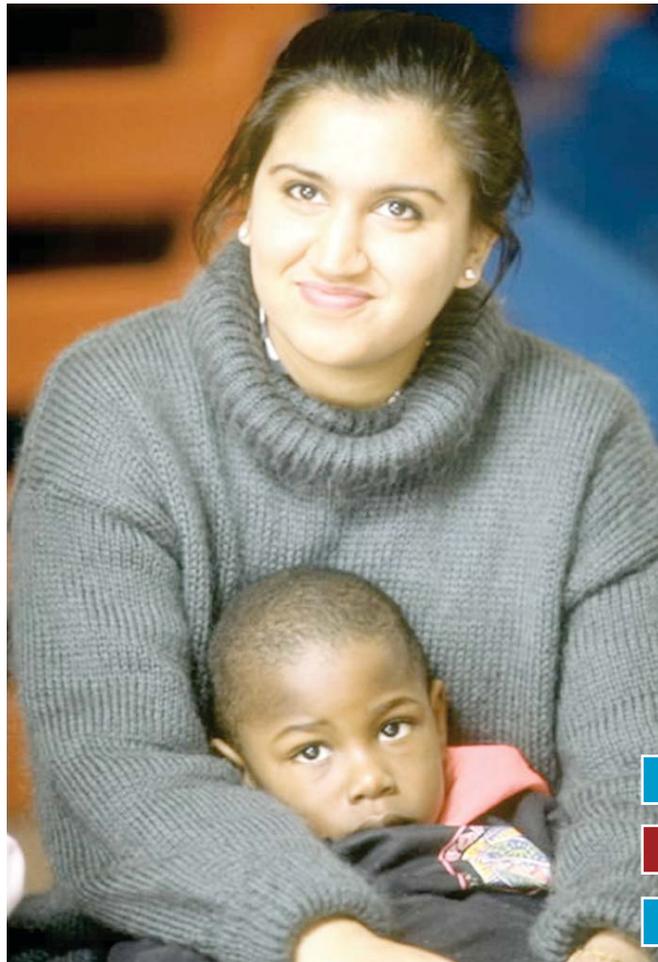
In addition to descriptive information, practical tools and suggestions are included in this resource manual.

The contents of this Cultural Competency Resource Kit are to be used as a **guideline** to educate health care professionals with general information regarding cross-cultural practices concerning the health and well-being of diverse populations. This kit is **NOT** designed to promote stereotyping of all individuals and families from these diverse ethnic backgrounds. **It is to be used as a tool to enhance cultural sensitivity, awareness, and practice within health care service delivery.**

It is also important to keep in mind that cultural competency is a continuous learning process. Health care providers are encouraged to utilize a variety of means to enhance their practices surrounding competent delivery of service. This resource kit is only one way to enhance one's knowledge and skills.



2.0 CULTURAL COMPETENCY IN HEALTH CARE



Culturally competent individuals have a mixture of beliefs/attitudes, knowledge/experience, and skills that help them to establish trust/rapport and communicate effectively with others.

American College Health Association, 2003.





Source: <http://wcfellowship.com/ph/wp-c080c381/wp-c080c381.html>

Barriers to Accessing Health Services

For many newcomers to Canada, becoming familiar with a new and complex health care system can be a daunting task. Depending on the nature of health services in their country of origin, newcomers may have little or no knowledge of the range of services or how they may be delivered in Canada. Diagnostic testing, history-taking practices, interdisciplinary teams, and Western medicine may be very foreign concepts to new Canadians.

Specific barriers encountered by new Canadians include: language barriers; economic barriers, (including transportation and child care costs, lack of extended health care coverage, inability to take time off work); and systemic barriers (such as hours of operation, lack of encouragement of family involvement, and hospital food to name only a few).

With Calgary's population now 23.6% foreign-born, the Alberta Health Services has needed to become more responsive to culturally

diverse populations. An external consultation was conducted and the Ethno-Cultural External Consultation Report (March 2002) identified the following priorities for the CHR:

- ▶ Addressing language barriers (considered to be the highest priority)
- ▶ Educating ethno-cultural communities and organizations and immigrant- serving agencies about the health care system (considered critical)
- ▶ Recruiting and training staff from various cultures
- ▶ Facilitating active ethno-cultural involvement that would include participation at all levels of planning, policy, and decision-making, and
- ▶ Providing outreach in the form of members of specific ethno-cultural communities hired to educate and make connections.

Removing Barriers II - Summary of Recommendations

Issues relating to barriers in accessing health care services are not unique to Calgary. Such concerns have been identified by many throughout Canada (and other jurisdictions). Within the country, the Removing Barriers initiative began in 1997, which led to national symposia being held in Toronto (1998) and Vancouver (2000). The following is a summary of recommendations from the 2000 Vancouver symposium.

Alternative Approaches to Health and Healing

- ▶ Psychotherapies outside of psychiatry are accessible to marginalized populations by universal health insurance and/or by providing salaried psychotherapists.
- ▶ The curriculum in medical schools includes knowledge of alternative psychotherapies.
- ▶ This Symposium and **other** national forums ensure that integrated health care remains on our agendas as a “diversity” issue.

Hospital and Community

- ▶ People working in clinical areas need opportunities to spend time on administrative responsibilities.
- ▶ Rehabilitation of older and marginalized people is recognized as more than replacing degenerated parts of the body and regaining range of movements and

muscular strengths.

- ▶ A safe supportive environment is needed to gain and practice skills of daily living using new potential achieved during conventional therapies.

Cross-Cultural Care Issues

- ▶ Every curriculum in the mental health professions include training on social-cultural issues, including, ongoing recognized and accredited training to professionals already in the profession.
- ▶ Support is needed for mental health professionals in the field across the nation.
- ▶ Website and Canadian data bank be developed to identify cultural networks that can be used as a resource.
- ▶ Research for cross-cultural assessment tools needs be developed.
- ▶ Shortage of professionals and services across Canada needs to be addressed.

Women’s Health

- ▶ Professional cultural/language interpreters be funded.
- ▶ Men be involved in public education programs.
- ▶ Different sectors in public education be involved in violence prevention within their individual communities.

- ▶ Violence be seen as a community issue, not just a women's issue.
- ▶ Newcomers' orientation package needs to involve the family in a timely manner.
- ▶ "One stop shop" development of comfortable, safe multicultural family places be promoted.
- ▶ Affordable and appropriate child minding be made available.
- ▶ There be more public health nurses who are from diverse backgrounds.
- ▶ Theoretical models be used, recognizing that many cultural concepts with potential relevance to health practices have not been adequately researched.
- ▶ Information, cultural, linguistic, economic and systemic barriers in care be reduced.
- ▶ The community be involved in planning, design and delivery of interventions.
- ▶ "Link leaders", local leadership, and media be used.
- ▶ Determinants of immigrant women's health be addressed, for example, family, social and community support, control over income/resources and social and work environments.
- ▶ The processes be dynamic, as immigrant's attitudes, beliefs and behaviors change as part of an acculturation process.

Mental Health

- ▶ Federal, provincial, territorial, and regional authorities to move to ACTION on reducing barriers for those with mental illnesses.
- ▶ The voice of the mentally ill must be heard. Advisory Committees be set up with the people who experience mental illness in a position of decision-makers.
- ▶ The mentally ill need "informed choices" of treatment. A spectrum of services and modalities is needed, not just the Western Medical model of psychiatry.

Adapting to Diversity

- ▶ Health Canada take a leadership role in developing indicators to measure the impact of diversity on the financial and human resources required to appropriately adapt services.
- ▶ Health Canada encourage national organizations to ensure that their members integrate diversity as an essential consideration in their practice and that, where such organizations have the power to do so, they hold their members accountable for this integration.
- ▶ Criteria for Health Canada funding requests includes evidence that the diversity of the population for which projects are intended has been included.
- ▶ Diversity of the population is fully integrated into the health and social services sectors and the impact of this

diversity should be considered in resource allocation.

Reaching Out to Ethnocultural Communities

- ▶ Barriers are complex and interdependent, therefore solutions must be collaborative and sustainable.
- ▶ All levels of government must have a long-term plan for isolated communities, for example, Laotian Cambodian Community in Vancouver.
- ▶ Long term funding be provided for programs dealing with issues of ethnocultural communities.
- ▶ Communication among agencies be improved.

Improving Access of Non-English Speaking Clients & Families

- ▶ Institute practical standards on cultural interpreting including, accreditation and comprehensive training of cultural interpreters, with appropriate on-going professional development to be optimally involved in health care delivery.
- ▶ There is a need for awareness of the issue at all levels of government to provide funding and support for cultural and linguistic services.
- ▶ A national dialogue be established on health interpretation services.
- ▶ Cultural competence training for health professionals includes training/orientation on working effectively with cultural interpreters.

(Source: Masi, Ralph, editor, Removing Barriers II Keeping Canadian Values in Health Care, 2000)





Alberta Health Services (AHS) Calgary Framework (former Calgary Health Region)

In April 2002, the *Blueprint for Enhancing Cultural Competency in the Calgary Health Region* established the organizational framework for addressing barriers in accessing health services. The purpose of this blueprint is “to guide the design and provision of culturally competent health services in Calgary”.

The Calgary Regional Diversity Steering Committee adopted the following definitions to set the organizational context:

Diversity is simply all the ways we are unique and different from others. Dimensions of diversity include, but are not limited to, such aspects as race, religion and spiritual beliefs, cultural orientation, color, physical appearance, gender, sexual orientation, physical and mental ability, education, age, ancestry, place of origin, marital status, family status, socioeconomic situation, profession, language, health status, geographic location, group history, upbringing and life experiences (Agger-Gupta, 1987).

Cultural Competency is the ability of individuals and systems to respond respectfully and effectively to people of all cultures, backgrounds, races, ethnic backgrounds and religions in a manner that recognizes, affirms and values the cultural differences and similarities and the worth of individuals, families, and communities and protects and preserves the dignity of each. (Cross Cultural Health Care Program, 2002).

Culturally Competent Organization “...holds cultural diversity and equitable services in high regard. It continually self-assesses its structures, policies and procedures, adapts to a variety of service models and engages culturally diverse people in all aspects of the organization” (Ngo, 2000).

(More detailed information on the *External Consultation* and *Blueprint* documents can be obtained from the Manager of the Healthy Diverse Populations in Calgary).



3.0 UNDERSTANDING CULTURE



“If you want one year of prosperity, grow grain. If you want ten years of prosperity, grow trees. If you want one hundred years of prosperity, grow people.”

Chinese Proverb





Importance of Culture in Health Care

As immigration continues to increase in Canada, the identity of this country is being enriched by the influence of many cultures.

Culture is defined as patterns of learned behaviours and values that are shared among members of a group, are transmitted to group members over time, and distinguish the members of one group from another. Culture can include: ethnicity, language, religion or spiritual beliefs, race, gender, socioeconomic class, age, sexual orientation, geographic origin, group history, education and upbringing, and life experiences. (Agger-Gupta, 1997).

The concept of *culture* is not reserved for immigrants and refugees. All individuals, regardless of ethnic, religious and political backgrounds, possess unique cultural attributes. With regards to health care, newcomers are unique in that their cultural background may have a significant impact on accessing the established health care systems and while there are many factors that determine the health of an individual, **culture** is perhaps the most important. It is suggested that cultural belief patterns

related to health and health seeking behavior influence individuals' approach to health care and subsequently the appropriateness of the services received (Spector, 1991). Health Canada (1999) reports culture among twelve factors to be a key determinant of health. The following factors have been found to affect ethno-cultural communities when investigating determinants of health:

- ▶ Income and Social Status
- ▶ Social Support Networks
- ▶ Education and Literacy
- ▶ Employment/Working Conditions
- ▶ Social Environments
- ▶ Physical Environments
- ▶ Personal Health Practices and Coping
- ▶ Skills
- ▶ Healthy Child Development
- ▶ Biology and Genetic Endowment
- ▶ Health Services
- ▶ Gender
- ▶ Culture

Cultural Summaries

This section of the resource kit is designed to provide descriptive information on the values, child-rearing practices, beliefs, etc. of some of the more prevalent ethno-cultural communities in Calgary. The cross-cultural profiles developed by the Peter Lougheed Multicultural Awareness Project (2000) is included as a reference for specific information on various ethnocultural groups. As the trends and patterns of immigration continue to change, it is important that health care professionals have an understanding of practices in the ethno-cultural communities that are accessing health care services within Calgary.

Also included in this section is information on the Cultural Profiles Project, created

by the Anti-Racism Multiculturalism and Native Issues (AMNI) team at the University of Toronto. Health care practitioners are encouraged to use this resource as a means of enhancing their degree of cultural sensitivity and competency, in order to facilitate the task of working with individuals from diverse communities.

Please refer to this information as a guide in your practice, remembering to approach patients and families as individuals. As cultural trends continue to change, health providers and associated teams are encouraged to develop their own cultural profiles as a guideline for practice on cultural communities which they most frequently serve, as well as to review current literature on an ongoing basis to inform their practice.





Cambodians

Culture

Family Structure

- ▶ The family is the primary social and economic unit in traditional culture.
- ▶ Extended family acts as a financial and emotional support network.
- ▶ *Traditional role of women:* subordinate, responsible for child-rearing, household duties, and often managing family finances. Women usually not employed outside the home in South East Asia, but many were forced to support the family when men died in the war or were involved in military.
- ▶ *The husband:* head of the household, decision- maker and breadwinner.

Acculturation Issues

- ▶ Many Cambodian families struggle with settlement issues as they may have had only 2 years or less of formal education.
- ▶ The dramatic contrast between Canadian and Cambodian society magnifies intergenerational issues, socioeconomic and literacy issues, lack of health prevention, and access to health care.

Cross-Cultural Interactions

- ▶ It is very disrespectful to touch the head or shoulder of another person in casual contact, especially if he or she is

older. The head is believed to house the soul. It is best to minimize direct eye contact, thus showing a sign of respect.

- ▶ It is impolite to disagree; he/she may verbally agree but not follow through. Use soft tone of voice.

Marriage

- ▶ Concern regarding prospective husband's character, family background and social status.
- ▶ Dating is rare; often couples will meet in the form of group activities.
- ▶ Non-acceptance of premarital sex; a pregnant unwed girl results in family shame.

Religion

- ▶ Cambodians are predominantly Buddhist, but some have converted to Christianity.
- ▶ Host several celebrations during the year with Cambodian New Year (Apr. 12-13) being a major event.
- ▶ Monks are highly respected, supported by the community, and are not to be within close distance of females or to touch them.

Children

- ▶ Most families will quickly access

medical care for their children because it is highly available and inexpensive.

The Elderly

- ▶ As elders are highly respected, it is traditionally common for their children to provide care for them, especially women.
- ▶ Older men are involved in making important decisions/providing advice for family.

Food and Diet

- ▶ Rice is the primary food for Cambodians, along with fish, poultry, beef, pork, vegetables, and fruit. Most families do not use milk/milk products in their diets.

Literacy

- ▶ Many are not literate in Khmer or English as they often have less than 2 years formal education, and lived in rural areas.

Census Data

- ▶ In 2003 11.5% of new immigrants to Calgary cited South East Asia as their place of birth.
- ▶ About 900 immigrants from Cambodia reside in Calgary.
- ▶ Between 2001 to 2006, 7,810 of the immigrants arriving in Calgary were born in South East Asia.

History, Beliefs & Health Practices

Immigration History

- ▶ Arrived primarily after 1975 during Pol Pot Regime and policy of annihilation of educated or influential individuals/families. Many faced war, trauma, hardship, grief/loss, and torture.
- ▶ Documentation such as consent forms might provoke anxiety, as they were used in Cambodia before execution.
- ▶ Languages spoken may include Khmer (Cambodian), French and Chinese.

Traditional Health Practices and Beliefs

- ▶ Self-medication and traditional remedies common.
- ▶ Coin rubbing: traditional practice whereby the area of the body is rubbed with metal object such as a coin or spoon until the skin becomes red. Sometimes an ointment such as Tiger Balm is used.

Prevalent Diseases

- ▶ Tuberculosis, intestinal parasites, anemia, hepatitis B, and dental problems.
- ▶ Recently arrived Cambodians often experience poor health because of the severe deprivation.
- ▶ The lack of food, shelter and medical care has each had an impact. Lactose intolerance is common.

Health Care Systems

- ▶ Families had access to little or no formalized health care and preventative health services.
- ▶ Many Cambodians in Canada previously spent time in refugee camps – undernourished.

Treatment and Medication

- ▶ Strong belief in the effectiveness of injections versus other treatments.
- ▶ Some fear blood tests, believing that the loss of blood causes dizziness, fatigue or worsens illness; reassurance may be needed.
- ▶ Invasive procedures including surgery and post mortems, are not as acceptable, thus needing careful explanation.
- ▶ Often first try traditional medicines and treatments or use them in combination with other medicines.

Hospitalization

- ▶ Family involvement extremely important. The entire family is often expected to visit each day. In Cambodia, a relative is able to remain with the patient and helps to provide care. Visitors often bring food to the patients to substitute for hospital food.
- ▶ Cambodians in Canada may expect a doctor to visit two times per day, and may feel that less contact is indicative of a lack of concern.

- ▶ Family feels the patient should not be left alone, and the patient may use a passive role.

Death and Dying

- ▶ Prefer for the individual to die at home, but are also comfortable with death in the hospital.
- ▶ Serious or terminal illness should be discussed with the family first, and allow them to discuss it with the ill family member.
- ▶ Funeral is often by cremation, but ethnic Chinese may bury their deceased. Families prefer to have their family member die at home. Following death, a 3-day festive wake is held and family and friends visit. The cremation takes place at the temple following the wake.

Patient-Professional Relationship

- ▶ Typically in Cambodian cultures, the patient is expected to be more passive and dependent.
- ▶ Health professional is viewed as the authority, expected to diagnose and offer a quick treatment/cure. Doctors are highly respected.
- ▶ It is not viewed to be culturally acceptable for a health professional to imply that nothing is seriously wrong or that time will heal. Address the concern, or a physician may be seen as uncaring and unhelpful.
- ▶ Women most likely would prefer

female physicians, especially for obstetrics and gynecology. They may otherwise be reluctant to discuss complaints and access regular checkups. Individuals are reluctant to seek early medical attention, unless seriously ill. This may be a result of language difficulties and discomfort regarding cross-cultural differences.

Mental Health

- ▶ Highly stigmatized, and a family experiences shame when one member has mental health problems.
- ▶ Mental illness is often feared or avoided.
- ▶ As emotional weakness is unacceptable, more often, somatic complaints may be used to express psychological and emotional distress including headaches, insomnia, aches and pains, fatigue and dizziness, and individuals generally expect to receive medication.

Family Planning

- ▶ The preferred methods of contraception are birth control pills and the IUD. In refugee camps, women often had injections of Depo-Provera and may request it.

Childbirth

- ▶ In rural areas, a midwife often stays 3-4 days with a mother and newborn.
- ▶ Hospital births-usually a female family member stays with her. Traditionally the father does not participate in the

birth, but he may wish to participate in Canada.

- ▶ General fear of invasive procedures such as Cesarean section and episiotomy; thus is most helpful to have these carefully explained.
- ▶ Circumcision is not often chosen.

Post Partum Care

- ▶ Based on the principles of yin and yang, which considers internal balance, women are to keep warm after childbirth.
- ▶ Women may perceive the hospital to be cold, and a woman usually covers her head. The traditional belief is that after having a baby, women should not shower or cut their hair for the first month. In Cambodia a woman washes in a medicinal mixture of warm water and a special wine.
- ▶ During the post-partum period some Cambodian women may avoid beef, chicken and raw vegetables.

Culturally Sensitive Health Care

- ▶ A polite and formal approach is most effective.
- ▶ Many experience Post-Traumatic Stress as a result of violence and living in refugee camps. In addition, Cambodians will present with many significant health concerns and/or somatic complaints.
- ▶ Avoid using many abstract concepts and difficult terminology (non-translatable).

Central & South Americans

Culture

Family Structure

- ▶ Large families are accepted and promoted.
- ▶ Independent households with strong family ties on both sides.
- ▶ Husband is head of the family, but important decisions like those regarding health care, will involve consultation with the larger family.

Acculturation Issues

- ▶ Traditional family roles: women as family caregiver, husband/father as decision maker and provider. This is challenged in Canada as women integrate into the work place, and may be threatening to the husband/father.
- ▶ Increased incidence of depression and/or substance abuse among men. Sometimes men may prevent their wives from various opportunities like learning English, or they may become abusive.
- ▶ Youth and children are perceived as being out of control as they acculturate quickly with their peers and adopt new values and behaviors. It is important to normalize teen behaviours where appropriate.
- ▶ Like many immigrant communities, individuals may come to Canada with professional skills and experience



unemployment or underemployment due to language barriers, recognition of credentials, and lack of Canadian experience.

Cross-Cultural Interactions

- ▶ It is acceptable to shake hands and to touch the patient for support/comfort.
- ▶ It is most appropriate to first use more formal titles when addressing the patient (Mr., Miss, etc).
- ▶ Open and accepting of physical warmth and closeness between opposite sex and friends. family of the same sex.
- ▶ They may feel uncomfortable making immediate eye contact with strangers.

Marriage

- ▶ Often couples marry at a younger age: women may be 16-19 years of age, while men are more likely to be in their early 20s.

Religion

- ▶ Most families are Catholic, but some may be affiliated with Pentecostal or Mormon religions.

Children

- ▶ Both boys and girls are happily

received, but expectations for children are gender-based.

- ▶ Sometimes women wish to give a newborn the father's name as they feel it places financial responsibility on the father; they require information about Canadian practices.
- ▶ Women may be in Canada with one or more children remaining in Central/ South America.
- ▶ Parents feel they should determine what is best for their children.

The Elderly

- ▶ There are no homes for the elderly in Central America as younger generations are expected to care for older members. A family not providing such care is shamed.
- ▶ Great respect is given to elders.
- ▶ Women generally care for the sick.

Food and Diet

- ▶ A very social part of their lives, food is usually accompanied by fruit juice, involves few vegetables, and uses various meats.
- ▶ Prefer hot or warm drinks in the morning and may prefer warm bland foods when ill.
- ▶ Food preferences vary by region and may include tortillas, bread, rice, beans, soups, tamales, and other ethnic dishes. Raw fruits and vegetables are often

thought to cause illness.

- ▶ With respect to children, it is helpful to promote healthy nutrition, as some families prefer fast foods high in fat content, and it is culturally acceptable to provide such things as coffee to young children.

Literacy

- ▶ Literacy levels vary depending on socioeconomic background.
- ▶ Silence may represent misunderstanding or insecurity about disagreement.

Census Information

- ▶ 8,605 Calgarians in the 2001 Census identified themselves as Latin Americans.

History, Beliefs & Health Practices

Immigration History

- ▶ May have experienced trauma, violence, torture, grief/loss and limited access to health care in their country of origin.
- ▶ Literacy levels may be lower among refugees and those who previously lived in rural areas.
- ▶ Documentation and assessments are sometimes of concern for refugees in health care systems for fear of reports being made to government and affecting their status in Canada. Parameters of confidentiality should be

clearly explained.

- ▶ Languages spoken may include Spanish and Portuguese.

Political Violence and Torture

- ▶ Physicians often view evidence of torture and brutality among refugee patients. It is not necessarily best to confront the patient, even with sincere intentions, as it may cause distress.
- ▶ The painful experience is much more in-depth, and a lengthy period of perhaps 2 or 3 years may be needed before professional and patient develops the necessary degree of trust. However, it may be helpful to provide information regarding accessing support for such issues.

Traditional Health Practices and Beliefs

- ▶ View ill health as an imbalance relating to hot/cold & strong/weak, or may be aggravated by strong emotions. Treatment of a hot condition (i.e. fever) with a “hot” medicine (some antibiotics) will be seen as counterproductive.
- ▶ Sometimes menstruating women will not bathe or wash their hair, as they believe it will stop menstrual flow.
- ▶ External influences are believed to have an effect such as curses, spirits, “bad wind”, or other forces. These beliefs

are more common among those with a lower socioeconomic background.

- ▶ Taboo topics: sexuality not openly discussed, especially with the opposite sex. It may not be seen as culturally appropriate for a male physician to be alone with a female patient.
- ▶ Believe that people with fevers should not get wet.

Prevalent Disease

- ▶ Serious diseases are not common because they were screened before applying to immigration.
- ▶ Evidence of torture, such as broken legs or cigarette burns is not unusual among Central Americans.
- ▶ Parasites and worms are chronic problems as a result of prior health conditions.
- ▶ Sometimes tuberculosis is observed, but most often inactive cases are found on x-rays.
- ▶ Malnourishment can also be an ongoing problem and is linked to low income of refugee claimants and poor conditions.

Health Care Systems

- ▶ Health care available depends greatly on location and family income. Rural with low income – access to few Western-style medical personnel and facilities. Cities often have modern hospitals and treatment facilities.

- ▶ While some countries offer public health care, its coverage is not extensive and may only include basic immunization and emergency care.

Medication and Treatment

- ▶ Some Latin Americans are used to various medicines being available over the counter (e.g. Penicillin).
- ▶ Often will pursue traditional remedies before using bio-medicines.

Hospitalization

- ▶ Some Central Americans may perceive hospitalization to be associated with death rather than recovery.
- ▶ Often model hospital patients. May assume passive role. Family members may also be used to being involved in the care of patients.
- ▶ Patients with fever may resist bathing due to the belief that it is related to the illness.
- ▶ Tests are not often done unless for complicated problems.

Death and Dying

- ▶ Important to consult a family member regarding the illness of the patient – they may recommend that family tell the patient or that health service providers inform the patient.
- ▶ Sometimes consulting the father or eldest male is most appropriate.
- ▶ Traditionally, family look after a dying

relative.

- ▶ If a condition is stable, the person will be taken home from the hospital to die.
- ▶ In urban areas, after a death occurs the body is taken to a funeral chapel for burial preparation. A wake for family, close friends and sometimes a priest is organized, usually in the presence of the open casket and people generally stay up all night with the body.
- ▶ It is seen to be very important for the family to have the time together with the deceased. Burial is the norm.
- ▶ A stillborn baby of religious parents will be baptized and given a burial service. Autopsies are not well accepted, but organ donation may be acceptable.

Patient – Professional Relationships

- ▶ Patients defer to and respect positions of authority, including doctors.
- ▶ It is not appropriate to call a professional by his/her first name, as it is perceived to be patronizing.
- ▶ It is very important for health professionals to promote awareness of the health services and system, as it may be very new and complex.
- ▶ Patients believe successful recovery is related to treatments including shots, tablets or creams, and ask confidence in the physician when a prescription is not provided.
- ▶ It is often customary for a female relative to accompany a woman

when she sees her male doctor, as such a relationship may be seen as inappropriate or cause jealousy for the husband.

- ▶ A female physician may be preferred for women, but presence of a female nurse in the room may also increase the woman's comfort.
- ▶ Usually visit a doctor when they have a concern, even though many of the problems appear minor to Canadian health professionals.
- ▶ Latin cultures often believe that physicians assist in overall well-being in addition to treating medical problems, and it is important to listen and develop rapport.

Mental Health

- ▶ Other than pregnancy and childbirth, mental health issues and related physical symptoms are the primary reason for Central Americans accessing the Canadian health system. Depression, forgetfulness and withdrawal are frequently reported.
- ▶ Abnormal behavior may be linked to significant life events or sometimes to the supernatural.
- ▶ For chronic/serious mental illness in Central America, people are institutionalized with the expectation that they will never recover or be discharged.
- ▶ If the patient is male, family stress levels may be higher due to social

expectations and lack of financial support to the family.

Family Planning

- ▶ Open discussion not common.
- ▶ Sometimes women will consult a physician regarding contraception. Many women, especially depending on background and class, do not know information regarding fertility and reproduction.
- ▶ The pill is widely accepted, and the IUD may be used, but diaphragms are unpopular. Withdrawal is probably the most commonly practiced method.
- ▶ In the event of unwanted pregnancy, about 50% of women choose abortion.

Pregnancy

- ▶ Prenatal classes are generally non-existent in Central & South America, but many women respond very positively to participating in classes in Canada.
- ▶ Pregnant women are often given much attention, are encouraged to eat well and rest.

Childbirth

- ▶ Mother of laboring woman may wish to be present.
- ▶ Fathers are not normally involved in delivery in Central America, but may be willing to participate here in a passive role, with encouragement.

- ▶ Belief: newborn babies should have their waists tied with a belly band or they have a coin placed on the umbilicus to prevent a hernia; while it may seem unnecessary, it brings comfort to the new parents.
- ▶ Infant sons are not circumcised. Baby girls often have their ears pierced after 2 or 3 months.
- ▶ Women are familiar with Cesarean sections and generally accept procedures the doctor feels are best to deliver a healthy baby. Women will tolerate considerable pain before asking for an anesthetic; it is helpful to advise them of their options.

Post Partum Care

- ▶ Bathing considered risky because of its potential for chilling the new mother.
- ▶ She may feel it is necessary to wear a special girdle to help the uterus to return to its original size.
- ▶ Sick infants cause great concern, and any physical deformity on the baby may

be attributed to the mother's behavior during pregnancy such as attempted abortion, excessive emotion, or an unsatisfied food craving.

- ▶ It is believed that new mothers should avoid cold foods and drinks as the mother is thought to be in a cold state. Certain foods and herbal teas/baths are thought to return mother's strength.
- ▶ Bottle-feeding and disposable diapers are favoured, as these are believed to be a sign of financial security and westernization; women have been led to believe that infant formula is better for the baby's growth.

Culturally Sensitive Health Care

- ▶ Families may have had traumatic experiences in their country of origin and may have been victims or witnesses of violence.

It is important to consider that there is often suspicion of government authority, making consent issues challenging. It is necessary to be sensitive to the refugee experience.



Chinese

Culture

Family Structure

- ▶ Often large, extended, lives together, and is headed by the eldest working male.
- ▶ Elderly are highly respected and the young are obliged to take care of them.
- ▶ Male head of family: works, takes care of finances and usually disciplines the children, primary family decisions.
- ▶ Wife runs the household and cares for the children, and is usually responsible for routine health decisions. Decides on the choice of birth control, in consultation with her husband.
- ▶ Serious decision-making may involve husband, wife and extended family.

Acculturation Issues

- ▶ Acculturation of Chinese families in Canada often depends on their level of education, and region of origin. A family from rural mainland China will likely experience greater barriers than an entrepreneur from Hong Kong.
- ▶ Intergenerational issues are common as youth acculturate and parents wish to maintain traditional cultural values.
- ▶ “Satellite families” are not uncommon where one parent, usually the father, returns to the country of origin for employment purposes. This will affect the involvement of family in supportive

and decision-making roles.

Cross-Cultural Interactions

- ▶ Greet one another by bowing heads and smiling. It is most polite to use Mr. & Mrs. particularly with older patients.
- ▶ Indirect eye contact may be a sign of respect.
- ▶ Out of respect, patients may nod, and not ask questions. It is important to clarify understanding.
- ▶ Privacy is highly valued as it is important for families to “save face” to maintain respect.
- ▶ Body contact beyond a handshake, for example kissing and hugging, is uncommon.
- ▶ May not be familiar with the need to make appointments with health professionals.

Religion

- ▶ Many Chinese are Buddhists, but Catholic and Protestant religions are also common.

Children

- ▶ Traditionally, the male child is considered most desirable – carries the family name and is entitled to family inheritance.

- ▶ Children are valued and generally are the focus of family attention in their early years.
- ▶ Parenting and early education traditionally take place within the home. Chinese families highly value the education of their children.

The Elderly

- ▶ Traditional responsibility for care of the elderly lies with the family and the oldest son and his wife; otherwise unmarried children have the greatest obligation.

Food and Diet

- ▶ Lactose intolerant and dislike milk.
- ▶ Rice and noodles are common foods. Cooked vegetables are common as well as poultry and fish.
- ▶ Many hot liquids consumed, especially tea, when sick. Cold water believed to shock the system.
- ▶ Believe that hot and cold foods should not be eaten at various periods depending upon the illness, so as to maintain balance in the body (Yin and Yang)

Literacy

- ▶ The elderly are less likely to be literate in either Chinese or English.
- ▶ Families from rural areas or lower socioeconomic backgrounds may not be literate in Chinese.

- ▶ Avoid using male interpreter for an older female patient due to modesty issues.

Census Information

- ▶ Mainland China and Hong Kong were among the top ten source countries for immigrants arriving to Calgary in 2002, accounting for 12.5% of immigration.
- ▶ 51,855 Calgarians in the 2001 Census identified themselves as part of the Chinese community.
- ▶ 13,195 of new immigrants to Calgary between 2001 and 2006 came from East Asia.

History, Beliefs & Health Practices

Immigrant History

- ▶ As many families immigrated as early as 60 years ago, several practice Western medicine.
- ▶ Currently, most Chinese speaking families are arriving from Hong Kong, mainland China, & Taiwan. Mandarin and Cantonese are the most common dialects spoken.

Traditional Health Practices and Beliefs

- ▶ Beliefs based on Chinese medicine: 3 distinct types: classical Chinese medicine, Chinese folk medicine and medicine in contemporary China.
- ▶ Various parts of the human body correspond to the principles of Yin

and Yang. Yang is the positive male energy that produces light, warmth and fullness. Yin is the negative female energy, the force of darkness, coldness and emptiness.

- ▶ Illness viewed as a loss of balance in yin and yang or in hot and cold foods.
- ▶ Causes of illness may include foods that are excessively hot/cold, or those believed to be 'poisonous.'
- ▶ Illness is linked to presenting symptoms and the goal is to then get rid of the symptoms,
- ▶ Difficulty understanding the implications of chronic illnesses where symptoms persist for a long time and there is no absolute cure.

Health Care Systems

- ▶ Treatment often includes herbal medicine, acupuncture, acupressure, moxibustion (the burning of small quantities of dried herbs on the body) and chiropractic care. Two types of hospitals: expensive private hospitals and government hospitals used by those who are not wealthy.

Medication and Treatment

- ▶ Chinese want immediate results from medications. May question prolonged Western treatment regimes and may prematurely discontinue taking an antibiotic prescribed for two weeks without immediate results. There is a need for explanation of the importance

of follow-up.

- ▶ Injections regarded as more effective than pills. Pills considered more effective than drops.
- ▶ They may refuse blood tests as they believe loss of blood will weaken their bodies and that these tests are too invasive.
- ▶ Value the wholeness of the body and thus may avoid surgery because it is seen as a form of mutilation; surgery is resorted to only if all other treatments fail.

Hospitalization

- ▶ Elderly often associate hospitalization with death, & may prove reluctant hospital patients.
- ▶ Family members may rush an elderly parent to hospital thinking that he or she may receive better treatment for the illness.
- ▶ Death of a person at home is considered to bring bad luck.
- ▶ A patient may not complain of pain, so it is important to offer pain medication.
- ▶ Common for many guests to visit a patient and bring food and gifts.
- ▶ Sick role is common for the Chinese patient – behaves passively and expects others to care for him/her.
- ▶ Some are fearful of having blood drawn, as they believe it will weaken the body, and they may be inclined to avoid surgery.

Death and Dying

- ▶ Death is viewed as natural and inevitable.
- ▶ Families often prefer that health professionals do not reveal the prognosis to dying patients so their last days should be free of worry and pain.
- ▶ Family wishes to be present when addressing serious or terminal illness. Ensure involvement of the male head of household.
- ▶ Family members may refuse postmortems as they are viewed to be unnecessarily invasive.
- ▶ Family members, relatives and friends gather to mourn the deceased. Pregnant women are often not allowed to attend funerals for fear of harming their health.
- ▶ Relatives of the deceased may not wish to visit others for a certain period for fear of bad luck.

Patient – Professional Relationship

- ▶ In China patients usually request their preferred treatments from their doctors. These same patients may appear aggressive in Canada when they use this approach.
- ▶ The concept of preventive medicine may be unfamiliar to some that only will seek help when they feel ill, and thus impacts annual check-ups and the continual monitoring of health.
- ▶ Health professionals in Canada

must ensure that patients adequately understand the diagnosis, treatment, and medical procedures, as they may be hesitant to ask questions.

Mental Health

- ▶ Explain the causes of mental illness in terms of external factors or events; problem presented in the form of somatic complaints.
- ▶ Pre-migratory trauma and stress, separation from family and community, unemployment, underemployment, and language barriers are considered additional risk factors. Youth and mothers with absent parents/spouses also have elevated rates of mental health issues.
- ▶ Traditionally, different emotions are perceived to be related to different organs. For example, anger is associated with the liver, and joy and depression with the heart. Clients may seek relief of physical symptoms but not discuss mental health problems.
- ▶ Mental health issues such as depression are considered shameful and are not discussed.
- ▶ Family members have a great influence on how mental health is viewed. Overprotectiveness is common. May refuse treatment because they view mental illness as bringing shame on the family.
- ▶ Talk therapy is often less effective in contrast with a concrete solution-focused intervention.

Family Planning

- ▶ Traditional Chinese prefer large families.
- ▶ Male children especially the first born are highly valued because the family name is assured.
- ▶ Intrauterine devices and birth control pills are commonly used.

Pregnancy

- ▶ Women may avoid hot foods or 'poisonous' foods such as shellfish during pregnancy.
- ▶ Chinese mothers may avoid cold and try to eat more hot foods, sweet vinegar, chicken, eggs, and certain types of herbs in an attempt to balance yin and yang.

Childbirth

- ▶ A woman may be more stoic during labor, though it is acceptable to demonstrate pain by moaning. Usually female family members are involved, with fathers not often playing an active role.

Post Partum Period

- ▶ Postpartum period considered dangerous, as the woman is susceptible to excessive coldness.
- ▶ Must avoid cold foods and cold winds, and stay inside – a practice called 'sitting for a month'.
- ▶ The current trend in mainland China is

to breastfeed; immigrants from Hong Kong may prefer to bottle-feed, but some women feel it is not healthy for the baby to breastfeed during the first 3 days after birth.

- ▶ Cold water is avoided by not bathing or washing hair for one month, and heavy lifting is avoided to protect the uterus. Sponge baths acceptable.
- ▶ Any problems with the baby should be addressed with the male head of the household.
- ▶ Male circumcision is quite common.
- ▶ Infants may be bathed very frequently, as cleanliness is highly valued.

Rehabilitation

- ▶ Rehabilitation services for family members who are physically/mentally handicapped may be avoided as they are thought to be painful.

Delivering Culturally Sensitive Health Care

- ▶ May seldom ask questions and thus need encouragement to express concerns.
- ▶ Professionals should also be cognizant of the somatic ways in which clients portray illness or the way they blame illness on external causes.
- ▶ Approaching the head of the family should be considered in order to respect family structure and decision-making.



Filipinos

Culture

Family Structure

- ▶ Family oriented with both extended and nuclear family. Sometimes 3 generations live in one home.
- ▶ Father, or eldest son/daughter is the family spokesperson, but the whole family usually makes decisions.
- ▶ Men are expected to make decisions or arrangements regarding patient transfer, long-term care, or burial arrangements, while women are the main caregivers at the bedside.

Acculturation Issues

- ▶ May experience a number of intergenerational issues as youth are raised as bicultural in the Canadian context and families may wish to preserve traditional beliefs and practices.

Cross-Cultural Interactions

- ▶ Often shy yet affectionate
- ▶ Respectful to elders and figures of authority.
- ▶ Direct eye contact not often used, especially when interacting with authority figures or elders.

- ▶ Polite, and will not likely openly disagree. Be aware of the use of silence; it does not necessarily mean agreement.
- ▶ Handshakes are commonly used.
- ▶ Filipinos smile a great amount, and often use animated facial expressions.
- ▶ Elderly are greeted with a kiss to the hand, forehead or cheeks.
- ▶ Tone of voice is changed to show emotion and may be loud when agitated or nervous.
- ▶ Feel strongly about being shamed or losing face.
- ▶ Religion
- ▶ Predominantly Catholic and like to use medallions, rosary beads, or religious figures.
- ▶ Some are Protestants or Muslims.

Children

- ▶ Highly protective environment for children.
- ▶ Parenting style may offer warnings (frightening or shaming) regarding misconduct.
- ▶ Taught to be quiet, avoid confrontations, be obedient and respectful.
- ▶ Strong emphasis on education.

The Elderly

- ▶ Respect given, softer tone of voice used.
- ▶ Care provided by family to elderly. Often feel that placement in a nursing home is disrespectful.

Food and Diet

- ▶ Prefer soft warm foods when ill.
- ▶ Do not like cold or iced drinks.
- ▶ Usually diet includes rice, fish, meats and vegetables. Enjoy fried foods and those with flavor; enjoy sauces and broth with food.
- ▶ Drink a good deal of room temperature water.
- ▶ Some are lactose intolerant.
- ▶ Often abstain from meat on Fridays, especially during Lent.
- ▶ Do not like cold or acidic foods in the morning, including fruit and fruit juices.

Literacy

- ▶ Most Filipinos speak and understand English. Some individuals with less education may need assistance reading/writing English.
- ▶ It may be best to use family members in interpretation for sensitive issues including sex, diagnosis/prognosis and socioeconomic status.

Census Data

- ▶ 16,380 Calgarians identified themselves as belonging to the Filipino community in 2001.
- ▶ There are 18,710 immigrants from the Philippines living in Calgary in 2006.

History, Beliefs & Health Practices

Immigration History

- ▶ Most Filipinos in Calgary have been in Canada for a longer period of time (i.e. over 10 years)
- ▶ The national language spoken is Filipino (Pilipino – spelling in the Philippines) also known as Tagalog. There are 85 major languages and dialects spoken including Ilocano, Cebuano, Bicolano, Pampango, and Chabacano. English is very common and is used in schools, media and business.

Traditional Health Practices and Beliefs

- ▶ Belief in fate, where one must accept what life and death bring.
- ▶ Illness is a result of an imbalance in the body. Some feel illness results from bad behavior or punishment. Health promotion is linked with maintaining balance and keeping warm.
- ▶ Believe in and practice both traditional medicine and Western medicine.
- ▶ Eating well (not necessarily a balanced diet) is linked with good health. Being overweight is not seen as unhealthy but represents prosperity and happiness.
- ▶ Exercise not considered a regular activity.

Treatment and Medication

- ▶ Because of Chinese influence, some families use herbal medicines before

seeking medical attention.

- ▶ It is important to emphasize the need to follow a medication schedule, as the perception of time may be less strict.
- ▶ Fear of becoming addicted to narcotics and may not like to take medications.

Hospitalization

- ▶ In hospital, Filipinos often rely on biomedicine.
- ▶ Often will not seek medical attention until it is advanced with severe pain.
- ▶ Procedures and consents must be explained clearly. It is helpful to elicit feedback, or the patient may not voice concerns.
- ▶ Value cleanliness and therefore may wish to shower daily. Also prefer using the bathroom for reasons of privacy and cleanliness.
- ▶ May have high pain threshold or may be stoic when experiencing pain.
- ▶ Female family members provide support and may inhibit self-care or ambulatory activities. May wish to remain at the patient's bedside at all times.
- ▶ The entire family may come to visit.
- ▶ It is often very important for the patient to see the chaplain/priest.
- ▶ Family will often provide food from home.

Death and Dying

- ▶ Diagnosis should not be explained to

the patient without family consultation, or discussion with the oldest son or daughter.

- ▶ Patient's family may wish to disclose the prognosis, but may wish to have a health professional present.
- ▶ Notify chaplain for patient to receive the Sacrament of the Sick. Resuscitation is a difficult choice often made by the family.
- ▶ May request that religious symbols or figures are kept near the patient and family may pray at the bedside.
- ▶ Family may cry loudly or uncontrollably.
- ▶ Death is given very high regard. Family members may wish to wash the body and for all family members to say goodbye before the body is moved to the morgue.
- ▶ Cremation is not common, and the family may refuse organ donation or autopsy.

Patient-Professional Relationship

- ▶ Respect given to health professionals.
- ▶ May need to emphasize the importance of keeping appointments and being on time.
- ▶ Should consider modesty issues with screening.
- ▶ Most patients willing to share medical history and important related information.

Mental Health

- ▶ Occurs if there is a disruption of harmony between the individual and the spiritual world. May feel that contact with another life force, soul, or environmental factor can cause mental illness. Others believe that physical or emotional strain, sexual frustration, or genetically inherited conditions are responsible for mental illness.
- ▶ Traditional healers are seen to help with placating or exorcising spiritual influences.
- ▶ Feel shame when experiencing mental health issues such as depression.

Pregnancy

- ▶ Prenatal care is expected.
- ▶ Family gives much attention to the pregnant woman, who is not generally allowed to continue working.
- ▶ Sexual intercourse is taboo in the last 2 months of pregnancy.
- ▶ Near delivery, woman is encouraged to eat fresh eggs and slippery foods to help the baby slip out during delivery.

Childbirth

- ▶ Believe that making noise or movement will increase labor pain.
- ▶ Fathers will not usually participate. A female family member who is a mother is preferred as the labor coach.
- ▶ Vaginal delivery preferred.
- ▶ Woman assumes active role in labor

and may give direction to family or caregivers.

- ▶ Some women will moan or grunt as socially acceptable, but others may scream and become hysterical.

Post Partum Care

- ▶ Breastfeeding expected possibly until the child is a toddler. Working mothers may breastfeed and formula feed concurrently.
- ▶ Mother expected to be with baby 24 hrs/day.
- ▶ Mother encouraged to rest and drink nourishing soup. Seafood usually avoided.
- ▶ New mothers discouraged from showering, though sponge baths are acceptable.
- ▶ If there is a problem with the baby, it is recommended that the father and family be consulted first. It is important for the MD to discuss these issues with the mother.
- ▶ Parents may choose to have baby boy circumcised.

Culturally Sensitive Health Care

- ▶ Important to ask about the support of family within the home, which is usually very strong.
- ▶ Modesty issues should be considered and feedback requested in order to ensure patient comfort. Issues regarding sex and poor prognosis are most sensitive.



Koreans

Culture

Family Structure

- ▶ Family is very important, and self-esteem stems from family and its honour/respect within the community. Much life focus on family values: cohesion, interdependence, hierarchy in relations, and harmony.
- ▶ Decision-making historically patriarchal, though there is now more focus on family involvement.
- ▶ Husband, father or eldest adult child usually acts as the family spokesperson. Women often considered caregiver responsible for the home, while most decision-making is by the father.

Acculturation Issues

- ▶ Many families experience intergenerational issues as youth acculturate at a faster rate than their parents, and parents wish to maintain traditional roles and values.

Cross-Cultural Interaction

- ▶ When comfortable with another person, it is acceptable to use touching, friendly pushes, or hugs. Touching is considered disrespectful among

strangers unless for medical purposes.

- ▶ Like within the Vietnamese culture, it is considered rude to direct the sole of a person's foot or shoe towards another individual.
- ▶ Direct eye contact not used unless the person is very comfortable with another.
- ▶ Silence will exist among strangers, while it is less common among those that are familiar with each other.
- ▶ Should use Mr., Mrs., or other pronouns and the last name, unless the patient requests differently.
- ▶ Respect for elders is important and is often demonstrated by slight bow.
- ▶ Tone of voice varies, with loudness placed on what is considered important; it may seem like arguing.
- ▶ Commands are louder and authoritative when directed to someone younger while may be softer and quieter with an elder.
- ▶ Note: January 1 is considered every Korean's birthday, and they add a year to their age on this date regardless of the date they were born.

Marriage

- ▶ Wife traditionally stays within the home after marriage.
- ▶ The husband is expected to hand over all or most of his salary to the wife, who manages the family finances.

Religion

- ▶ Predominantly Christian, though influenced by Shamanism – spirit worship, and Taoism, Buddhism, and Confucianism were originally practiced.
- ▶ Chanting and praying are common, and often people utilize a mixture of faiths.

Children

- ▶ Expected to be obedient and responsible. Focus on family interdependence. Education highly regarded.

The Elderly

- ▶ Have high amount of respect, welcomed to live with the family. Grandparents often involved in care of grandchildren.

Food and Diet

- ▶ Cold fluids may not be consumed as it is felt to be linked with the cold/hot balance of the body.
- ▶ Diet high in fiber and spice with rice, beans, vegetables, seafood, and lean meats. Many meals include soups with meat, vegetables, and noodles. Often lactose intolerant.

Literacy

- ▶ Elder first generation and recent immigrants may not speak English, or

may use limited spoken English.

- ▶ It is important to use family members as interpreters when possible, as the patient is more comfortable. Gender issues are less of an issue in the professional setting.

History, Beliefs & Health Practices

Immigration History

- ▶ Many families have left Korea seeking new opportunities in Canada and arrive as independent class immigrants or entrepreneurs.

Traditional Health Practices and Beliefs

- ▶ Illness and death are accepted as a natural part of the life cycle, but many see illness as bad luck related to something they may have done in the past (Karma).
- ▶ Patients may be stoic as they feel their fate is determined, and thus may experience depression, helplessness, or denial.
- ▶ Illness traditionally believed to be related to an imbalance of hot and cold – Yin and Yang.
- ▶ May practice both Eastern and Western medicines congruently.
- ▶ Holistic concept of health with harmony and balance between soul and physical health, as well as having balance with family, finances and home.

Health Care Systems

- ▶ Koreans usually have access to comprehensive health care and pay premiums.
- ▶ May not be used to obtaining prescriptions from a doctor as pharmacists in Korea can also prescribe medicines.
- ▶ Health system in Korea recognizes both traditional and modern medicine.

Hospitalization

- ▶ Patients may be less familiar with the training, qualifications, and role of nurses in Canada.
- ▶ Older patients may have family members involved in some patient care – often the duty of children.
- ▶ Privacy is a very highly maintained value, and an embarrassed patient will be less likely to disclose information. Establishment of trust assists more difficult or personal assessments.
- ▶ Patients prefer sponge bathing while in hospital and are often very clean.
- ▶ Patient may have a sick role in which they behave very ill, maybe even worse than they actually are. May be more expressive or dramatic regarding their illness when family are present.
- ▶ Patient, and men in particular, may appear stoic when experiencing pain. It may be most useful to ask how bad pain is rather than using a pain scale which may seem less concrete.
- ▶ Family and other visitors will

frequently come to see the patient out of respect.

- ▶ Family may expect to stay with the hospitalized patient, and will bring food/feed the patient.

Treatment and Medications

- ▶ Some view surgery as an illness in itself.
- ▶ Pain medications are not often used for fear of addiction or complications. IV is viewed as less invasive.
- ▶ Herbal therapies are often used, and a traditional herbal medicine doctor may be accessed.

Death and Dying

- ▶ A palliative illness should be discussed first with the head of the family, who will then tell the family.
- ▶ Family likely to prefer that the patient remain in the hospital if it is best for their care.
- ▶ Common for family to mourn or cry loudly, and chanting and praying may take place.
- ▶ Family wishes to spend time with the patient after death; cleansing may or may not be requested. Cremation uncommon; it is seen to destroy the spirit.
- ▶ Organ donation and autopsies are not very acceptable.

Relationship Between Doctor and Patient

- ▶ Much respect for health professionals.

- ▶ Clarity is needed for development of rapport and patient comfort level. May even need to discuss simple procedures with family members.
- ▶ Females may prefer to work with female gynecologist.

Mental Health

- ▶ Mental health issues or depression are viewed as shameful and are not openly revealed. May be hesitant to use anti-depressants.
- ▶ May be believed to be linked with behavior in a previous life, or may be linked to spirits.

Pregnancy

- ▶ Prenatal care is expected, and woman believes in following advice provided.
- ▶ Avoidance of cold soups or liquids, and traditionally, some meats/seafood are avoided as they are believed to harm the baby's appearance.
- ▶ Rest and restriction of activities are promoted.

Childbirth

- ▶ Birthing support may be anyone in the family, and often husbands will participate.
- ▶ Lukewarm water, no ice, will be preferred during labor.
- ▶ Pain control may not be seen as important in case it affects the baby. Vocalization common, though elders may discourage loudness.

Post Partum Care

- ▶ Breastfeeding may or may not be chosen or freezing, storage, and pumping may not be considered.
- ▶ Family focuses on rest for the new mother.
- ▶ Problems with a baby should be discussed with the family spokesperson, like the baby's father. Mother may view a problem as her fault related to her behavior.
- ▶ Parents usually have a male baby circumcised.

Culturally Sensitive Health Care Practice

- ▶ It is important to acknowledge the roles of family members in making health care decisions.
- ▶ Showing much concern and spending time with the patient and family will help develop trust. Health practitioners should be aware that combined use of medical and traditional therapies is common.

Census Information

- ▶ The Republic of Korea was one of the top 10 places of origin for immigrants arriving to Calgary in 2002. 3,885 Calgaryians in the 2001 Census identified themselves as part of the Korean community.



Somalis

Culture

Family Structure

- ▶ Living with extended family is common, and a woman goes to live with her husband's family or clan.

Acculturation Issues

- ▶ Though several Somali families have been living in Calgary for a number of years, many families are experiencing difficulty with settlement issues including housing, employment, education, large family size, and sometimes issues relating to multiple marriages.
- ▶ Families have difficulty affording accommodation to include extended family, which places strain on the family.
- ▶ Often face various acculturation issues linked with intergenerational differences in values and practices.

Cross-Cultural Interactions

- ▶ Men and women do not touch each other in public settings. It is appropriate for members of the same gender to shake hands.

Marriage

- ▶ Married women are to cover their bodies including their hair in traditional dress called hejab.
- ▶ Marriages are sometimes arranged, but also may be based on choice. Common age to marry is 14-15 years of age.
- ▶ It is common for men to have up to 4 wives, if it possible to afford it, and sometimes in urban areas, he will have separate homes with different families.
- ▶ Men are to work while women are to stay home and raise children.
- ▶ Divorce may occur, though the husband must initiate it.

Religion

- ▶ Almost all Somalis are Muslim and believe in one God, Allah. Celebrate Ramadan between December and January (depends on the calendar year), where daytime fasting occurs.

Children

- ▶ Children in Somalia have the same educational opportunities.
- ▶ Anniversaries of one's death are celebrated instead of birthdays.

Food and Diet

- ▶ Large component of rice, vegetables, corn and beans. Region of origin has an influence on diet. Teas and hot beverages common.

Literacy

- ▶ Literacy in first language among women and men is relatively high.

Culturally Sensitive Health Care

- ▶ Respect for cultural beliefs and values, which are linked to the Muslim religion, is paramount in establishing rapport.
- ▶ Somali women will feel most comfortable with female health service providers, and it is helpful to have awareness of their health beliefs and values.

History, Beliefs & Health Practices

Immigration History

- ▶ Somalia consists of one ethnic group with a common language, religion and culture. May speak Somali, Arabic, and/or French. Older Somalis speak either English or Italian due to colonization.
- ▶ Beginning in 1991 people began leaving due to existing hunger, assaults, death and refugee camp conditions.

Traditional Health Practices and Beliefs

- ▶ Illnesses are seen as resulting from angry spirits – the Koran is read, special foods may be eaten, and incense is burned.
- ▶ One person can give another the ‘evil

eye’ by giving praise – for example saying someone is beautiful.

- ▶ Traditional doctors – often male elders, perform herbal remedies, prayer and ‘fire-burning.’ Fire burning involves the burning of a stick from a special tree, which is pressed to the skin.
- ▶ During Ramadan, medicines are often taken only at night. Ill pregnant women and children are exempt.

Prevalent Diseases

- ▶ May have been exposed to TB in refugee camps.

Health Care Systems

- ▶ Most Somalis are familiar with Western medicine, but nurses and doctors are associated with care for the ill, rather than with routine prenatal care and preventative health aspects.
- ▶ Families may expect to go to the emergency department for vomiting, diarrhea, or fever, for antibiotics.

Death and Dying

- ▶ A physician who provides a palliative diagnosis to the patient or family is considered uncaring. It is, however, more acceptable to describe the extreme seriousness of the illness.
- ▶ A section of the Koran is read to the dying individual.
- ▶ Following death, someone from the same gender cleans and perfumes the

body, and places it in white clothing. Prayers are stated.

Census Information

- ▶ Somalia was one of the top ten source countries in 1998 for convention refugees (those supported by the government) arriving to Canada, but this category included less than 25 Somali individuals.

Patient-Professional Relationship

- ▶ Somali women prefer female health care providers.
- ▶ Important to encourage ongoing contact with health care providers for health promotion and prevention.

Mental Health

- ▶ May connect mental health issues with the ‘evil eye’ placed on individuals by others or by spirits.
- ▶ Less familiarity with Western mental health diagnoses and treatment.

Family Planning and Pregnancy

- ▶ Family planning has little relevance.
- ▶ Childbearing begins shortly after marriage, and the more children a woman has enhances her status. Men adopt more than one wife in order to have additional children.
- ▶ Sex during pregnancy is not viewed as acceptable.

Childbirth

- ▶ Strong support network for new mothers.
- ▶ In Somalia, a party before the birth takes place to show support. The birth is usually at home with a midwife.

Post Partum Care

- ▶ Newborns are given warm water baths, sesame oil massage, and herbal treatment for the umbilicus. Baby may wear a bracelet of herbs and string to ward away any evil spiritual influence.
- ▶ A new mother and baby stay for 40 days, while female friends and family visit. After this a party is held and the baby is then named. Sometimes a naming ceremony occurs 2-3 weeks after birth.
- ▶ Diet for mothers involve soups, porridge, and special teas.
- ▶ Health practitioners should be aware that some compliments might be seen as placing an “evil eye” on the baby. It is acceptable to describe the baby as healthy.
- ▶ Incense is burned to protect the baby from ordinary smells believed to make the baby ill.
- ▶ Breastfeeding common until the age of 2 years. Milk may be given to babies and within the first few days after birth, the mother’s milk is considered unhealthy. Women uncomfortable with breast pumps and storing milk.

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- ▶ Circumcision traditionally practiced for both males and females and is seen as a rite of passage in order to become an accepted adult of the community. It is viewed as necessary for marriage, otherwise, the individual is viewed as unclean.
 - ▶ Circumcision takes place between birth and 5 years of age, and for girls it is traditionally performed by female family members or another woman in the community. This remains to be sensitive, and physicians and nurses should maintain open communication with the family.
 - ▶ It is important for nurses and physicians to provide education as to the risks and consequences of female circumcision, and the legal/child protective service aspects of such practices in Canada.



Sudanese

Culture

Background

- ▶ Sudanese people have endured persecution and conflict for many years. These include religious and political oppression, famine, floods, locusts, and civil war. There are 500 tribes and 57 ethnic groups in Sudan. The life expectancy is 42.6 years for men and 43.5 years for women.
- ▶ The official language is Arabic; about half of the population speaks it.
- ▶ There are over 100 other languages spoken, many of them are tribal dialects (Nubia, Ta Bedawie, diverse dialects of Nilotic, Nilo-Hamitic, Sudanic languages, etc.).

Geography

- ▶ Sudan is the largest country in Africa, covering about 2,505,813 square kilometers.
- ▶ It is located in Northeast Africa.

Family Structure

- ▶ Men work outside the home and are the head of the family while women

take care of the home and children.

- ▶ South Sudanese allocate more rights and freedom to their women while in the north, males are dominant.
- ▶ The household consists of extended family members including uncles and cousins; usually three generations of males and their families. They make numerous decisions around one's life, work and marriage.
- ▶ Family members are responsible for the old, the sick, and the mentally ill.
- ▶ The Elderly are respected as authorities on the way of life.
- ▶ A mother's opinion is valued when it comes to family, community affairs, such as marriage, or conflict resolution.
- ▶ Most Sudanese hold strong to traditional values.

Acculturation Issues

- ▶ Different gender roles in Canada have deeply and negatively affected Sudanese women and families. Wives assume two roles, as family caregiver and provider.
- ▶ Some Sudanese who try to adjust to the Canadian laws and culture are faced with conflict with their own culture, identity, and family members.
- ▶ Some Sudanese children, brought here from Sudan or born in Canada, experience different peer pressure from their parents: Families complain that children learn to use drugs, and abuse alcohol. Contrary to Sudanese culture,

the children disrespect their parents and move out of the house before they turn 18 years.

Cross Cultural Interactions

- ▶ Touch: Northern and southern Sudanese differ in their traditional greetings.
- ▶ Northern Sudanese, predominantly Muslim, accept only same sex shaking hands.
- ▶ Southern Sudanese accept verbal greetings and shaking hands between males and females.
- ▶ Eye contact: Direct eye contact is not allowed. Women are not to have direct eye contact with unknown men, or with holy men.

Marriage

- ▶ Arranged marriages are common.
- ▶ Soon after a girl reaches puberty she will become eligible for marriage.
- ▶ In the South, the groom's family is required to pay heads of cattle for dowry (gift from bride to bridegroom's parents before marriage is accepted) to the brides' family.
- ▶ In the North, money is accepted for dowry.
- ▶ While the Northern Sudanese accept marriages between clan members, the Southern Sudanese prefer marriages between different clan members.

Religion

- ▶ Sudan is a multi-religious country. More than 70 percent of the population is Sunni Muslim, lived mostly in the northern and central Sudan, 25 percent indigenous religions, and 5 percent Christian.

Children

- ▶ Male children are often preferred as they carry on the family name.
- ▶ First born males are usually given special attention.

Food and Diet

- ▶ Staple food consists of meat (beef, chicken, goat, and mutton), fish, vegetables, potatoes, fruits, regular bread, and porridge made from sorghum (Aseeda), millet, or wheat.

Education

- ▶ The illiteracy rate is 61 percent. This is due to poverty, overenrolled school systems and the need for children to provide income for the family.
- ▶ In Sudan, classes for the eradication of illiteracy have been introduced to numerous communities.

Culturally Sensitive Health Care

- ▶ It is important for health practitioners to ask families about their beliefs and values.

- ▶ Families from rural areas will be less exposed to such health care systems.

History, Beliefs, and Traditions

Immigration History

- ▶ Most families have left Sudan to escape war, discrimination, or for economic reasons.
- ▶ Sudan has been in a civil war for the past 17 years.
- ▶ The majority of Sudanese in Canada are government sponsored refugees.

Languages

- ▶ English is spoken by most educated Sudanese in the south.

Traditional Health Care Practices

- ▶ Most Sudanese consult traditional healers prior to seeing a doctor.
- ▶ In rural communities a Faki (holy man) is consulted before a doctor about health concerns.
- ▶ Traditional healers are used in numerous rural communities. Traditional healers use such methods as herbal medicine, scarification, and cauterization.
- ▶ In the Muslim community recitation of the Koran coupled with ritual are used to heal the affected area.

Illness Etiologies

- ▶ Illness is usually believed to be caused

by possession by demonic spirits or by someone giving the evil eye.

- ▶ Mental illness is believed to be a result of demonic possession.
- ▶ A Faki (a holy man), or other men known as other sorcerers are brought in to remove the evil eye from the person.

Prevalent Diseases

- ▶ Malaria, Tuberculosis, Leprosy, Cutaneous and Visceral Leishmaniasis, and Schistosomiasis are the major endemic diseases in the country.
- ▶ According to World Health Organization, about 400, 000 people between ages 15-49 are affected by HIV/AIDS.
- ▶ Sickle cell anemia is prevalent among the Messeyria tribes.
- ▶ Cases of heart disease and diabetes are increasing in the North.

Health Care System

- ▶ Medical care varies throughout the different regions of the country.
- ▶ In rural communities health services are limited or non-existent
- ▶ In urban communities modernized medical facilities have a fee-for-service system that is used for those seeking medical care.
- ▶ There are not enough trained professionals, clinics, hospitals, or medicine in Sudan.

Death and Dying

- ▶ Sudanese Muslims consider death as the will of God: Following a death, the body is perfumed and placed in white cloth. Prayers are stated and mourning continues for three to seven days.
- ▶ For non-Muslims and non-Christians, death is seen as the will of a spirit. Burial ceremonies involve many weeks/months of mourning by relatives to pacify the spirits so that another death does not occur.

Census information

- ▶ Due to the political turmoil and war in Sudan, the number of refugees have increased.
- ▶ There are about 7, 500 Sudanese in Calgary and 1, 500 in Brooks (Wek Kuol, Sudanese Leader, 2007).

Mental Health

- ▶ Increasing number of Sudanese experience posttraumatic stress and other psychological disorders.
- ▶ The cause of Mental Illness is believed to be a demonic possession.
- ▶ Individuals with a Mental Illness were confined in solitary inhumane conditions.
- ▶ Individuals who are confined receive only bread and water for nourishment.
- ▶ The individuals are often beaten to remove the demons that are said to possess them.

- ▶ The conditions they live in often lead to health concerns such as scurvy.
- ▶ A traditional treatment in Sudan is a Zar (name of demon) ceremony. It is performed to release a patient from sickness (Mental illness) brought on by evil spirits or Jinni.

Patient-Professional Relationship

- ▶ Doctors are revered; a doctor is referred as Hakeem which is Arabic for “the wise”.
- ▶ A midwife is held in high regard and has influence.
- ▶ Sudanese usually share both over-the-counter medications and prescription drugs with others for similar symptoms.
- ▶ Sudanese are likely to discontinue prescriptions as soon as symptoms appear to reduce rather than finishing the whole treatment.

Family Planning and Pregnancy

- ▶ Women usually eat a specific salty clay during pregnancy. It is believed that the clay will give appetite and reduce nausea associated with pregnancy.
- ▶ It is also a taboo for pregnant women to eat specific food such as snake.
- ▶ Family planning is known, but accessibility to services or methods is limited.
- ▶ In Sudan, family planning services and training are being expanded in health facilities.



Child Birth

- ▶ Traditional birth attendants or village midwives assist with birth at home, because only the wealthy and civil servants have access to hospitals.
- ▶ Most women breastfeed for about two years. They usually eat sorghum porridge and boiled meat soup to increase breast milk.

Post Partum Care

- ▶ A mother is confined to her home for 40 days after birth.
- ▶ A person who has been to a cemetery or seen a dead body is not allowed to visit the new mother and her baby.



West Africans

Culture

- ▶ Although there are many countries in West Africa with diverse cultures, this text focuses on some of the common cultural practices found in the region. It cites Ghana and Nigeria as examples.

Geography

- ▶ West Africa is on the Western part of the Continent of Africa. It includes 16 countries covering an area of about 6, 140, 000 km.
- ▶ The British colonized Gambia, Sierra Leone, Ghana, and Nigeria. France colonized Senegal, Guinea, Mali, Burkina Faso, Cote d'Ivoire, Niger, Togoland, and Guinea-Bissau. Liberia was never colonized.
- ▶ Despite the wide variety of cultures in West Africa, there are generally similarities in traditions, dress, cuisine, music, culture, and language.

Family Structure

- ▶ Family structure of many ethnic groups in West Africa is based on the extended family system.
- ▶ The family structure is based on either a matrilineal or patrilineal system. Nuclear family system is not common.
- ▶ Residential units consist of generations of brothers, sisters, and sisters' children from their mother's side.

- ▶ In most ethnic groups, men are the breadwinners and decision makers while women are homemakers.

Acculturation Issues

- ▶ Most immigrants from Nigeria and Ghana maintain their cultural identity through integration into African communities in Canada, as well as participate in religious worship, social gatherings, and business transactions.
- ▶ Some Nigerian and Ghanaian immigrants in Calgary are civil servants or work in such professions as medicine, law, engineering, computer science, pharmacy, and post-secondary teaching.

Cross-cultural Interactions

- ▶ Acquaintances must shake hands and ask about each other's health and families upon meeting.
- ▶ Visitors to a house must greet and shake hands with each family member.
- ▶ Host must provide their guests with something to eat and drink, even if the visit did not occur at mealtime.
- ▶ Friends of same age and gender hold hands while walking.

- ▶ Great respect is attached to age and social status.
- ▶ A younger person addresses a senior as father, mother, brother, or sister and must show appropriate deference.
- ▶ It is rude to offer or take an object or wave with the left hand.
- ▶ It is also rude to stare or point at people in public.
- ▶ Words such as fool(ish), silly, or nonsense are highly offensive and are used only in extreme anger.

Marriage

- ▶ Arranged marriages are accepted.
- ▶ Customary law marriages, consensual unions, marriages contracted under Islamic rules, and those contracted under the ordinance (civil or church) are all recognized as legal.
- ▶ Marriage under customary or traditional law accounts for most marriage contracts.
- ▶ Polygamy is accepted.
- ▶ Parents of fiancé and fiancée must consent about marrying out their children before it is socially accepted.
- ▶ The bride's father takes a dowry from the bridegroom before the marriage is recognized.

Religion

- ▶ The major religions are `Christianity, Islam and traditional indigenous religions.

- ▶ Indigenous religions are practiced by all ethnic groups. They acknowledge many spiritual beings, including the supreme beings, the earth goddess, the higher gods, the ancestors, and a host of spirits and fetishes.

Children

- ▶ Older children receive considerably less pampering and occupy the bottom of an age hierarchy.
- ▶ Both boys and girls are expected to be respectful and obedient.
- ▶ Boys and girls are expected to take responsibility for domestic chores, including tending their younger siblings.
- ▶ Boys and girls are expected to seek advice from adults in a variety of situations.

Food and Diet

- ▶ The basic diet consists of starchy staple food eaten with soup or stew.
- ▶ Plantain, cassava, cocoyam (taro), millet, and tropical yams are the staple food in most ethnic groups.
- ▶ Soup ingredients include vegetables, fish, meat, hot pepper, palm nuts, or peanut butter.

Literacy

- ▶ English is the official language of the countries colonized by the British and French is spoken by those countries ruled by France.



History, Beliefs & Health Practices

Immigration History

- ▶ Ghanaians and Nigerians migration to Canada started in the early 1980s and increased through the 1990s in their effort to escape from economic hardship and political turmoil.
- ▶ According to 2001 census, 16, 985 Ghanaians were residing in Canada.

Beliefs and Illness

- ▶ Physical illnesses are caused by evil spirits, witchcraft, curses, and the ancestors' spirits.
- ▶ A person can experience serious illness or misfortune if he or she fails to honour/respect the spirit of a dead relative.

Traditional Health Care Practices

- ▶ Health care system consists of biomedical and traditional medicine.
- ▶ Many West Africans consult both traditional healers and doctors simultaneously.
- ▶ Traditional healer's treatments for disease focus on supernatural causes, the psychosocial environment, and medicinal plants.
- ▶ The fetish priests and priestesses deal with illness through prayer, sacrifice, divination, and herbal cures.
- ▶ Keepers of fetish shrines use magical charms and herbs.

- ▶ Secularly oriented herbalists focus primarily on medicinal plants that they grow, gather from the forest, or purchase in the market place.
- ▶ Traditional healers treat common diseases such as malaria, typhoid fever, inflammatory diseases, infertility, and skin afflictions.

Prevalent Diseases

- ▶ Common diseases include cholera, typhoid fever, pulmonary tuberculosis, anthrax, pertussis, tetanus, chicken pox, yellow fever, measles, infectious hepatitis, trachoma, malaria, and schistosomiasis.
- ▶ Others include guinea worm or dracunculiasis, different types of dysentery, river blindness or onchocerciasis, many types of pneumonia, dehydration, venereal diseases, and poliomyelitis.
- ▶ Malaria and measles are the leading causes of death in Ghana
- ▶ Among children under five years of age, 70 percent of deaths are caused by infections from malnutrition.

Health Care System

- ▶ Modern medical services in West African countries are provided by the government, local institutions, religious organizations and small number of private clinics and hospitals.
- ▶ Traditional health care sector which include herbalists and spiritual healers are important source of health care.

- ▶ A Center for Scientific Research into Herbal Medicine has been created in some countries, to incorporate traditional herbal knowledge and treatment into the formal health care sector.
- ▶ Some Ghanaians may consult both traditional and biomedicine simultaneously or adhere to only one type.

Death and Dying

- ▶ The traditional concepts of ancestorhood play an important role in beliefs about death and dying.
- ▶ Death is seen as an opportunity to meet the ancestors.
- ▶ Euthanasia is unacceptable by all ethnic groups.
- ▶ Mourning for the dead lasts for 40 days in some ethnic groups. Among the Ashanti, members of the family will fast during the 40 days. It consists of wearing red or black mourning clothes, family gathering, and abstaining from cooking in the house.

Mental Illness

- ▶ Mental illness is perceived to be caused by evil spirits or witchcraft. Evil spirits are sent by enemies to punish or inflict chaos in the person's life.
- ▶ Healers use forceful eviction or negotiations with other powerful spirits to remove the evil spirits.

Patient-Professional Relationship

- ▶ Doctors are respected, but Western doctors or local doctors trained in western countries are more highly respected than those educated at home.
- ▶ West Africans believe that doctors from Western countries are better trained and can cure numerous diseases.

Family Planning

- ▶ Contraception is accepted by some women.
- ▶ Married women rarely accept contraception because of the desire for more children and the fear of side effects.

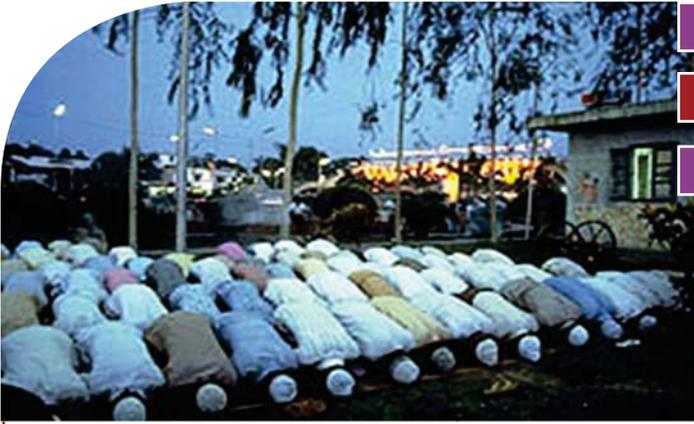
Childbirth

- ▶ Childbirth is very important for all families. A woman's failure to bear children is considered shameful: she becomes the end of a genealogical line of her family.
- ▶ A pregnant woman must observe some taboos and regulations to protect herself and the unborn baby: no sexual intercourse as soon as she becomes pregnant, abstain from certain foods that may cause harm to the baby's health or cause misfortune.
- ▶ She eats special kind of earth found on anthills or trees to strengthen the body of the baby.
- ▶ Birth generally takes place in the house of the expectant mother, or the house of her parents.

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- ▶ In small towns and villages, elderly women act as midwives.
 - ▶ Men are forbidden to be present in the house where delivery is taking place.
 - ▶ Among the Akan tribe from Ghana, the child is called by its day-name as soon as it is born. For example, every male born on Wednesday is called Kwaku and female is Akua.
 - ▶ The umbilical cord is cut with a wooden knife and the ghost hair cut off. The baby is cuddled for a week.
 - ▶ Among some ethnic groups, the father gives the baby a large piece of cloth on the eighth day.
 - ▶ The grandmother takes the child out for a sunbath at dawn and puts three white spots on its brow.

Post Partum Care

- ▶ Women are expected to abstain from sex after childbirth in order to ensure the survival of the mother and child.
- ▶ A mother must stay home with her baby for about three months.
- ▶ Among the Akan tribe, a mother is fed everyday with palm nuts soup mixed with special herbs to produce excess breast milk for her baby.
- ▶ The grandmother assists the new mother for about a year to provide care for the baby.



South Asians

Culture

Family Structure

- ▶ Family is the most important social unit, and includes parents, children, and grandparents, brothers, sisters, and their families.
- ▶ Traditionally the extended family lives together in one household. The extended family provides the identity of the individual as well as economic and emotional security. Interdependence valued.
- ▶ Earnings are often pooled in an extended family. Sometimes, either the grandmother or the eldest son manages the finances.
- ▶ Most decisions are made by the head of the household – often the most established financially secure male.
- ▶ Close relatives are consulted for all important decisions. Health care decisions, like seeing a doctor with an ill child, are made by the senior members of the family.
- ▶ Care for ill family members is the responsibility of the wife and mother.
- ▶ The opinions of relatives and other members of the community are held in high regard and gossip can be used to

effect social control.

Acculturation Issues

- ▶ South Asian families experience many significant acculturation issues. Grandparents often become primary caregivers and have feelings of loss of respect, youth face racism from their peers, many professionals are underemployed, and sometimes women who did not previously work enter the workplace.
- ▶ Many intergenerational issues and conflicts present in adjusting to life in Canada as parents and grandparents wish to maintain the same traditions.
- ▶ Traditional dominance or authority held by the elderly within the family is frequently weakened after moving to Canada. Usually sponsored by a son or daughter, elderly people arrive here in a dependent role, not knowing the language or culture.

Cross-Cultural Interactions

- ▶ Traditional greeting: palms of the hands pressed together in front of the chest. Shaking hands particularly by women or between women and men is not common.
- ▶ Direct eye contact may be considered rude and disrespectful, especially with elders. Physical affection rare even among family and close friends, and is considered extremely inappropriate between members of the opposite sex, including husband and wife.

- ▶ For some groups, it is not appropriate for a woman to even state her husband's name in public, and many women are expected to walk a few steps behind men.
- ▶ It is more acceptable for elders to give commands or orders to younger individuals, but older individuals expect to be treated with respect.

Marriage

- ▶ Often still, many arranged marriages take place among South Asians in Canada.
- ▶ Couples are expected to stay together; this and the additional stress of immigration can sometimes result in violence. Sometimes a woman is in Canada without her extended family and is more isolated without support for such issues.
- ▶ A South Asian woman who has separated from her husband is more isolated without support of such issues.
- ▶ A South Asian woman who has separated from her husband is unlikely to initiate divorce proceedings because it is more acceptable for a man to leave his wife and children and initiate divorce.
- ▶ In some cases, if a woman leaves her children with her husband she is considered a bad mother. For a Muslim family, however, it is expected that the husband's family maintain custody of the children.

Religion

- ▶ The most common religious groups in the South Asian communities in Canada are the Hindus, Sikhs and Muslims, although there are some Jains and Christians.

Hinduism

- ▶ Concept of the unity of life: all is interdependent, both human and animal, and is a continuous circle.
- ▶ After death, the soul is reborn in another life form which is determined by behaviour in former lives. This is the law known as Karma.
- ▶ High caste Hindu men participate in a religious ceremony in their youth in which a sacred thread (or string) is tied around the body; it goes over one shoulder around the chest and is tied at waist level. This thread should not be cut or removed without the permission of the patient or his family.

Sikhism

- ▶ Sikhism includes Hindu concepts of reincarnation as well as Karma. However, representation of God in pictures and the worship of idols are forbidden.
- ▶ The most important ceremony for a Sikh is that of baptism. Baptized Sikh men wear turbans and do not cut their hair or beards. They wear a

comb, white undershorts symbolic of chastity and typical of soldiers, and in their home country a small symbolic sword.

Islam

- ▶ “Islam” means “submission” and a Muslim is one who submits to the will of God, rejects all other gods and follows the teachings of the Koran, the holy book.
- ▶ Ethical conduct requires generosity, fairness, honesty and respect.
- ▶ Muslims are required to pray five times a day, facing the direction of Mecca, after a ritual washing. They should additionally attend a mosque to pray together on Friday.
- ▶ Muslims sometimes wear 33 beads around their necks or wrists and these represent the 93 names of God. They should not be removed unless absolutely necessary.

Children

- ▶ South Asian families are patriarchal, and male children are often preferred as they carry on the family name as well as tradition.
- ▶ It is not uncommon for children up to the age of 12 to share a bedroom with their parents or with siblings of the opposite sex.

The Elderly

- ▶ When South Asian parents grow old

they expect to be cared for by children, particularly sons, and the sons recognize this obligation. Women are more commonly involved in the daily care.

- ▶ The reversal of traditional patterns of dependence and authority can cause conflicts and a loss of self-esteem/ depression in the elderly.

Food and Diet

Hindu Food Practices

- ▶ Strict Hindus believe in non-violence against living things and abstain from meat or fish. The more orthodox, especially women, also do not eat eggs.

Muslim Food Practices

- ▶ Muslims follow dietary laws of the Koran – forbidden to eat pork or the blood of any animal.

Sikh Food Practices

- ▶ No significant dietary restrictions, but many Sikhs are vegetarians by choice.
- ▶ Health, Beliefs, & Health Practices

Immigration History

- ▶ The majority of South Asians are from India, Pakistan, Bangladesh, Sri Lanka, East Africa, and Fiji.
- ▶ Over 400 dialects are spoken. India

alone has 15 official languages. The most common languages are Hindi, Punjabi, Urdu, Gujarati, Kachi, and Swahili.

- ▶ South Asians come to Canada in various immigration categories including independent, family class, and refugee status.

Traditional Practices and Beliefs

- ▶ Illnesses are seen as the result of imbalance in the body humors, bile, wind and phlegm, and the purpose of treatment is to re-establish the balance.
- ▶ Dietary imbalance is thought to be a common cause of illness. Often specific foods are used to reestablish bodily balance. Foods are classified as “hot” or “cold” or “neutral” not in terms of temperature or spiciness.
- ▶ It is generally thought that bathing in still water (bathtub) is unclean. South Asians use running water such as a stream, shower or by pouring buckets of clean water over their bodies.
- ▶ Bathing (or its avoidance), massage and rubbing oil on the body are other ways to rebalance and thus thought to cure. In South Asian villages it is common to explain stressful circumstances by the supernatural.
- ▶ Many methods are believed to treat illness.
- ▶ Traditional medicines, vows, rituals and biomedicine may all work, and may be used for the same illness.

- ▶ Even for those of higher socioeconomic status who may not believe in such traditional medicines, many habits, treatments, foods, and the day-to-day health practices are based on these traditional beliefs, and they may hesitate to utilize biomedicine for particular illnesses.
- ▶ Traditional ways of making health decisions persist particularly initially while in Canada.

Prevalent Disease

- ▶ Infections and parasitic diseases are the most prevalent.
- ▶ South Asian immigrants may have experienced typhoid, dengue fever, cholera, tuberculosis, hepatitis, and amoebic dysentery.
- ▶ Most South Asians have had their immunizations and medical exams before coming to Canada.

Treatment and Medicines

- ▶ The concern that bio-medicines may be too strong or upset the body’s balance leads many South Asian patients to avoid their use or stop taking them prematurely.
- ▶ Many traditional remedies are used, and elderly women often recommend home treatments. Elderly members and the male household head are consulted about the need to see a doctor.

Health Care Systems

- ▶ A visit to a biomedical doctor is very costly for rural families and is avoided unless the disease is serious and the family can afford the fees, medicines and travel. Government sponsored social services, such as those in Canada are non-existent.
- ▶ People most often access hospitals for more serious illnesses. The ratio of available hospital beds in India is 1 to 1310 people, versus 1 per 110 people in Canada.
- ▶ Use of traditional medicines often continues even where the family has health insurance and easy access to biomedicine.

Hospitalization

Visiting

- ▶ Family, friends and neighbors want to visit a hospitalized person, who the patient is happy about seeing; patient may be upset if certain people do not appear.
- ▶ If necessary to limit the number of visitors, it is best for hospital staff to speak with the patient's husband, father or a male elder to explain the situation and to seek the cooperation of visitors.
- ▶ Family may wish to stay with the patient and assist in providing care.
- ▶ Some individuals feel uncomfortable providing written

consent and it may be necessary to provide an explanation.

Hospital Food

- ▶ Religious dietary restrictions can present problems for South Asians. For example, a vegetarian may not accept a vegetarian meal if it was prepared in a kitchen where meat was also cooked, or if the meat has simply been removed from the plate.

Hospital Clothing

- ▶ Some South Asian patients in Canada hesitate to wear cloHospital Treatments and Surgery
- ▶ Surgery is sometimes felt to be threatening – only after detailed explanations about the surgical procedure and its necessity will the family agree.
- ▶ The decision is made not by the individual patient but by the whole family.
- ▶ There is no religious or other belief that prevents blood transfusions or organ transplants.
- ▶ Most South Asians prefer that a staff member of the same sex perform catheterizations or enemas.

Literacy

- ▶ South Asians from urban settings are more likely to be fluent and literate in both English and their first language.

- ▶ Women are sometimes less fluent in English and may not be literate in their first language, as education for males is emphasized more than education for females.
- ▶ South Asians may prefer that family members act as interpreters, and the individual is preferred to be of the same gender but older in age.

Census Information

- ▶ India and Pakistan were among the top 5 source countries of immigrants arriving in Calgary in 2002.
- ▶ 36,855 Calgarians in the 2001 Census identified themselves as part of the South Asian community.
- ▶ As of 2006, 31,880 of immigrants living in Calgary hail from South Asia.
- ▶ Food and the Prevention of Illness
- ▶ Diseases are thought of as cold. Rheumatism, respiratory infections, upset stomach and other gastrointestinal problems and circulatory problems.
- ▶ It is considered important for ill people to be given easily digested soft foods such as cream of wheat, lentils without spices, khichari (lentils and rice) and soup made of whole-wheat flour and milk. These are the foods a South Asian family might bring a patient in the hospital.
- ▶ Most common foods are rice or chapatti (flat baked bread) with vegetables, meat or lentil curry.

- ▶ During Ramadan (Dec. – Jan.: dates vary according to the calendar) Muslims fast from sunrise to sunset, children and the ill are considered exempt. Fasting may also be recommended for fever, cold, or arthritic pain.

Relationship Between Doctor and Patient

- ▶ Extensive trust in both traditional and modern physicians. Patient may expect the doctor to have all the answers and make all the decisions.
- ▶ Patient takes a passive role, often not asking questions and waits for the physician to determine diagnosis and recommendations. Medical advice often accepted without question.
- ▶ Patient expects treatment in the form of medicine, injection, pills or tonics. Otherwise patient may be skeptical and unsatisfied. May prefer the physician to take charge.
- ▶ South Asian women hesitate to be seen by male physicians; they and their husbands believe that women should have a female doctor.
- ▶ South Asians may be less familiar with the professional role of nurses in Canada, and health practitioners may need to provide some orientation regarding this aspect.

Mental Illness

- ▶ Mental illness is sometimes believed to have supernatural causes, particularly spells or curses cast by jealous relatives or acquaintances, and are resolved by visiting temples.
- ▶ Mental illness is stigmatized and is generally hidden for the sake of arranged marriages.
- ▶ Severely ill family members are not ignored or rejected, but may be kept hidden and untreated until a crisis.
- ▶ While most South Asians prefer medicines for treatment, some patients in Canada do resort to psychiatric help. Western “talk” therapy is not usually compatible. Instead it may be more appropriate to provide direction and clear advice about patient and family involvement.
- ▶ Inquiries regarding family interactions and issues are not very culturally acceptable as the family operates in a close unit and maintains privacy.
- ▶ The Western therapeutic value of independence from the family is less appropriate in intervention for South Asian families.

Family Planning

- ▶ Often the husband makes decisions about family size. The favorite methods of contraception are the IUD and contraceptive pill; diaphragms and condoms are seldom used.

Pregnancy

- ▶ Viewed as a very natural process, some South Asian women do not see the need for prenatal care. Visits to a doctor are associated with problems or abnormalities.
- ▶ Sex not openly discussed with strangers. Prenatal classes are embarrassing for both women, who feel they should not exercise in front of others, and for men.

Childbirth

- ▶ In South Asia women often utilize midwives who encourage women to be active, walk around, and sometimes herbal medicines are given. Delivery is often in a squatting or sitting position.
- ▶ Laboring woman may take a passive role, following instructions.
- ▶ Most commonly fathers are not present for delivery, but female family members may be involved.
- ▶ Canadian hospital practices will be unfamiliar to many women from South Asia.
- ▶ Women prefer natural delivery and often will not request an anesthetic or know little info.
- ▶ Decisions are left to the physician. Forceps and Cesarean section are usually accepted if clearly explained by the doctor.

Post Partum Period

- ▶ After the birth of a Muslim child, a family member is to recite a prayer in the baby's ear as soon as possible.
- ▶ A male Muslim baby must be circumcised. For other groups circumcision is by choice.
- ▶ South Asian women expect the baby to stay with them, and may have concern regarding the baby being in a nursery.
- ▶ South Asian women are to eat hot foods and to avoid cold foods.
- ▶ Hot foods are to strengthen the body, balance the system and promote bleeding and discharge so that a flat stomach results. Cold foods are thought to cause weight gain.
- ▶ It is believed that excessive admiration or compliments about the baby may have a negative effect.
- ▶ Breastfeeding is preferred, although the baby may be bottle fed if the mother has to return to her job and the grandmother is the primary caregiver. Women breastfeed for at least six months and sometimes up to 2 to 3 years.

Culturally Sensitive Health Care

- ▶ Religious practices play a critical role. It is important for health practitioners to ask families about their beliefs and values.
- ▶ Many who are of higher education and socioeconomic status are well aware of

bio-medical practices, though family members expect to be very involved in the patient's care and in decision-making.

- ▶ Families from rural areas will be less exposed to such health care systems.
- ▶ For many, there is little experience with social service agencies and sometimes distrust of government sponsored agencies.

Death and Dying

- ▶ Accept death as part of a life cycle, and that it occurs when it is time.
- ▶ A peaceful death at home surrounded by family is strongly preferred to death in hospital.
- ▶ Generally, South Asian physicians do not inform the patient that he or she will soon die, and the family might wish to be informed first, so they are able to make the decision to tell that patient.
- ▶ Families and friends are expected to express their grief openly by moaning and crying.

Hindu

- ▶ Before death relatives of the dying person may bring clothing and money for him to touch before distributing them to the needy.
- ▶ A passage from holy books or chant prayers may be read to the dying patient to help them in the next life.

- ▶ The eldest surviving son plays an important part in the rituals after death. He, along with other relatives, washes the body and dresses it in new clothing.
- ▶ In the case of a married woman, red clothing and jewelry signifying her married state are used.
- ▶ When a person dies in a Canadian hospital, the family prefers to wash and dress the body before it is removed from the hospital. Bodies are cremated, usually on the same day as the death and ashes are kept until they can be thrown on to the surface of the sacred river, the Ganges. In Canada the family may also throw the ashes into a local river or the sea.
- ▶ Traditionally only men attend cremation ceremonies. Mourning period lasts 40 days.

Muslim

- ▶ As a patient nears death, Muslims repeat the words of the Koran to the person.
- ▶ Once death has occurred the body is ritually washed before being buried with the face pointing towards Mecca.
- ▶ If death occurs in hospital, it is preferred that staff do not wash the body but that they turn the head towards the right shoulder before wrapping the body in a plain sheet.

- ▶ During these procedures family members may wish to read passages of scripture or to make lamentation.
- ▶ Religious rules stipulate that the body should be cremated as soon as possible after death and that it be complete and whole. For these reasons, Muslims will agree to a post mortem only if it is legally necessary and will request that the organs be returned to the body for burial.

Sikh

- ▶ After death, members of his or her family prefer to wash the body and prepare it for cremation. The body is viewed at the hospital if that is where death occurred.
- ▶ Sikhs do not readily agree to post mortems nor do they agree to donate organs.
- ▶ After the cremation there is a memorial service at the Sikh temple, at which time prayers are said for the soul of the person.



Vietnamese

Culture

Family Structure

- ▶ Identity is related to the family unit, and there is strong loyalty to family.
- ▶ Family may include the elderly, an adult couple and their children, and spouses of married children.
- ▶ In Vietnam women have fewer rights than men relating to education, political influence and employment.
- ▶ Family obligations are strong, even toward those members outside Canada, which may impact a family's ability to become established in Canada.
- ▶ Father or eldest son represent the family and make decisions.
- ▶ Women are responsible for the care of an ill family member.

Acculturation Issues

- ▶ While many families from Vietnam have been in Canada for several years, they face issues in intergenerational relationships, language, employment, and settlement.

Cross-Cultural Interactions

- ▶ Prefer formal relationships; Use the title and first name (e.g. Mrs. May).
- ▶ Avoid joking and pointing the finger, which may be disrespectful.
- ▶ The importance of politeness may

hide an individual's disagreement or misunderstanding.

- ▶ Prefer glances in contrast to continual direct eye contact.

Marriage

- ▶ Marriages are generally arranged by both sets of parents.
- ▶ Husbands and wives do not expect to have close nurturing marriages.
- ▶ Husbands and wives tend to socialize separately and the wife may avoid confronting her husband regarding drinking or extramarital affairs. The marriage itself is not usually threatened.

Religion

- ▶ Many families are Buddhist; may also worship a variety of shrines and practice Confucianism or Catholicism.

Children

- ▶ Vietnamese families are very attentive to their babies who are not often allowed to cry, but instead are held by mother or sibling.
- ▶ Parents traditionally believe they have the right to beat a child without intervention, but it rarely occurs.

The Elderly

- ▶ Elderly are respected and privileged.
- ▶ Ill parents are often cared for at home. Children are expected to provide care and support for their parents. Institutional care is viewed as disrespectful.

Food and Diet

- ▶ Foods are classified as hot, cold or neutral; balance prevents illness.
- ▶ Prefer warm soft foods when ill. Never consume cold drinks, like ice water. Many are lactose intolerant.

Literacy

- ▶ Many elderly Vietnamese and several women are not literate in Vietnamese.
- ▶ There is often a need for interpreters.

Census Data

- ▶ 12,560 Calgarians listed themselves as from the Southeast Asian community in 2001, which includes but is not limited to Vietnam. In 2006, this number rose to 19,825.

Hospitalization

- ▶ Elderly are reluctant to be admitted to hospital because it is perceived to be linked with death.
- ▶ Vietnamese prefer privacy and often want curtains pulled around the bed. Often do not reveal the body area between waist and knees, even to

closest relatives. Will wear hospital gowns, but with discomfort.

- ▶ Concern regarding effects of wind in hospital rooms from windows and the impact on health.
- ▶ Admission to hospital in Canada may be delayed beyond the optimal point of treatment and a patient may be taken home as soon as he appears to have improved.
- ▶ Elderly patients in particular may avoid hospitalization or try to go home to avoid dying in hospital.
- ▶ Nurses and doctors are highly respected.
- ▶ Patient may prefer family member of the same sex to assist with personal care – privacy and modesty are critical issues.
- ▶ Patient acts passively and expects to be cared for by a family member.
- ▶ If needed, family members are willing to donate blood.

Death and Dying

- ▶ Among the Vietnamese there is a very strong feeling that death should occur at home with dignity unless it is an acute illness. If death does not occur in the hospital, it is important to move the body home as soon as possible.
- ▶ Inform the head of the family – parents or adult child.
- ▶ Generally the family wishes to be told about a terminal illness, but may not tell the patient. It is important to

consult the head of the family.

- ▶ Traditional mourning family members wear white clothing for 14 days, followed afterwards by their wearing of black armbands. A wake is held 49 days later.
- ▶ A spiritual or religious rite may take place after death. It may be important to involve a priest or monk.
- ▶ Family may wail loudly and need extra time with the deceased.
- ▶ Traditionally, organ donation/autopsies are not permitted.

History, Beliefs & Health Practice

Immigration History

- ▶ While some Vietnamese families come from more established backgrounds with professional skills, a number of Vietnamese in Canada have had experiences as refugees and have been in refugee camps.
- ▶ Languages: Three major languages spoken are Vietnamese, French and Chinese.

Traditional Health Practices & Beliefs

- ▶ Many traditional methods are used in addition to Western biomedicine. Physical exercise is often not perceived to be a part of healthy living.
- ▶ Hot and Cold: Like the Chinese belief regarding two opposing forces of yin and yang – hot and cold.
- ▶ The body must have equilibrium to

avoid illness.

- ▶ Illnesses are believed to be the result of excessive heat or cold. Hot illness might include constipation, dark urine or hoarseness.
- ▶ Wind and Water - may result in headache, cough, nausea. The bad wind is thought to be released by creating small bruises on the body with a coin or a spoon or by cupping – placing a hot cup on the body and letting it cool until the air contracts and draws the skin upward.
- ▶ Bathing is thought to be risky as it cools the body and may create illness.

Traditional Medical Practitioners

- ▶ Vietnamese try home remedies before going to a doctor. If they do not work, he/she may approach herbal practitioner.

Prevalent Diseases

- ▶ Hepatitis B is prevalent in the refugee camps where water is often contaminated.
- ▶ Pulmonary tuberculosis is sometimes present in immigrants from Vietnam – usually inactive.
- ▶ Malaria is sometimes brought from Vietnam.

Health Care Systems

- ▶ In Vietnam the hospital is the last choice and used for emergencies when all other treatments are unsuccessful

and the family cannot provide care.

- ▶ In Vietnam, a family member usually stays with the hospitalized individual to assist in providing personal care. Many family members visit the patient at all times except at night or during physician's rounds.
- ▶ Family has considerable control over decisions and treatment.
- ▶ As families are less involved in the hospital care in Canada, they may feel powerless and that they are abandoning their family member.

Treatment and Medications

- ▶ May be stoic when experiencing pain, and often do not request medication.
- ▶ Hold the belief that medications may lead to addiction, and may not want to take pills.
- ▶ Home remedies are often practiced before going to the doctor – examples include cupping and coin rubbing. Be aware that some of the bruising from these treatments may seem similar to bruises from abuse.
- ▶ In Vietnam good doctors are expected to give medicine – both pills and injections are acceptable. May be resistant to Western medicine. As there is a tendency to stop taking medicines prematurely, it may be helpful to reduce the recommended dosage of biomedicine. Vietnamese may feel Western medicines do not apply to them.

- ▶ People often insist on X-rays, and most laboratory tests are acceptable such as urinalysis.
- ▶ Many Vietnamese fear and resist blood tests that require even small samples of blood, feeling that it is not able to be replenished.
- ▶ May feel headaches or weakness are related to blood tests.
- ▶ Great reluctance to surgery, as the soul is believed to be attached to parts of the body. If those parts are removed or if the body is merely cut, the soul might escape maybe leading to death.

Family Planning

- ▶ Traditionally in Vietnam contraception was not valued or legal.

Pregnancy

- ▶ Believed to be a normal condition, but care should be taken to maintain the body's equilibrium.
- ▶ Much attention given to pregnant woman. Strenuous activity not allowed. During pregnancy, sex is considered taboo.
- ▶ Once in Canada most women are willing to make regular prenatal visits to the physician and even attend prenatal classes, particularly where classes are conducted in Vietnamese or Cantonese.

Childbirth

- ▶ If pain relief methods are made available, Vietnamese women use them and may even request.
- ▶ May appear self-controlled and stoic during labor.
- ▶ Father may participate if he has been involved in prenatal programs, but will likely take passive role.
- ▶ Much support from laboring woman's mother or close female family member.
- ▶ Both male and female babies are openly accepted.
- ▶ Strongly prefer vaginal delivery.

Relationship Between Doctor and Patient

- ▶ Vietnamese defer to health professionals. Doctors are highly regarded, and Vietnamese trust and rely on doctors for medical decisions.
- ▶ Nurses are perceived as support to physicians when they are present, not to initiate activities. The role of nurses may need to be clarified for Vietnamese.
- ▶ Expectations of physician: formal and unhurried, with quick diagnosis with few questions or an elaborate physical.
- ▶ Detailed questions about their lives, past or their families are not openly accepted.
- ▶ The act of talking too much about an illness is thought to induce it. Patients

do not expect detailed explanation of the diagnosis nor the purpose of the recommended treatment.

- ▶ Many people may be unable to give detailed medical histories from their life in Vietnam because doctors did not generally provide such information.
- ▶ Do not like to remove more clothing than is absolutely necessary for a physical examination.
- ▶ Family, who are usually with the patient, are to be informed of the diagnosis and treatment, as family and elders in particular make decisions for treatment.
- ▶ Married women often prefer female physicians and will accept a female nurse in the examining room, but not usually a family member. Unmarried women often are extremely reluctant to have pelvic examinations unless they are absolutely necessary and clearly explained.
- ▶ Politeness does not necessarily mean agreement, and patient may disregard treatment recommendations and further appointments.
- ▶ May find it difficult to adapt to appointment system.

Mental Health

- ▶ Mental illness is often equated with severe disorders versus other depression or anxiety. It is believed that there is no cure for a mentally ill individual.

- ▶ Supernatural Beliefs – forces are often used in explaining mental illness, and it is thought that a mentally ill person's behaviour may have offended a god, who then punishes him or her with the illness.
- ▶ A cure is thought to be reached by remaining at a temple to ensure that spiritual forces forget the ill individual.
- ▶ Mentally ill people are both feared and rejected, and their family members feel shame.
- ▶ Consulting a psychiatrist is seen as equivalent to diagnosing a family member as insane. Often a Vietnamese individual will resist treatment after the first contact with a psychiatrist or mental health clinic until they become ill again. At this time it may be possible for the patient to accept treatment, especially if rapport and trust were developed in the initial contact.
- ▶ Most often individuals are not willing to discuss personal feelings about family or other more senior persons, most will describe their childhood as satisfactory.
- ▶ “Talk Therapy” is not acceptable as it investigates family relationships and is the primary method of intervention. Open-ended questions are threatening.
- ▶ Intervention most appropriate when combined with medical treatment such as drug therapy or with some kind of social intervention. Sometimes, a referral to a spiritual leader, in combination with other interventions, is appropriate.
- ▶ Consider psychosocial factors that may have contributed to the illness by discussing the following: 1) life, problems and stresses in the home country; 2) escape or departure, who came, who remains overseas, the experience; 3) refugee camp experience; 4) attitudes towards and problems of being in Canada; 5) current worries and outlook for the future.
- ▶ It is important to consider that the patient may have experienced trauma as a refugee, and that the timing affects the reopening of these issues.

Post Partum Care

- ▶ Mother expects to be with baby at all times.
- ▶ Care during this period is viewed to be very important, and women are to rest and have nourishing soup.
- ▶ Woman is not to shower for 2-4 weeks, but sponge baths are acceptable.
- ▶ Traditionally breastfeed for one year, and the mother is to follow a strict diet without ‘cold’ or ‘windy’ foods.
- ▶ Male circumcision varies by family beliefs.
- ▶ Woman's body viewed to be in a cold state, so women are reluctant to bathe or wash their hair. Sponge baths are acceptable.
- ▶ It is important to avoid cold foods such as water, fruit juices, raw vegetables and fruit, and drafts/cold air.



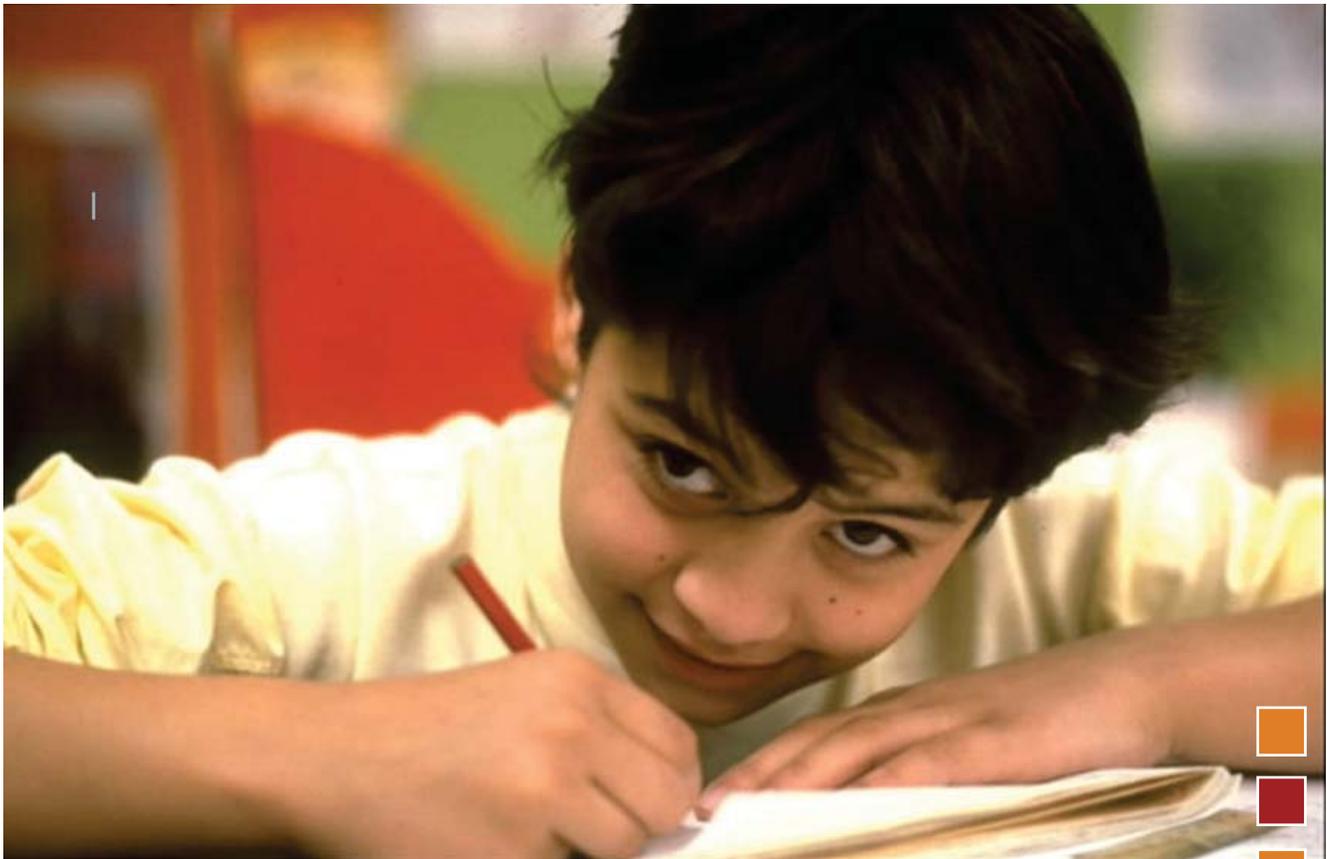
The AMNI (Anti-Racism, Multiculturalism & Native Issues) Centre within the Faculty of Social Work at the University of Toronto has developed a database of cultural profiles. Each cultural profile provides an overview of, and insight into the life and customs in the profiled country. Each country included in the list below includes a cultural profile. Please refer to <http://www.cp-pc.ca/english/index.html> for more information. Health care practitioners are encouraged to investigate the cultural profiles of the countries listed below as a means of enhancing the degree of cultural sensitivity found within individual health practices.



Afghanistan	Congo	Haiti	Mauritius	Slovakia
Albania	Croatia	Honduras	Mexico	Somalia
Algeria	Cuba	Hungary	Morocco	South Africa
Argentina	Czech Republic	India	Myanmar	South Korea
Australia	Dominican Republic	Indonesia	Netherlands	Sri Lanka
Bahrain	Ecuador	Iran	Nicaragua	Sudan
Bangladesh	Egypt	Iraq	Nigeria	Sweden
Barbados	El Salvador	Ireland	Pakistan	Switzerland
Belarus	England	Israel	Peru	Syria
Bolivia	Eritrea	India	Philippines	Taiwan
Bosnia	Ethiopia	Jamaica	Poland	Tanzania
Brazil	Fiji	Japan	Portugal	Thailand
Bulgaria	France	Jordan	Qatar	Trinidad & Tobago
Burundi	Germany	Kazakhstan	Romania	Turkey
Cambodia	Ghana	Kenya	Russia	Ukraine
Canada	Greece	Kuwait	Rwanda	USA
Chad	Grenada	Laos	Saint Vincent	Venezuela
Chile	Guatemala	Lebanon	Saudi Arabia	Vietnam
China	Guyana	Lithuania	Scotland	Yugoslavia
Colombia		Malaysia	Singapore	Zambia



4.0 COMMUNICATION AND LANGUAGE



“Think like a wise man but communicate in the language of the people”.

William Butler Yeats



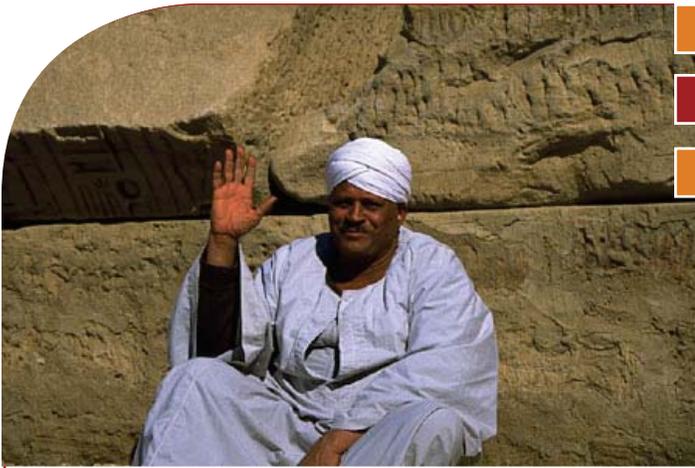


Multicultural Etiquette

As already identified, language and communication can be major barriers to receiving and providing quality health care. There are some ways to enhance interactions with diverse populations. The use of simplistic, direct language (i.e. avoidance of technical jargon, idiomatic expressions, metaphors, etc), speaking in short units of speech (i.e. avoidance of lengthy discussions) and

patience will help in the transmission of a comprehensible message.

As Canadian demographics continue to change, it is critical that health care providers become familiar with, and sensitive to proper etiquette when interacting with diverse populations. The following are some examples of things to keep in mind.



Greetings

The rituals surrounding greetings vary greatly among cultures, especially in terms of body contact when initially establishing a relationship. In general, avoid body contact (handshakes) with Asians, Middle Easterners, and Orthodox Jews. Latinos, Europeans and Armenians generally expect some body contact. Following the lead of the recipient is a safe way to avoid being offensive. Addressing individuals in a formal way (Mr., Mrs.) is also expected in many cultures, especially when addressing the elderly.

Eye Contact

Avoidance of eye contact may be intended as a sign of respect, especially by people from many Asian, Latin American, South African and Caribbean cultures. Alternately many African Americans when speaking tend to stare intently at the listener, but while listening will mostly look away.

Smiling

While North Americans smile primarily as an expression of friendliness, in many Asian countries it is used to signal sadness, happiness, anger, apology, confusion, or gratitude. Other cues such as eye expression and forehead movements help clarify the intended meaning.

Thumbs-Up & Other Gestures

It is important to keep in mind that gestures do not have universal meaning. For instance, in many parts of the world including Nigeria, Australia and Middle Eastern countries, the thumbs-up sign has the same sexual connotation as the American middle-finger gesture. The North American 'good-bye' gesture means "come here" in many Southeast Asian cultures. Finally, pointing the index finger at a person is considered especially rude to people from South Asian cultures. The crooked finger (to indicate "come here") is also considered obscene to people of South Asian cultures.

Concept of Time

Both Japanese and Korean cultures view being "on time" as arriving early for the scheduled appointment, whereas many Spanish-speaking cultures do not hold great importance to appointed time. It is useful to explain what your expectations are about time, and inquire as to what the cultural customs are in exchange.

Touching the Head

Many Asian cultures hold the belief that the soul is housed in the head. For this reason, it is prudent that outsiders avoid touching the heads and upper torsos of all Asians, including children, as it is believed that when another person touches their head they are placed in jeopardy.

(Source: Dresser, Norine, *Multicultural Manners New Rules of Etiquette for a Changing Society*, John Wiley & Sons, 1996)



Communication & Specific Cultural Groups

Ethnic Group	Verbal Communication	Non-Verbal Communication
Cambodians	The major language for Cambodians is that of Khmer with the written language based on Indian Sanskrit. The tone of voice used by Cambodians is generally quiet, as it is very important to speak softly and politely.	Touching of the head is inappropriate without permission due to the belief that the soul resides in the head. Silence is welcome and eye contact acceptable, although it is considered polite for women to lower their eyes somewhat when conversing with men. It is considered impolite to disagree with an argument or proposition; Cambodians may agree to something in order to avoid a disagreement, but not follow through on the expectation.
Chinese	The most common languages spoken by Chinese Canadians are Mandarin and Cantonese. These languages are very expressive and are sometimes interpreted as being 'loud' to non-Chinese people.	Eye contact and touching are more common with family and friends than with unfamiliar people. One may avoid eye contact with an authoritative figure as a sign of respect. Asking questions is also interpreted as being disrespectful.
Ethiopians & Eritreans	There are three predominant languages spoken in Ethiopia and Eritrea: Amharic, Tigrigna, and Oromigna. Ethiopians and Eritreans are generally soft spoken, non-confrontational and polite. Shouting is frowned upon at all times.	Ethiopians and Eritreans are generally very shy, polite and reserved. They are respectful towards and avoid eye contact with authority figures. Touching and caressing the face and hands of a sick person are acceptable expressions of love, care and concern, as touching is considered to be healing.



Ethnic Group	Verbal Communication	Non-Verbal Communication
Filipinos	Tagalog is the national language of the Philippines, although there exist 85 major languages and dialects on the island. English is the language of choice in schools, businesses and mass media.	Filipinos are typically shy and affectionate but awkward in unfamiliar surroundings. Touching is common, as is avoidance of eye contact with elders. Smiling is used as a greeting or an acknowledgement, as are other facial expressions (i.e. raised eyebrows) instead of verbal responses. Filipinos will avoid direct expression of disagreements.
Iranians	Farsi is the national language of Iran, but is only spoken by a little more than half the population. Other predominant languages are Turkish, Armenian, Baluchi and Kurdish. English and French are also spoken for business purposes.	Communication patterns are influenced by a hierarchical system of social relationships. Outer expressions may mask inner feelings in order to maintain smooth social relationships. Eye contact is acceptable between equals and loved ones. Personal space is generally closer than the standards found in North America.
Japanese	Japanese is the predominant language among Japanese Canadians although newly immigrated Japanese are usually able to communicate in English. Remaining emotionally neutral is an important practice, as expressions of anger or loss of temper reflects negatively upon the family.	Japanese are typically quiet and polite and will generally not ask questions or disagree. Facial expressions are generally controlled, and there is little direct eye contact. Touching is quite uncommon, especially in unfamiliar surroundings.
Koreans	The major language is Korean. It is spoken with a wide variety of pitches, with emphasized loudness on important utterances.	Touching and embracing are acceptable practices among family and friends, but are considered disrespectful unless for examination purposes. It is considered rude to direct the sole of the shoe or foot toward another person and eye contact is infrequent among strangers.



Ethnic Group	Verbal Communication	Non-Verbal Communication
South Asians	There are more than 400 dialects spoken among South Asians. Common languages spoken by South Asians include Hindi, Urdu, Gujarati, Punjabi, Pushto, Bengali, Oriya, Marathi, Telugu, Tamil, Kannada and Malayalam.	Touching is quite uncommon among South Asians, as affection and caring is generally expressed through eye contact and facial expressions. Direct eye contact is considered to be a sign of disrespect towards elders of the community, while silence generally indicates approval, acceptance and tolerance. Shaking hands is common among men as a greeting, but not common among women in most South Asian cultures. It is generally acceptable to impose commands on younger individuals, however elders should be treated respectfully and politely.
Vietnamese	There are three major languages common to Vietnamese Canadians: Vietnamese, French and Chinese. In general, Vietnamese people are soft spoken, as a raised tone of voice is considered to be a sign of disrespect.	Respect is demonstrated by avoiding eye contact with those of higher status (based on age, education, gender, etc). In general, personal space is more distant than in North American traditions. The head is considered to be a sacred body part, while the feet are viewed as profane. Gentle touch within the conversation may be appropriate, especially with older, more traditional individuals.

(Source: Lipson, Juliene, Dibble, Suzanne, Minarik, Pamela, Culture & Nursing Care: A Pocket Guide, UCSF Nursing Press, 1996)

For additional information and helpful tips on Communication Across Cultures, see Dr. Valerie Pruegger's article at the end of this chapter.



Interpreters and Health Care

Do clients really need interpreters?

Limited and non-English speaking clients' access to quality health care is not only jeopardized when they are not familiar with health care terminology, but health care providers are also at risk of committing errors, as well as violating human rights.

Studies have shown that limited and non-English speaking clients are subject to inferior quality of care that can lead to serious and sometimes fatal results. In addition, language barriers result in inappropriate use of the health care system, one example being the over-utilization of emergency departments for regular, non-urgent care. Language barriers also negatively impact treatment and follow-up processes. Ultimately, language barriers can result in more expensive services due to delays in early diagnosis and treatment.

Alberta Health Services Interpretation and Translation Services

In order to address these issues, the AHS in Calgary has responded to the need (identified in the External Consultation) for health care interpreters. The following information is provided to inform practitioners.

The vision of Interpretation and Translation Services is to meet the interpretation and translation needs of a culturally and linguistically diverse patient population. The goal is to provide effective, coordinated,

equitable, and operationally efficient interpretation and translation services that address the communication needs between the clients and health care providers.

The Alberta Health Services has established a standard that a Certified Health Care Interpreter should be used when interactions are important to the health of the individual to ensure informed consent and informed treatment. These interactions include, but are not limited to, assessment and diagnosis, history, informed consent, health teaching, most counseling situations and abusive situations. In cases where the patient/client declines the offer of a certified health care or language interpreter and/or insists on using an informal (family member or friend) interpreter, these circumstances should be documented on the patient's/client's health record.

In situations where assessment has been completed and informed consent given for treatment and diagnostic tests, a family member, friend or other staff member may assist in simple communication during the agreed upon test or treatment. These situations may include the routine exchange of information, and simple instructions or requests.

Minors should **never** be used as interpreters.

Certified Health Care Interpreters

Alberta Health Services Certified Health Care Interpreters are available at no cost* to ensure clients/patients and their families receive high quality health care and accurate

health information. Certified Health Care Interpreters:

- ▶ are Alberta Health Services employees;
- ▶ have demonstrated proficiency in speaking, writing and reading English and the language in which they provide interpretation services;
- ▶ provide face-to-face and over-the-phone interpretation; and
- ▶ are available in the most commonly spoken languages in Calgary including **Cantonese, Vietnamese, Punjabi, Mandarin, Arabic, Hindi, Farsi, Spanish, French, Korean, Urdu, and Sudanese languages.**

Call **944-0202** Monday to Sunday 0800-2200 to arrange for a Alberta Health Services Certified Health Care Interpreter in Calgary at **no cost***. Interpreters are available to provide face-to-face interpretation or over-the-phone interpretation, depending on the situation.

After hours, call 1-800-523-1786 for 24/7 **over-the-phone** interpreters in 170 languages at **no cost***. Give the operator this information:

Language required: for example, “**Punjabi**”

Client ID number: (if you do not know this number, call 944-0202)

Organizational Name: Calgary Health Region

Personal Code: Your manager’s last name

You will be connected with an interpreter in less than one minute.

Sign Language Interpretation is mandated by the Supreme Court of Canada for all clients/patients who communicate in American Sign Language. To arrange for a Sign Language Interpreter 24/7 at **no cost***, call Deaf and Hard of Hearing Services at (403) 284-6203, 08:30-16:30 business days or (403)229-6939 after hours.

*All costs for Interpretation are covered by the Alberta Health Services Interpretation and Translation Services.

For general inquiries about Interpretation and Translation Services, please contact the Interpretation and Translation Services Assistant Manager at 944-9033.

What is translation?

Translation is the conversion of written words from one language into another language. Translation of patient/client education materials is an important indicator of a Diversity Competent organization that the Alberta Health Services in Calgary has initiated. Translated documents allow patients/clients and their families who read languages other than English to access written health information.



What do I do if I need client/patient education material translated from English into another language?

A list of translated client/patient education materials and the languages in is available through Interpretation and Translation Services, or call (403) 944-9033 for more information. For a recent list, see Appendix A.

How do I request a document to be translated?

Complete the Translation Request form (see Appendix B) and fax your request with the English version of the document you would like translated to the Interpretation and Translation Services Assistant Manager at 944-9033.

If you have patient education materials that you would like to have translated, contact: Interpretation and Translation Services (403) 944-9033 for more information.

Do not use translated patient education materials unless they are approved Alberta Health services health information or pamphlets.





5 Steps to Better Communication Across Cultures

(adapted by Dr. Valerie Pruegger from the McDonald Guide to Communication Across Cultures, Cross-Cultural Communications, Inc.)

1. Cultivate Patience

- ▶ Allow extra time to establish rapport.
- ▶ Take the time to listen carefully, or pause after you speak to be very sure you are being understood. Check for understanding with questions.
- ▶ Never interrupt. Listen until you are sure the speaker has finished.

2. Avoid Making Quick Judgments & Resist Stereotypes

- ▶ Do not assume your knowledge of another's culture is correct. Your knowledge may not be accurate or applicable for that individual.
- ▶ Do not assume that accented English means there are significant cultural differences or that the speaker is not intelligent or knowledgeable.
- ▶ Don't assume that specific physical features (e.g., skin colour) indicate predictable differences in cultural and/or linguistic backgrounds.

3. Pay Attention to Verbal and Non-Verbal Signals

- ▶ Be aware of the different ways people structure their statements and replies. Important information may come at the end.
- ▶ Be constantly aware of your body language, pitch and tone of voice.

- ▶ If a response seems evasive or confused, ask yourself "What is really happening here? Where is the communication breaking down?" before leaping to conclusions.
- ▶ Take body gestures and facial expressions into account, but be careful not to impose your own cultural norms/standards too rigidly.

4. Don't be Afraid to Use Indirect Communication Techniques

- ▶ Use analogies or relevant stories, illustrations, and examples as they are often viewed to be less threatening.
- ▶ Ask for assistance from others more familiar with the culture.
- ▶ Employ props, sketches, or sign language.

5. Be Aware of Your Own Language Use

- ▶ Avoid expressions specific to English.
- ▶ Try not to use abbreviations, acronyms or technical jargon.
- ▶ If you're not being understood, do not raise your voice or merely repeat what you've been saying. Try other words or paraphrasing. Remain calm and understanding. As the native speaker, it is your responsibility to communicate in a different way.



General Tips for Approaching Minority Clients & Communities

1. Be aware of and willing to admit to your own lack of knowledge when approaching or preparing to enter an ethnocultural community that is not your own.
2. Be willing to learn through observation, analysis, and questioning.
3. Recognize that you need assistance and information.
4. Conduct preliminary reading of reliable factual materials regarding the community, but do not over-generalize.
5. Find individuals willing to work as guides or interpreters. These could be community members, leaders, elders, or non-community members who have been successful in gaining access.
6. Put your own assumptions and evaluate judgments aside to be open to new ideas, values and behaviors.
7. Introduce yourself to community leaders to show respect and gain support. Focus on how you can benefit the community and show a willingness to adapt to its needs.
8. Be prepared for initial reactions of distrust, rebuff, prejudice, stereotypes, and/or resentment. Take your time to establish relationships before focusing on interventions.
9. Do not enter the community until you know what your goals are. What do you want from the relationship?
10. Observe communication patterns, e.g., giving feedback, expressing emotions, touching and personal space, meaning of silence, non-verbal behavior such as eye contact, and taboo topics.
11. Note things you do not understand. Ask your guide.
12. Learn some key words of the language and appropriately adapt your communication style and behavior to fit the community.
13. Choose language carefully to avoid unconscious offenses, e.g., not 'disabled', but 'people with disabilities'.

Above all, relax, enjoy, be accepting, avoid defensiveness, be humble, be able to laugh at yourself, learn from your mistakes, and keep learning!

Please remember that the following are gross generalizations based on traditional cultural values for each community. They are offered as GUIDELINES only and should only be applied to an individual/family with extreme caution. Culture is constantly changing over time and members of a particular culture will display its values, beliefs, and behaviors to different degrees – or not at all!

Community Specifics

Chinese

1. Do not assume the person is an immigrant e.g., “How long have you been here”. If you need to ask, ask “Were you born in Calgary?” which allows him/her to fill in details.



2. Reciprocity and obligations are important. A favor asked is a favor returned.
3. Punctuality is valued.
4. Avoid face- to- face confrontation. Use a mediator or a third party.
5. Public display of anger or other strong emotions are seen as a lack of control, immaturity. Lose trust/respect.
6. Be very tactful. The concept of face is important. Open confrontations, accusations, disagreements, disapproval are very embarrassing.
7. May be unwilling to interrupt a discussion. Pause to give the individual a chance to participate.
8. Feedback behavior is minimal. Little nodding, attentive listening behavior.
9. Taboo topics include death and sex.
10. Uncomfortable with opposite sexes touching in public. Same sex may touch.
11. Young people may avoid eye contact with elders/authority as a sign of respect.
12. Decision-making and problem solving are group activities.
13. Deflect praise to group. Direct praise may make individuals uncomfortable.
14. Speakers of tonal language may inadvertently place tone or stress on a word. Check for understanding. For example, 'No' may sound like a question or be very abrupt. These do not indicate

uncertainty or rudeness.

South Asian – India Sub-Continent

1. 'East Indian' is geographically incorrect and may be offensive. Use "South Asian".
2. Major groups include Sikhs, Pakistanis, Indians.
3. Many are highly educated professionals, males and females.
4. Personal relations take priority over task completion. Socialize before getting 'down to business'. Personal networking is important.
5. Punctuality is less important.
6. Shaking the head may mean "yes" or "I understand", or "I'm listening." Eye contact with elders/authority may be avoided as a sign of respect.
7. Personal and family honor is valued. Direct, especially public criticism should be avoided.
8. Loss of status upon entry to Canada is common in these groups. Be sensitive to resulting loss of dignity.
9. May avoid conflict. May not say "no" directly. May say "I'll try" or "Maybe". Failure to respond at all may be polite way of saying "no."
10. Problem solving and decision- making are formal processes. Slow, careful examination of documents, methodical.
11. Serve refreshments.

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12. Religion and language may be more important than “race”.
 13. The traditional family is male-centered.
 14. Women may be reluctant to shake hands with men or women.
 15. Compliments to a South Asian woman by an unrelated man may be considered inappropriate. However, do not make assumptions about South Asian women. Many are very influential in the family and are highly educated.
 16. South Asians, especially males, may speak loudly with animated gestures. This should not be seen as hostility or argument.
7. Problem solving and decision- making may involve passionate argumentation, use of power.
 8. Intuition and impulsivity are valued.
 9. Loyalty is valued.
 10. Traditionally, men are leaders.
 11. Mothers/sisters are highly honored and must not be insulted. Women may be actively prevented/ discouraged from seeking jobs or higher education (this varies greatly across cultures).
 12. Many Latin Americans may have had traumatic experiences in their homeland.

Latin American

1. Wide range of cultures/ countries of origin therefore generalizations are very difficult. Always check.
2. Small personal space requirements especially if interacting positively with an individual.
3. Touching is common for people of the same sex, and is often used as a sign of warmth or acceptance.
4. Personal dignity/honor is very important. Direct criticism, especially in front of others should be avoided.
5. Broad non-verbal behavior, emotionally expressive and willing to show sensitivity.
6. Punctuality is less important.

13. Do not assume lack of language skills equals lack of intelligence. Many Latin Americans are highly educated.

Southeast Asian (Vietnamese, Laotian, Cambodian)

1. Southeast Asia represents a wide range of cultures therefore generalizations are very difficult. Always check.
2. Time is not an important value.
3. Patience is admired and respected.
4. Reciprocity is valued in favors, therefore offers of assistance may not be accepted easily.
5. Third party mediation is preferable to direct confrontation. “Saving face” is important. Avoid direct criticism. Prefer to avoid open conflict.



6. Phrases such as “thank you” “please” “may I” “sorry” “pardon” etc...are used sparingly and only when sincerely meant.
7. Physical touching in public between opposite sexes is forbidden. Same sex, males or females, may hold hands or walk arm in arm.
8. Personal relationships/networking important to success. Maintenance of these relationships is important.
9. Problem solving and decision making requires a trusting personal relationship. Do not get straight to the point. “Yes” may mean uncertainly or possible “no”. Paraphrase to ensure you understand.
10. Respect for elders/authority figures, and personal humility important. Ancestors are often revered.
11. Discomfort with praise (may minimize own achievements).
12. Uncomfortable topics include personal or emotional problems, intergenerational conflict, finances.
13. Family comes before self or work. Men are the authority in the home.
14. Be sensitive to the possibility that this person may have experienced traumatic events in the homeland.
2. Individual and group dignity is important. Avoid direct criticism, open displays of anger. Third party mediation is valued.
3. Open conflict or questioning may be avoided. “Perhaps” or “maybe” may signal disagreement.
4. Taboo topics: marital status, children, family, money, & age.
5. Decision making and problem solving involve well thought out plans prepared for group consensus.
6. Women and men rarely show affection in public.
7. Family commitments over-ride personal desires.
8. Wife may have a great deal of power in the family, also financially. Women enjoy equality with men.
9. When greeting a group, the eldest or most important individual should be greeted first.
10. Do not use nicknames unless invited to do so!
11. Keep in mind that the Philippines are the third largest English speaking country in the world. Most Filipinos speak English very well.
12. May be reluctant to question those in authority.

Filipinos

1. Punctuality for social gatherings may not be important.



5.0 WORLD VIEWS ON HEALTH AND ILLNESS



“Health is not simply the absence of sickness.”

Hannah Green





Cultural Perspectives on Health and Illness

The World Health Organization (WHO), defines health as a state of complete physical, mental and social well being; it is not merely the absence of sickness. Webster's Dictionary defines illness as the condition of being ill, or in poor health, sickness.

Most cultures outside Canada have their own unique perceptions of health and illness, preventive practices, treatment methods, views on health care systems and sick roles which may vary when compared to Canada.

Every culture has its own unparalleled way in their beliefs around health and illness and the causes of the specific condition.

When health care professionals and patients/families from diverse cultural backgrounds do not have the same understanding of causalities of health conditions the likelihood that families will follow through with recommendations are nil.

Perceptions around health and illness are not to be confused with culture-bound syndromes. Culture-bound syndromes "are collections of symptoms and disease processes whose linkages are well recognized and given unique labels within the medical culture of a specific group but are not recognized outside that culture. They are distinguished by a characteristic etiology and accepted modes of treatment. Persons afflicted by these illnesses

have a legitimate claim to the culture's sick role, with all the privileges, social concern and assistance that accrue to that role" (Highlights in Cultural Competency, 1999).

The variety among health and illness beliefs, including culture-bound syndromes, may create obstacles between health care practitioners and patients from diverse backgrounds, therefore decreasing the potential of successful assessment, treatment and recovery. For this reason, health care professionals are encouraged to provide culturally competent health care services by understanding the unique perception of health and illness of their patients. Health education must also address the world views and customs that visible minorities have.

It is important to remember that each one of us have our own world views and this might or might not impact the ways we practice.

The following section discusses the health and illness belief systems of several ethnocultural communities that are served by the Alberta Health Services in Calgary. It is certainly not expected of health care professionals to know all these beliefs surrounding multicultural health practices; they are included to avoid common misunderstandings that arise between health care professionals and patients from diverse cultural backgrounds.

Perceptions of Health and Illness Across Cultures

Cultural Group	Perceptions of Health	Perceptions of Illness
Arabs	<p>According to the Arab culture, health is defined as a gift of God manifested in being able to eat well, to have minimal stress and pain, to have strength and to meet social obligations (Meleis,1996). Arab Canadians generally respect health care systems and providers and tend to accept health recommendations presented to them if they understand the rationale and motivation behind the advice. Health promotion within the Arab culture includes avoiding hot-cold, dry-moist shifts, wind and drafts and cold, hunger and fatigue. Being overweight is a symbol of health and strength (Meleis, 1996).</p>	<p>Common beliefs surrounding the cause of illness within the Arab community include bad luck, stress, germs, imbalance in hot and cold, sudden fears, God’s will and tests of endurance. In general, physically sick individuals are treated well whereas mentally ill individuals are believed to be controlling their illness, and are therefore not treated well by family. Patients will generally expect to be treated with a high level of care and attention. The Arab culture generally respects Western medicine, although home remedies such as herbal teas and religious devotions are also utilized.</p>
Cambodians	<p>The concept of health is that of equilibrium. Family and community members can influence an individual’s health (i.e. ancestral spirits can make family members ill if certain negative activities are engaged in). Nutrition is considered to be a means by which health equilibrium is achieved.</p>	<p>Imbalances in hot and cold, or sins from past life are considered to be the primary causes of illness. Genetic defects are generally blamed on past sins or parental activities during pregnancy. Herbal remedies are commonly used.</p>



Cultural Group	Perceptions of Health	Perceptions of Illness
Central Americans (Salvadorans, Guatemalans, & Nicaraguans)	The general perception of health is that of balance between hot and cold, strong and weak. Good health is closely associated with the ability to perform functional roles within the community. Health promotion and prevention practices may include adequate sleep, fresh air, food and rest. Positive thinking and a calm demeanor are also attributed to good health.	The cause of physical illness is generally associated with an imbalance of hot and cold, strong and weak. Outside sources, such as 'evil eye' or ghosts may also be associated with the onset of physical illness, while mental illness is generally attributed with supernatural forces. Genetic illnesses may be seen as God's will, or to mother's behavior during pregnancy. There is a great reliance on over-the-counter medications although home and folk remedies may also be used.
Chinese	The perception of health is generally that of balance between the Yin (cold) and Yang (hot) influences in the environment and body. The mind, body and spirit must be in harmony to achieve health. A balanced diet of yin and yang foods is a common preventative measure used by the Chinese Canadian community.	An imbalance between Yin and Yang is considered to cause most physical illnesses, while mental illness is attributed to a lack of harmony of emotions. Genetic defects are generally thought to be caused by the mother, either something she consumed during pregnancy or a significant action. Home and folk remedies are common, usually involving certain roots and animal meats.



Cultural Group	Perceptions of Health	Perceptions of Illness
Colombians	<p>In the Colombian culture, health is generally associated with feeling happy and being able to perform in expected roles as parents, workers, and others. Promotion of health consists of proper nutrition, rest and physical hygiene.</p>	<p>The causes of physical illness are generally attributed to God's design and may also be attributed to behavior or punishment. The causes of mental illness are explained as a result of an overwhelming situation, or in women, results from love deceptions. Genetic defects may be explained by parents (especially the mother) doing something wrong during pregnancy. Illnesses are treated with both home remedies (i.e. herbal teas) and biomedical approaches.</p>
Ethiopians & Eritreans	<p>Health is considered to be the equilibrium among physiological, spiritual, cosmological, ecological and social forces, with an importance in maintaining a peaceful relationship with the super-natural world. Moderate eating and drinking, avoidance of emotional distress, and the maintenance of cleanliness are thought to achieve a healthy lifestyle.</p>	<p>In general, two theories of disease exist. Naturalistic causes are those influenced by external factors such as poor nutrition or hydration. Magico-religious causes are those attributed to God, nature, magical forces or a breach of social taboos. Evil spirits and the will of God are generally considered to cause mental illness and genetic defects. Biomedicine is generally relied on, although certain home remedies are used.</p>



Cultural Group	Perceptions of Health	Perceptions of Illness
Filipinos	Health is achieved by the maintenance of balance. Good food, strength and freedom from pain are associated with health. Being overweight is a symbol of good socioeconomic standing, and is not viewed as a health concern.	Illness is caused by an imbalance in one's life. For instance, mental illness is seen as a disruption of harmonious function of whole individual and spiritual world, including supernatural, mystical and naturalistic factors. Illness may be associated with bad behavior or punishment, which must be corrected for health to return.
Japanese	Good health is associated with balance and harmony between oneself, society and universe, and is related to maintaining independence and disease-free living.	Older generations of Japanese Canadians may be less likely to seek Western medical advice during early stages of illness, while younger generations may hold more of a Western ideology with regards to illnesses. Evil spirits, punishment for previous behavior and not living a good life are thought to cause mental illness. Genetic defects thought to be caused as a punishment for family's bad behavior during pregnancy.
Koreans	The concept of health is closely associated with the balance between soul and physical being. Keeping this balance is the main goal of health promotion and prevention.	In keeping with Buddhist doctrine, illness and death are accepted as inherent aspects of life. Illness may be viewed as the result of bad luck or misfortune, which may lead to feelings of helplessness, denial and depression.

Cultural Group	Perceptions of Health	Perceptions of Illness
Russians	Regular bowel movements and the absence of symptoms such as colds, influenzas, etc are closely associated with the concept of health. Good health is maintained by dressing warmly, eating well, exercising, and enjoying pleasant entertainment.	The perceived causes of illness include poor nutrition, stress, family history, not dressing warmly, and poor pregnancy are factors associated with physical illness. Mental illness is thought to be caused by stress and moving into a new environment. Russians will generally treat themselves first before seeking biomedical advice. Excessive drug use is thought to be harmful and poisonous. Home remedies include the use of ointments, oils, baths, teas and foods.
South Asians	The body is thought to be in a state of good health when digestive fires are in balanced condition, bodily humors are in equilibrium, waste products are in normal levels, senses are functioning normally and body, mind and consciousness are working as one. Health promotion and illness prevention are emphasized in everyday life, with an emphasis on adequate rest and sleep, good hygiene, moderate eating and regular prayer and exercise.	Many perceptions of illness depend on the religious designation of the individual. In Hindu and Sikh belief systems, diseases are believed to be caused by actions in past lives, which determine the individual's susceptibility to illnesses. Muslims believe that illness can result from bad actions, which wash away a person's sins. The causes of mental illness are often believed to be due to spells cast by an enemy or the body falling prey to evil spirits. Most individuals will use home and folk remedies before consulting a physician.

Cultural Group	Perceptions of Health	Perceptions of Illness
Vietnamese	The concept of good health is closely associated with a balance and harmony within all aspects of one's life. Being overweight is a sign of good socioeconomic standing. Illness prevention rituals include maintaining high personal cleanliness standards and ensuring a warm environment.	There exist four primary causes for illness. Natural causes are the immediately visible circumstances, such as rotten food. Balance between yin and yang accounts for the Chinese-Vietnamese explanation for illness. Supernatural explanations include punishment for personality flaws or violation of religious practices. Western biomedical causes (i.e. "germs") also is considered to be a cause of illness.
West Indians	Good health is associated with an absence of physical pain, the ability to perform one's usual activities and weight gain, even among overweight individuals.	Illness is thought to be attributed to exposure of germs or cold air, or not eating the right types and quantities of food. Mental illness is viewed as a weakness of inability to cope with the stresses of everyday living, and stress and worries are perceived as sources of mental illness. Genetic defects are thought to be caused by spiritual factors, such as God's will. Home remedies continue to be a part of health care, especially the use of herbal teas.

(Source: Lipson, Juliene, Dibble, Suzanne, Minarik, Pamela, Culture & Nursing Care: A Pocket Guide, UCSF Nursing Press, 1996)

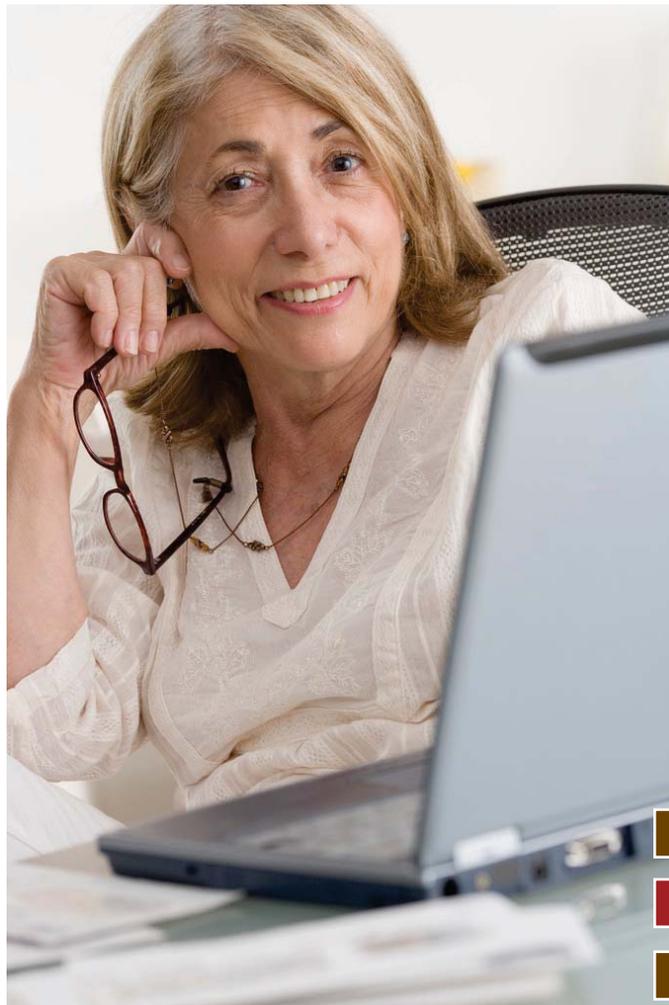
Culturally competent nursing care is defined as being sensitive to issues related to race, culture, gender, sexual orientation, social class and economic situations, among other factors (Meleis, Isenberg, Koerner, & Stern, 1995).

Additional Resource

The EthnoMed web site (www.ethnomed.org) contains information about cultural beliefs, medical issues and other related issues pertinent to the health care of recent immigrants to Seattle or the US, many of whom are refugees fleeing war-torn parts of the world (ethno-med, 2004). Also included is access to translated materials.



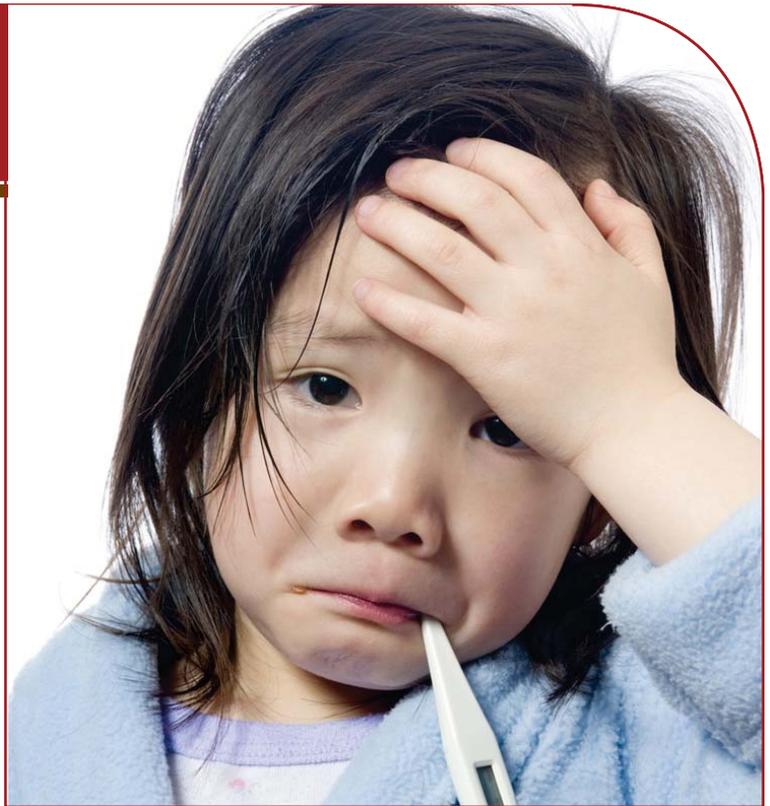
6.0 INFORMATION GATHERING



“They may forget what you said, but they will never forget how you made them feel.”

Carl Buechmer





Introduction

Picture yourself at work waiting for your next patient. She walks in and you are not able to communicate with her at all because she can not communicate in English. You arrange for an interpreter and continue your session but it seems as if the patient has a whole other understanding of what is causing her illness.

What would you do?

Do you get anxious?

Do you know what questions to ask the patient to continue the assessment?

How do you communicate your recommendations effectively with this patient?

The following section is included to support health care professionals to better understand their patients regarding their health issues when collecting information from patients of culturally diverse backgrounds. The chosen assessment models include relevant questions

to be used as is or in addition to standard assessment questionnaires. In cross-cultural situations these models can assist health care practitioners overcome any potential cultural barriers that may exist in providing care.

There are four models that will be highlighted:

- ▶ The Vancouver Community Mental Health Services (2001) model
- ▶ The Kleinman model
- ▶ The ETHNIC model
- ▶ The LEARN model

It is important to take into consideration the client's style to share information versus a more formalized assessment tool. In working with ethno-cultural clients be prepared to adapt, and be eclectic in style and method of information gathering.

Culturally Sensitive Assessment Guidelines

Vancouver Community Mental Health Services

Illness Factors

Concept of Mental Illness

- ▶ Client/Family members' understanding of the diagnosis
- ▶ Acceptance of illness
- ▶ Signs and symptoms
- ▶ Previous experience with illness among client's family members
- ▶ Client's view of the illness, treatment and medication
- ▶ Reason for seeking treatment at this time

Hospitalization

- ▶ Former experience of hospitalization – mental illness
- ▶ Past problems and foreseeable problems related to hospitalization

Health Maintenance Practice in Client's Family

- ▶ Use of traditional remedies
- ▶ Client's opinion of Western medicine, psychotropic medication and side effects
- ▶ The person who usually makes the decision on medical issues in the family

Personal Factors

- ▶ Ethnic origin of client
- ▶ Place of birth:
 - ▶ If born here, check when client's parents or ancestors came to Canada
 - ▶ If client was born abroad, check immigration and relocation history:
 - ▶ Length of stay in Canada
 - ▶ Immigration status: landed immigrant, citizen, visitor, refugee, work permit, student visa
 - ▶ Number of times client has moved between provinces after immigration. With whom? Reason for move?
 - ▶ Age when the client immigrated to Canada
 - ▶ Place of origin, from urban or rural areas (important especially in the case of new immigrants)
 - ▶ Frequency of travel between home country and Canada
 - ▶ Upward or downward mobility since immigration, as perceived by the client (i.e. change in social and financial status)

Employment

- ▶ Change and stress – underemployment? Unemployment?
- ▶ Present Occupation – works in ethnic language environment?
- ▶ Previous employment in home country/before onset of illness?
- ▶ Birth Order and its implication in client's culture – oldest? Youngest? Only boy?

Language

- ▶ Mother tongue (specify dialect used)
- ▶ English Language competency
- ▶ Contact person if not fluent in English
- ▶ Language spoken at home

Religion

- ▶ Support network provided by religious bodies
- ▶ Possible problem caused by client's religious beliefs

Diet

- ▶ Client's food beliefs
- ▶ Any interference with treatment

Financial State

- ▶ Who is the breadwinner?
- ▶ Is client eligible for financial assistance, if needed?
- ▶ Who sponsored client to come

to Canada, if anyone? Length of sponsorship?

- ▶ Other family members left in home country

Interpersonal Factors

Family

- ▶ Members of family (whom does client consider his family?) Extended? Stem? Nuclear?
- ▶ People client lives with
- ▶ Client's role in family
- ▶ Position in family hierarchy
- ▶ Marital Status
- ▶ Spousal relationship
- ▶ Parent/child relationship

Extended Family

- ▶ Members
- ▶ Frequency in meeting
- ▶ Assisting with baby-sitting, interpreting, transportation, and other services
- ▶ If close, check their concept of client's illness, belief in traditional remedies, view of client's treatment, language spoken, help seeking preferences, health status and proximity to their home to that of client
- ▶ Intergenerational differences
- ▶ Extent of support system (including sponsors, friends, and loved ones in home country)



Environmental Factors

- ▶ Housing: whom does the client live with?

Ethnic Network in Community

- ▶ Sources of support
- ▶ Information of client's illness provided by ethnic media and other communication networks
- ▶ Ongoing political and economic events in Far East and Canada – i.e. change in immigration and refugee laws.
- ▶ Social network:
 - ▶ Factor of acculturation



Kleinman, 1980

In the context of an interview, staff are recommended to utilize some of the following approaches in an informal format. The timing and phrasing of these questions should be incorporated into discussion versus being presented as a list of assessment questions, thus demonstrating the clinician's genuine interest in the client's information.

Culturally Appropriate Assessment Questions

1. What do you call your problem? What name do you give it?
2. What do you think has caused it?
3. Why did it start when it did?
4. What does your sickness do to your body? How does it work inside you?
5. How severe is it? Will it get better soon or take longer?
6. What do you fear most about your sickness?
7. What are the chief problems your sickness has caused for you (personally, family, work, etc.)?
8. What kind of treatment do you think you should receive? What are the most important results you hope to receive from the treatment?

Areas of understanding regarding the use of traditional medicine

1. The kinds of remedies people use for a

particular illness.

2. Home remedies currently being used which are believed to be helpful.
3. Remedies used in the country of origin and their effectiveness.

The following areas should be included in the assessment

- ▶ Marital status
- ▶ Presence of extended family in household
- ▶ Relatives in the local community
- ▶ Traditional medicine used in the home country and/or Canada
- ▶ Children in the family; starting with question about children, especially with mothers, may increase ease of the client
- ▶ Support inside and outside the home
- ▶ Who the client turns to for help and the kind of help sought
- ▶ Elderly family members - inquire as to how they are managing

Adjustment difficulties to consider

- ▶ Employment status and role changes
- ▶ English language skills
- ▶ Intergenerational issues
- ▶ Financial support; how the family is currently obtaining income



E.T.H.N.I.C. Model

The ETHNIC model is a framework designed to encourage cultural competency in health care. When patients and families have an understanding of the patient's health concerns, this facilitates the process of treatment planning. This model is a set of questions that can be used with all families but proves to be helpful with culturally diverse patients. It is suggested that these questions be asked after the routine questions.

E: EXPLANATION

What do you think may be the reason you have these symptoms?

What do friends, family, others say about these symptoms?

Do you know anyone else who has had or who has this kind of problem?

Have you heard about it on TV or radio or read about it in a newspaper? (If patients cannot offer explanations, ask what most concerns them about their problems).

T: TREATMENT

What kinds of medicines, home remedies, or other treatments have you tried for this illness? Is there anything you eat, drink, or do (or avoid) on a regular basis to stay healthy? Please tell me about it. What kind of treatment are you seeking from me?

H: HEALERS

Have you sought any advice from alternative/ folk healers, friends, or other people (non-doctors) for help with your problems? Tell me about it.

N: NEGOTIATE

Negotiate options that will be mutually acceptable to you and your patient and that do not contradict, but rather incorporate, your patient's beliefs. Ask what are the most important results your patient hopes to achieve from this intervention.

I: INTERVENTION

Determine an intervention with your patient. May include incorporation of alternative treatments, spirituality, and healers as well as other cultural practices (e.g., foods eaten or avoided in general, and when sick).

C: COLLABORATION

Collaborate with the patient, family members, other health care team members, healers, and community resources.

© 1997 Developed by: Steven J. Levin, MD Robert C. Like, MD, MS Jan E. Gottlieb, MPH Center for Healthy Families and Cultural Diversity Department of Family Medicine UMDNJ-Robert Wood Johnson Medical School



L.E.A.R.N. Model

The **L.E.A.R.N.** model is a set of guidelines for overcoming obstacles in cross-cultural communication with patients. It was also developed to heighten the awareness of professionals around cultural issues and to increase the number of families following through with recommendations. This model could also be used as a process oriented framework to explore social, personal, and cultural information that may affect a diagnosis. In using this model, the process of discussing, negotiating, and incorporating diagnoses will be a much smoother process between families/ patients and health care professionals.

L: Listen with empathy and understanding of the patient's perception of the problem.

E: Explain your perceptions of the problem.

A: Acknowledge and discuss the differences and similarities.

R: Recommend treatment.

N: Negotiate agreement.

Listen

- ▶ Questions that could be asked are:
- ▶ What do you feel may be causing your problem?
- ▶ How do you feel the illness is affecting you?
- ▶ What do you feel might be of benefit?

Explain

Provide the patient with the biomedical/ western explanation of their health issue.

Acknowledge

Both patient beliefs around illness and professional beliefs should be incorporated in the treatment options.

Recommend

Treatment plans developed with patients' involvement with inclusiveness of culturally appropriate aspects.

Negotiate

Based on the biomedical, psychosocial or cultural, a treatment plan is discussed and negotiated.

Elois Ann Berlin and William C. Fowkes Jr., A Teaching Framework for Cross-Cultural Health Care. *The Western Journal of Medicine*, 1983, 139(6), 934.



7.0 PROVISION OF CARE



“Civilization is to be judged by its treatment of minorities.”

Mahatma Ghandi





Professional Standards and Guidelines

The provision of culturally competent health services has been outlined by various professional associations, as well as through accreditation standards. The following are some examples:

Canadian Nurses Association, Position Statement - Promoting Culturally Competent Care

“Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients¹. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served and being sensitive to these while caring for the

¹ A client may be an individual, a family, a group or a population

individual.”

“Individual nurses are responsible for acquiring, maintaining and continually enhancing cultural competencies in relation to the clients that they care for. They are responsible for incorporating culture into all phases of nursing process and in all domains² of nursing practice.”

(For full Position Statement see end of Chapter).

Registered Psychiatric Nurses: Competency Profile for the Profession in Canada 2002

A Registered Psychiatric Nurse will:

² Domains of nursing practice include clinical practice (direct care), education, research and administration.



Demonstrate knowledge and understanding of social and cultural factors including but not limited to: age, gender, education, family, economic status, ethnic beliefs, lifestyle, and religious influences.

Demonstrate knowledge and understanding of how social and cultural factors influence the mental health of individuals, families, groups and communities.

Alberta College of Social Workers, Standards of Practice

“**Cultural Competence:** A social worker will not impose any stereotypes on a client based on behaviour, values or roles related to race, ethnicity, religion, marital status, gender, sexual orientation, age, socio-economic status, income source or amount, political affiliation, disability or diagnosis, language, or national origin, that would interfere with the provision of professional services to the client.

A social worker will be able to work with a wide range of people who are culturally different from the social worker or who may be considered to be members of vulnerable populations on the bases of attributes such as those listed in section 84” (ACSW Standards of Practice, 2007).

American Psychological Association Guidelines, 1990

- a. Psychologists educate their clients to the processes of psychological intervention, such as goals and expectations; the scope, and where appropriate, legal limits of confidentiality; and the psychologists’ orientations.
 - b. Psychologists are cognizant of relevant research and practice issues as related to the population being served.
 - c. Psychologists recognize ethnicity and culture as significant parameters in understanding psychological processes.
 - d. Psychologists respect the roles of family members and community structures, hierarchies, values, and beliefs within the client’s culture.
 - e. Psychologists respect clients’ religious and/or spiritual beliefs and values, including attributions and taboos, since they affect world view, psychosocial functioning, and expressions of distress.
 - f. Psychologists interact in the language requested by the client and, if this is not feasible, make an appropriate referral.
 - g. Psychologists consider the impact of adverse social, environmental, and political factors in assessing problems and designing interventions.
 - h. Psychologists attend to as well as work to eliminate biases, prejudices, and discriminatory practices.
 - i. Psychologists working with culturally diverse populations should document culturally and sociopolitically relevant factors in the records.
- a. Psychologists educate their clients to the processes of psychological intervention, such as goals and expectations; the scope, and where appropriate, legal limits of



Knowledge, Skills and Attitudes

Canadian Council on Health Services Accreditation (CCHSA)

“Cultural diversity is an aspect that should be considered throughout the standards. In some sections, the CCHSA specifically asks for culturally related comments in the guidelines under the standards.” (Sharon Zibin, Regional Accreditation Coordinator, Calgary Health Region)

The following is a list of principles in cultural competency for health care clinicians:

Knowledge

1. Clinician’s self- understanding of race, ethnicity and power.
2. Understanding of the historical factors which impact the health of minority populations, such as racism and immigration patterns.
3. Understanding of the particular psychosocial stressors relevant to minority patients. These include war trauma, migration, acculturation stress, socio-economic status.
4. Understanding of the cultural differences within minority groups.
5. Understanding of the minority patient within a family life cycle and intergenerational conceptual framework in addition to a personal developmental network.

6. Understanding of the differences between “culturally acceptable” behavior of psychopathological characteristics of different minority groups.
7. Understanding indigenous healing practices and the role of religion in the treatment of minority patients.
8. Understanding of the cultural beliefs of health and help seeking patterns of minority patients.
9. Understanding of the health service resources for minority patients.
10. Understanding of the public health policies and its impact on minority patients and communities.

Skills

1. Ability to interview and assess minority patients based on a psychological/ social/ biological/ cultural/ political/ spiritual model.
2. Ability to communicate effectively- cross-cultural use of interpreters.
3. Ability to diagnose minority patients with an understanding of cultural differences in pathology. Ability to avoid under diagnosis or over diagnosis.
4. Ability to formulate treatment plans that are culturally sensitive to the patient and family’s concept of health and illness.

- 
5. Ability to utilize community resources (church, self- help groups, etc.)
 6. Ability to provide therapeutic and pharmacological interventions, with an understanding of the cultural differences in treatment expectations and biological response to medication.
 7. Ability to ask for consultation.

Attitudes

1. Respect the “survival merits” of immigrants and refugees.
2. Respect the importance of cultural forces.
3. Respect the holistic view of health and illness.
4. Respect the importance of spiritual beliefs.
5. Respect and appreciate the skills and contributions of other professional and paraprofessional disciplines.
6. Be aware of transference and counter transference issues.

(Source: Lee, Evelyn, Bridge to Wellness program, San Francisco)



Self-Assessment

Promoting Cultural Diversity and Cultural Competency

Self-Assessment Checklist for Personnel Providing Services and Supports to Children and their Families

Physical Environment, Materials & Resources

_____ 1. I display pictures, posters and other materials that reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

_____ 2. I insure that magazines, brochures, and other printed materials in reception areas are of interest to and reflect the different cultures of children and families served by my program or agency.

_____ 3. When using videos, films or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

_____ 4. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and the society in general.

Communication Styles

_____ 5. For children who speak languages or dialects 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.

_____ 6. I attempt to determine any familial colloquialisms used by children and families that may impact on assessment, treatment or other interventions.

_____ 7. I use visual aids, gestures, and physical prompts in my interactions with children who have limited English proficiency.

_____ 8. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings, or other events for parents who would require this level of assistance.

_____ 9. When interacting with parents who have limited English proficiency I always keep in mind that:

_____ * Limitations in English proficiency is in no way a reflection of their level of intellectual functioning.



_____ * Their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language of origin.

_____ * They may or may not be literate in their language of origin or English.

_____ 10. When possible, I insure that all notices and communiqués to parents are written in their language of origin.

_____ 11. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values & Attitudes

_____ 12. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

_____ 13. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs before sharing them with children and their parents served by my program or agency.

_____ 14. I intervene in an appropriate manner with I observe other staff or parents within my program or agency engaging in behaviours that show cultural insensitivity or prejudice.

_____ 15. I understand and accept that family is defined differently by different cultures (e.g. extended family members, fictive kin, and godparents).

_____ 16. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

_____ 17. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g. who makes major decisions for the family, play and social interactions expected of male and female children).

_____ 18. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g. high value placed on the decisions of elders or the role of the eldest male in families).



_____ 19. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision makers for services and supports for their children.

_____ 20. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

_____ 21. I accept that religion and other beliefs may influence how families respond to illnesses.

_____ 22. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care needs.

_____ 23. I understand that traditional approaches to disciplining children are influenced by culture.

_____ 24. I understand that families from different cultures will have different expectations of their children for acquiring toiling, dressing, feeding, and other self help skills.

_____ 25. I accept and respect that customs and beliefs about food, its value, preparation, and use are different from culture to culture.

_____ 26. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations that are unique to families of specific cultures and ethnic groups served by my program or agency.

_____ 27. I seek information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

_____ 28. I advocate for the review of my program's or agency's mission statement, goals, policies, and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

Tawara D. Goode. Georgetown University Center for Child and Human Development, University Center for Excellence in Developmental Disabilities Education, Research & Services. Adapted from Promoting Cultural Competence and Cultural Diversity in Early Intervention and Early Childhood Settings, June 1989. Revised 1993, 1996, 1999, 2002 and 2002.



Multicultural Practice Competencies Tool³



Child and Women's Health Diversity Program

³ Adapted from: The Multicultural Counseling Competencies developed by the Association of Multicultural Counseling and Development, A Division of the American Counseling Association, 1996

Introduction

Clinical practice in Alberta has evolved significantly as our community has become more diverse. Currently, many cultures exist that previously were unknown to our region and in some instances we have become the primary destination point in Canada for certain cultural groups.

The purpose of this Multicultural Practice Competencies tool is to assist professionals to move towards greater cultural competency. The tool can enable practitioners to examine their sensitivity, competency and skillfulness in practice. Additionally, it is intended to help individuals recognize their own biases and the impact of limitations in providing service to the ever expanding ethno-cultural community.

The Child & Women's Health Multicultural Committee⁴ and the Diversity Program Coordinator have been working towards the goal of helping health care professionals to become more responsive to, and inclusive of, families from diverse backgrounds. In 2003, 208 staff participated in a cultural competency self assessment developed by Carrie Bon Bernard and implemented by Linda Kongnetiman. This assessment focused on cultural sensitivity and awareness of staff in the Child and Women's Health Portfolio. This assessment was to determine the needs of staff regarding support for culturally competent practice. One of the recommendations was to develop a more in depth self assessment tool that extends beyond sensitivity and awareness to aid in the development of skilful practice.

After careful consideration a decision was made to adapt the Multicultural Counselling Self Assessment tool developed by the Association of Multicultural Counselling and Development (American Counselling Association, 1996) to support staff in their assessment of their own cultural competencies.

It is our hope that completing this tool will be helpful in the identification of areas for further growth in your attitudes, beliefs, knowledge and skill in the following domains:

- personal cultural values and biases
- personal awareness of client's worldview
- culturally appropriate intervention strategies

This document includes:

- working definitions
- instructions for completing the tool
- the self assessment tool
- case studies
- resources
- practice enhancement plan

This tool can be used to:

- Inform administrators of the Child and Women's Health portfolio regarding the incorporation of cultural competence as an educational tool to support staff in service provision through feedback in order to develop their Practice Enhancement plan
- Conduct a personal and practice related self-assessment
- Serve as part of a professional development plan
- Stimulate a team discussion re: cultural competency with the goal of skill development
- Develop new research projects
- Identify evidence-based practice

We thank you for taking the time to work through this document and to complete the tool. We look forward to your feedback which will assist in the further development of this tool.

⁴ Key contributors: Pamela Dos Ramos, Bev Berg and Lisa Semple

What is Cultural Competency?

Until the 1960s, Canada accepted immigrants predominantly from European countries. That trend has changed and Canada has become a haven where people from different ethnic backgrounds settle, integrate and become Canadian citizens. Over half of the current Canadian population is the result of international immigration (Statistics Canada, 2001). In Calgary, the ratio of visible minorities to Caucasians was 1 to 350 in 1959 (Calgary Network for Equity and Diversity, 2000). Currently, about 18.7%, almost 1 of 5 Calgarians, is from a non-European ethno-cultural background (Statistics Canada, 2001).

Considering the statistics above, these data fuel the need to support health care professionals in their interaction with culturally diverse families. The need for education about cross cultural issues is particularly important since many professional associations are moving towards incorporating cultural competence as part of their requirements for professional qualification. Historically cultural competence has not been required by most institutions.

As a culturally competent health care professional you should be able to adjust your assessments, interventions/recommendations to the culture-specific needs of the families with whom you work. This means that you should look not only at the medical diagnosis, but also take into consideration all other components such as both the patient's and professional's culture and a cultural understanding of the medical diagnosis and procedures in the context of his/her culture as well as other institutions involved (adapted from Coleman, 2003).

In general, it is important to examine your own practice and the influence of your world views in working with clients from diverse backgrounds.

Definitions:

Multicultural Competency is a professional's ability to integrate into his/her theoretical and technical approach to assessment and intervention relevant human diversity factors that are important to the process and successful outcome of care. (Adapted from Fuertes & Ponterotto, 2003)

Human diversity is any salient group reference that is meaningful to the individual, and may include gender, socio-economic background, religion, race, ethnicity, regional/national origin, and sexual orientation, all or any of which may inform or shape individual identity behaviour world view, values, attitudes and beliefs. (Fuertes & Ponterotto, 2003).

Cultural competence is a continuous process of seeking cultural sensitivity, knowledge and skills to work effectively with individuals and families from diverse cultural communities and with their culturally diverse providers (Agger Gupta, 1995).

Ethno cultural refers to a group of people who shares a common distinctive ethnicity, heritage, culture, language, social patterns and a sense of belonging (Agger Gupta, 1995).

Visible minorities refer to people who are not White or Caucasians in ancestry (Agger Gupta, 1995).

Multicultural Practice Competencies Tool

Introduction to the Tool

This tool will take you through an exercise to explore your personal as well as your professional values related to culturally competent practice.

While completing this tool you may have a range of thoughts and feelings. It is natural that emotions and anxieties regarding your own beliefs and attitudes may surface. However, working through this discomfort can enhance this learning process.

In developing cultural competence, professionals need to examine their own beliefs and attitudes. This development of self awareness is essential to the delivery of culturally competent care. It is our personal and professional attitudes and beliefs that can facilitate or hinder an effective working relationship with a client from a diverse background.

It will take you approximately 1 hour to complete the tool.

There are three domains in the tool:

1. Professional Awareness of Own Cultural Values and Biases
2. Professional Awareness of Client's Worldview
3. Culturally Appropriate Intervention Strategies

Within the three domains are three competency areas supported by specific examples:

- A. Attitudes and Beliefs
- B. Knowledge
- C. Skills

You will be using a scale to rate yourself in these areas.

Following the completion of the tool, three case studies are presented for you to review.

We invite you to take your time with this reflective exercise.

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I. Professional Awareness of Own Cultural Values and Biases

A. Attitudes and Beliefs

1. Culturally skilled professionals believe that cultural self-awareness of one's own cultural heritage is essential.

I can identify the culture(s) to which I belong and the significance of that membership including the relationship of individuals in that group with individuals from other groups, institutionally, historically, educationally, etc.

1 2 3 4

2. Culturally skilled professionals are aware of how their own cultural background and experiences have influenced attitudes, values, and biases about psychosocial processes.

I can articulate the beliefs of my own cultural and religious groups around differences, such as world religion, and beliefs around health and illness, and the impact of these beliefs on a patient/professional relationship.

1 2 3 4

3. Culturally skilled professionals are able to recognize the limits of their multicultural competency and expertise.

I can recognize in a patient/professional relationship that the impact of my attitudes, beliefs and values may be interfering with providing the best service to patients.

1 2 3 4

4. Culturally skilled professionals recognize differences and similarities that exist between themselves and patients in terms of race, ethnicity and culture.

I can identify at least five specific cultural differences when caring for culturally diverse patients.

1 2 3 4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I can identify the needs of culturally different patients.

1

2

3

4

I can identify how these differences are handled in a helping relationship.

1

2

3

4

B. Knowledge

1. Culturally skilled professionals have specific knowledge about their own racial and cultural heritage and how it personally and professionally affects their definitions of biases against normality/abnormality and the process of caring for individuals.

I can recognize and discuss my family and cultural perspectives of what feels normal or what are unacceptable codes of conduct and how this may or may not vary from those of other cultures and families.

1

2

3

4

2. Culturally skilled professionals possess knowledge and understanding about how oppression, racism, discrimination, and stereotyping affect them personally in their work. This allows individuals to acknowledge their own cultural bias, beliefs and feelings. Although this standard applies in groups, for Caucasian professionals it may mean that they understand how they may have directly or indirectly benefited from individual, institutional, and cultural racism.

I can specifically identify, name, and discuss privileges that I personally receive in society due to my race, socioeconomic background, gender, physical abilities, and sexual orientation.

1

2

3

4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

3. Culturally skilled professionals possess knowledge about their social impact upon others. They are knowledgeable about communication style differences, how their style may clash with or foster the therapeutic process with visible minorities or others different from themselves, and how to anticipate the impact it may have on others.

I can describe the behavioural impact on patients different from myself and their reaction to my communication style. (For example, the reaction of an older (60's) Vietnamese male, recent immigrant, to continuous eye contact from a young female professional.)

1

2

3

4

C. Skills

1. Culturally skilled professionals seek out educational, consultative, and training experiences to improve their understanding and effectiveness in working with culturally different populations. Being able to recognize the limits of their competencies, they (a) seek consultation, (b) seek further training or education, (c) refer out to more qualified individuals or resources, or (d) engage in a combination of these.

I understand and communicate to the patient that the consultation and involvement from other culturally skilled practitioners is being made because of my professional limitations regarding my cultural competence rather than their fault.

1

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I actively consult regularly with other professionals regarding issues of culture in order to receive feedback about issues, situations and whether or where a referral may be necessary.

1

2

3

4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

2. Culturally skilled professionals are constantly seeking to understand themselves as racial and cultural beings and are actively seeking a non-racist identity.

I maintain relationships (personal and professional) with individuals different from myself and actively engage in discussions allowing for feedback regarding my behaviour (personal and professional) concerning cross-cultural issues.

When I receive feedback regarding my culturally-related interventions I demonstrate receptivity and willingness to learn.

1

2

3

4

II. Professional Awareness of Client's Worldview

A. Attitudes and Beliefs

1. Culturally skilled professionals are aware of their negative and positive emotional reactions toward other racial and ethnic groups that may prove detrimental to the professional relationship. They are willing to contrast their own beliefs and attitudes with those of their culturally different clients in a non-judgmental fashion.

I can identify my common emotional reactions to individuals and groups different from myself and observe my own reactions in encounters. (for example, do I feel fear when approaching a group of three young African Canadian males? Do I assume that the Asian Canadian patients for whom I provide care do well in math?)

1

2

3

4

2. Culturally skilled professionals are aware of their stereotypes and preconceived notions that they may hold toward other racial and ethnic minority groups.

I recognize my stereotyped reactions to people different from myself (e.g., silently articulating my awareness of a negative stereotypical reaction . . . "I noticed that I locked my car doors when that African Canadian teenager walked by").

1

2

3

4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I can give specific examples of how my stereotypes (including “positive” ones), impact my professional-patient relationship.

1

2

3

4

B. Knowledge

1. Culturally skilled professionals possess specific knowledge and information about the particular group that they are working with. They are aware of the life experiences, cultural heritage, and historical background of their culturally different patients.

I can articulate (accurately) differences in nonverbal and verbal behavior of the five major different cultural groups most frequently seen in my work experience.

1

2

3

4

I understand and can explain the historical point of contact with mainstream society for various ethnic groups and the impact of the type of contact (enslaved, refugee, seeking economic opportunities, conquest, etc.) on current diversity issues in society.

1

2

3

4

I can identify within-group differences and assess various aspects of individual clients to determine individual as well as cultural differences. (For example, I am aware of differences between 3rd and 4th generation Chinese Canadians because the Chinese community has been here since the mid to late 1800's.)

1

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2. Culturally skilled professionals understand how race, culture and ethnicity may affect personality formation, vocational choices, manifestation of psychological disorders, help - seeking behaviour, and the appropriateness or inappropriateness of professional approaches.

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I can distinguish cultural differences and expectations regarding roles and responsibilities in families, participation of family in seeking help, appropriate family members to be involved, culturally acceptable means of expressing emotion and anxiety, etc.

1

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3. Culturally skilled professionals understand and have knowledge about socio-political influences that impinge upon the life of racial and ethnic minorities. Immigration issues, poverty, racism, stereotyping, and powerlessness may impact self-esteem and self-concept which in turn influence the professional process.

I can identify implications of concepts such as internalized oppression, institutional racism, privilege, and the historical and current political climate regarding immigration, poverty, welfare (social assistance).

1

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3

4

I can explain dynamics of at least two cultures and how factors such as poverty and powerlessness have influenced the current conditions of individuals of those cultural groups.

1

2

3

4

C. Skills

1. Culturally skilled professionals familiarize themselves with relevant research and the latest findings regarding mental health, epidemiology, culture and pain, child rearing practices, feeding practices, etc. that affect various ethnic and racial groups. They actively seek out educational experiences that enrich their knowledge, understanding, and cross-cultural skills for more effective professional behaviour and service provision.

I can identify at least five multicultural educational experiences in which I have professionally participated within the past 3 years.

1

2

3

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Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I can describe in concrete terms how I applied various information gained through current research in mental health, education and career choices.

1

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2. Culturally skilled professionals become actively involved with minority individuals outside the professional setting (community events, social and political functions, celebrations, friendships, neighbourhood groups, and so forth) so that their perspective of minorities is more than an academic or professional exercise.

I actively plan experiences and activities that will contradict negative stereotypes and preconceived notions I may hold.

1

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III. Culturally Appropriate Intervention Strategies

1. Culturally skilled professionals respect patients' religious and/or spiritual beliefs and values, including attributions and taboos, because they affect worldview, psychosocial functioning and expressions of distress.

I can identify the positive aspects of spirituality (in general) in terms of wellness and healing aspects.

1

2

3

4

2. Culturally skilled professionals value multilingualism and do not view other languages as an impediment to health care.

I communicate to patients and colleagues the value and assets of multilingualism (if patient is multilingual).

1

2

3

4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

B. Knowledge

1. Culturally skilled professionals have a clear and explicit knowledge and understanding of the generic characteristics of the Western health care model and how these may differ from the cultural values of various cultural groups.

I recognize the predominant theories being used within my professional organization and educate colleagues regarding the aspects of those theories, assessments, recommendations and interventions that may differ with the cultural values of various cultural and racial minority groups.

1 2 3 4

2. Culturally skilled professionals are aware of institutional barriers that prevent minorities from using health care services.

I can describe concrete examples of institutional barriers within my organization that prevent visible minorities from using health services and share those examples with colleagues and decision making bodies within the institution.

1 2 3 4

I recognize and draw attention to patterns of usage (or non usage) of health services in relation to specific populations.

1 2 3 4

I can identify and communicate possible alternatives that would reduce or eliminate existing barriers within my institution and within local, provincial, and national decision making bodies.

1 2 3 4

3. Culturally skilled professionals have knowledge of the potential bias in assessment instruments and use procedures and interpret findings keeping in mind the cultural and linguistic characteristics of the clients.

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I understand the limitations as well as the importance of using language that includes culturally relevant connotations and idioms.

1

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4

4. Culturally skilled professionals have knowledge of family structure, hierarchies, values, and beliefs from various cultural perspectives. They are knowledgeable about the community where a particular cultural group may reside and the resources in the community.

I adequately understand patient's religious and spiritual belief to know when and what topics are or are not appropriate to discuss regarding perspectives on health and illness.

1

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3

4

I understand and respect cultural and family influences and participation in decision making.

1

2

3

4

5. Culturally skilled professionals are aware of relevant discriminatory practices at the social and community level that may be affecting the psychosocial welfare of the population being served.

I am aware of legal issues that impact various communities and populations.

1

2

3

4

C. Skills

1. Culturally skilled professionals are able to engage in a variety of verbal and nonverbal helping responses. They are able to send and receive both verbal and nonverbal messages accurately and appropriately. They are not tied down to only one method or approach to helping but recognize that helping styles and approaches may be culturally - specific. When they sense that their helping style is limited and potentially inappropriate, they can anticipate and modify it.

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I can articulate what, when, why and how I apply different verbal and nonverbal helping responses.

1

2

3

4

I can identify and describe services within the organization which provide support to patients with minimal English language skills.

1

2

3

4

2. Culturally skilled professionals are able to exercise institutional intervention skills on behalf of their clients. They can help clients determine whether a “problem” stems from racism or bias in others so that patients do not inappropriately personalize problems.

I can advocate on behalf of patients who feel as if they were discriminated against in our organization.

1

2

3

4

3. Culturally skilled professionals are not averse to seeking consultation with traditional healers or religious and spiritual leaders and practitioners in the treatment of culturally diverse patients when appropriate.

I participate or gather information regarding indigenous or community helping resources to make appropriate referrals.

1

2

3

4

4. Culturally skilled professionals take responsibility for interacting in the language requested by the patient and, if not feasible, make appropriate referral. A serious problem arises when the linguistic skills of the professional do not match the language of the client. This being the case, professionals should (a) seek an interpreter with cultural knowledge and appropriate professional background or (b) refer to a knowledgeable and competent bilingual professional.

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

I am familiar with resources that provide services in languages appropriate to clients.

1

2

3

4

I seek out whenever necessary, services in languages appropriate to clients.

1

2

3

4

When working within an organization, I actively advocate for the hiring of multilingual professionals relevant to the patient population.

1

2

3

4

5. Culturally skilled professionals have training and expertise in the use of traditional assessment and testing instruments. They not only understand the technical aspects of the instruments but are also aware of the cultural limitations. This allows them to use test instruments for the welfare of culturally different clients.

I understand that although an assessment instrument may be translated into another language, the translation may be literal without an accurate contextual translation including culturally relevant connotations and idioms.

1

2

3

4

Multicultural Practice Competencies Tool

Instructions: Rate yourself on each criteria. You will be rating yourself on a scale of 1-4.

1 = very well; 2 = well; 3 = fairly well; 4 = not at all

6. Culturally skilled professionals should attend to as well as work to eliminate biases, prejudices and discriminatory contexts in conducting evaluations and providing interventions, and should develop sensitivity to issues of oppression, sexism, heterosexism, elitism, and racism.

I recognize incidents in which clients, patients, students and others are being treated unfairly based on race, ethnicity, and physical disability, and take action by directly addressing the incident or perpetrator, or filing an informal or formal complaint.

1

2

3

4

I work at an organizational level to address, change, and eliminate policies that discriminate, create barriers, and so forth.

1

2

3

4

7. I take responsibility to educate patients in the processes of intervention, such as goals, expectations, legal rights, and the professional's orientation.

1

2

3

4

Case Scenario #1

You are asked to conduct a parenting assessment of a 21 year old Vietnamese woman with limited English speaking abilities. There is a question regarding cognitive abilities including her understanding and insight into her own behaviour and her ability to learn about and generalize positive parenting principles. This case presents with a number of challenges including differentiating whether current parenting practices could be attributed to cultural, language, acculturation, and /or cognitive issues.

1. In order to conduct the assessment, identify the resources and guidance you will require.
2. Who would you consult?

Case Scenario # 2

A 10 year old boy of mixed ethnicity presents in your clinical area and in the course of treatment he makes self derogatory statements about the color of his skin.

1. What is your first response?
2. How would you proceed to support the child and address this issue?

Case Scenario # 3

In your clinical area a critically ill infant requires treatment. You become aware that the mother is adhering to strict dietary regulations determined by her religion while caring for and nursing her child. You are concerned about the mother and baby's well being.

1. How do you approach the mother with your concerns?
2. Would you involve other health care professionals?
3. Would you involve her faith community or leader?
4. How would you involve the mother's faith community or leader?

Thank you for taking the time to complete this self assessment. We would appreciate your feedback on this exercise.

Please provide your comments regarding your experience in completing this assessment.

To: Linda Kongnetiman
Child and Women's Health
Diversity Program Coordinator
Family and Community Resource Centre
Alberta Children's Hospital

E-mail: linda.kongnetiman@albertahealthservices.ca
Phone: 403-955-7742

Alberta Health Services Resources

The following resource information is to assist in enhancing your professional relationship with families from diverse cultural backgrounds.

Child & Women Health Portfolio, Diversity Program, located at the Alberta Children's Hospital is available for clinical consultations, resources and training. A Cultural Competency Resource Kit is also available to support Health Care Providers. Contact the Coordinator at 403-955-7742.

Alberta Health Services Mental Health Diversity Program supports Mental Health Care Professionals in caring for families from diverse backgrounds who are experiencing mental health issues. For consultation contact the Coordinator at 403-944-6764.

Alberta Health Services Healthy Diverse Populations, 403-943-0205

Alberta Health Services Interpretation and Translation Services employ certified health care interpreters. To arrange interpretation call 403-944-0202.

Please complete the following Multicultural practice enhancement plan and forward a copy to Linda Kongnetiman.

MULTICULTURAL PRACTICE ENHANCEMENT PLAN

Action Plan:

List of activities for achieving your Multicultural Practice Learning Goal

	Timelines	Completion Date
1.		
2.		
3.		
4.		



Practical Tips for Provision of Care

Medications

It is important to keep in mind that different cultures may have different views about medications and treatment. A common source of misunderstanding involves the use of Western medications, which often differs from the application of traditional remedies. As a health care professional, it is important to explore the patient's use of traditional remedies (eg. herbal medicines, balms, pastes, ointments, "teas", other) and their understanding and acceptance of Western medication. If the patient and/ or family does not understand why they need Western medicine, noncompliance is high. Different cultural groups may also have fears about addiction, and preference for certain treatment methods (eg. injections).

It is also important to keep in mind that there are pharmacogenetic differences, and ethnic variation in reporting side effects.

Alternative Therapies

Alternative therapies refer to those practiced "instead of" Western medical approaches. In alternative therapy, the mind and body are seen as a whole. Herbal preparations, supernatural healing practices, holistic healing, acupuncture, and meditation are some examples of alternative therapies individuals may use.

When in contact with health care professionals, many individuals may not inform them of their alternative therapy practices. It is important for staff to be aware that persons from diverse

cultural backgrounds may have deeply ingrained beliefs about how to attain and maintain health, and it is therefore important that these be discussed and negotiated to obtain a shared understanding of the problem and the plan of action.

Talk Therapy

Talk therapy is a Western-based treatment approach and many individuals from diverse cultural backgrounds are unfamiliar with its purpose. It may also not be compatible with beliefs or expectations about treatment. Many may prefer clear and authoritative advice. Information- gathering about family relationships and other personal information may not be welcomed and can be seen as intrusive.

Interdisciplinary Teams- Different Roles

For some cultural groups, the "team approach" to health care can be confusing, as are the roles of the various professionals. Many individuals from diverse cultural backgrounds are familiar with a doctor at the time of a crisis only. They may not understand being sent for diagnostic tests, follow up appointments, or seeing specialists, social workers, occupational and physical therapists, and others. Some may not even know the role of the nurse. Clear explanations need to be provided. Otherwise, all this involvement of others may be interpreted as incompetence on the doctor's part.



Physical Examinations

In many cultures, women feel uncomfortable being examined by male practitioners. If this is a physical examination with a girl/women from a diverse background, it is important to examine what their preferences are in terms of their examination. Use strategies such as referring the patient to a female physician, if possible; having the mother in the room during the examination if it is a minor; asking the patient how this process could be.

Touch

Touch practices are an important way to express trust, acceptance and extend greetings, as well. However, these vary greatly from country to country and within different cultures. Some of the touch practices that we are accustomed to in Canada might not be acceptable in other cultures. A cue for health care practitioners is to always follow the lead of the patient, and to ask questions on what is appropriate for them and what is not. For example, a handshake is very common in many countries, including Canada. However, a Muslim woman is not allowed to shake the hands of any men except their husband's and first-degree family members. Touching the head of a child from the Vietnamese community is not acceptable, because the head is perceived as the center of the soul.

Family Involvement

The role of the extended family is significant in caring for someone who is ill in many cultures. Family members from diverse ethnic backgrounds usually bring food for

the sick person if hospitalized. Depending on which culture, terminal illness might not be discussed with the patient, but with a member of the family, who will decide if this will be communicated to the patient.

Expression of Grief, Pain

There is variance in expressing grief and pain among cultures. Both the expression of pain and grief might determine how people deal with illness or with a loss (adapted from Kenneth J. Doka, 2002).

Canadian Nurses Association-Position Statement “Promoting Culturally Competent Care”

(Reproduced with permission from the Canadian Nurses Association)

Key Concepts

Cultural competence is the application of knowledge, skill, attitudes and personal attributes required by nurses to provide appropriate care and services in relation to cultural characteristics of their clients³. Cultural competence includes valuing diversity, knowing about cultural mores and traditions of the populations being served and being sensitive to these while caring for the individual.

CNA believes that to provide the best possible patient outcomes, nurses must provide culturally competent care. CNA believes the responsibility of supporting culturally

³ A client may be an individual, a family, a group or a population.



competent care is shared between individuals, professional associations, regulatory bodies, health services delivery and accreditation organizations, educational institutions and governments.

Responsibilities

Responsibilities include, but are not limited to the following:

- ▶ *Individual nurses* are responsible for acquiring, maintaining and continually enhancing cultural competencies in relation to the clients that they care for. They are responsible for incorporating culture into all phases of nursing process and in all domains⁴ of nursing practice.
 - ▶ *Professional and Regulatory Nursing Organizations* are responsible to establish and promote standards encouraging culturally competent care. As well, they are responsible to encourage and support the integration of people from diverse backgrounds into the profession.
 - ▶ *Accreditation Organizations* are responsible to develop and test performance indicators and to measure health care organizations' ability to provide culturally competent care and positive responses to diversity.
 - ▶ *Educational Institutions* are responsible to integrate issues of diversity and culture into curricula and to provide educational programs that enable nurses to acquire, maintain and enhance cultural competencies. They are responsible to
- remove barriers and promote access to education for members of diverse communities and to provide programs that aid nurses from diverse cultures to make the transition to work effectively in the Canadian health care system. They are also responsible to carry out research related to cultural competence in collaboration with other stakeholders.
- ▶ Government is responsible to promote a climate of diversity and acceptance, to fight racism and to ensure that health care systems promote culturally competent care. Government is also responsible to provide funding to enable the provision of culturally competent health services and the research that supports an evidence-based approach.
 - ▶ *Health Service Delivery Organizations* are responsible to create environments that promote a positive response to diversity. They are also responsible to organize physical and psychological structures, systems and supports for the delivery of culturally competent care. Systems and supports include:
 1. Developing, implementing and regularly evaluating organizational policies and practices to ensure cultural competence;
 2. Ensuring effective cross-cultural communication with diverse clients;
 3. Providing regular and frequent professional development opportunities and resources in order to build the cultural competence of staff;

⁴ Domains of nursing practice include clinical practice (direct care), education, research and administration.

- 
4. Developing, implementing and evaluating strategies to recruit, retain and integrate people from diverse backgrounds and culturally competent staff throughout the organization;
 5. Designing, implementing and evaluating services to meet the health care needs of the community;
 6. Ensuring active and meaningful participation and representation of community members in organizational processes, including governance, by identifying and implementing innovative strategies;
 7. Regularly evaluating results of efforts and monitor progress toward cultural competencies; and
 8. Establishing mechanisms to develop meaningful research and evaluation methodologies, knowledge and data⁵.

⁵ Adapted from Position Statement: National Initiative for Cultural Competence in Paediatric Health Care by Second National Forum on Cultural Competency, 2002.

8.0 COMMUNITY RESOURCES



“Education is the passport to the future, for tomorrow belongs to the people who prepare for it today.”

Malcolm X





Immigrant Serving Agencies

Calgary is fortunate to have several immigrant-serving agencies that provide a variety of supports to newcomers. The following is a list of the major agencies:

Calgary Catholic Immigration Society (CCIS)

Services include business, employment and training; community education; settlement services; child and family services; in-home assessment; counselling support and referral; licensed daycare. Many languages are accessible.

Address: 3rd Floor, 120 -17th Avenue SW
Calgary, AB T2S 2T2
Telephone: (403) 262-2006
E-mail: contact@ccis-calgary.ab.ca
Website: www.ccis-calgary.ab.ca
Hours of Operation:
Monday – Friday, 8:30 a.m. – 4:30 p.m.

► Margaret Chisholm Resettlement Centre

Services include transitional housing for immigrants and refugees. Many languages are accessible.

Address: 23 McDougall Court NE
Calgary, AB T2E 8R3
Telephone: (403) 262-8132
Email: mcrc@ccis-calgary.ab.ca

► The New Family Place and Daycare

Services include a licensed daycare, resource and toy libraries, collective kitchen, parenting programs, recreation and respite program, summer day camps, computer and internet access.

Address: 1410 – 1 Street SW
Calgary, AB T2R 0V8
Telephone: (403) 266-6686
E-mail: nfp-frc@telusplanet.net

▶ **Immigrant Youth Outreach Project**

Services include outreach and referral support to immigrant youth (ages 16-24) and educational and bridging support to community agencies.

Address: Calgary Achievement Centre for Youth
100 A, 315 – 10 Avenue SE
Calgary, AB T2G 0W2

Telephone: (403) 268-8131

E-mail: iyp@ccis-calgary.ab.ca

▶ **CCIS Outreach Office**

Services include access to CCIS programs and services for North of McKnight communities, counselling, workshops and community development.

Address: North of McKnight,
Community Resource Centre
Lower Floor,
95 Falshire Drive NE
Calgary, AB T3J 1P7

Telephone: (403) 293 - 0424

▶ **Cross Cultural Children's Centre**

Services include child development programs for children (0-6 years), full-time, part-time temporary/emergency care, provincially licensed ESL kindergarten, before and after school program.

Address: 100, 120 – 17th Avenue SW
Calgary, AB T2S 2T2

Telephone: (403) 262-5695

Immigrant Services Calgary

Services include first language settlement services, language assessment and referral, parenting groups, educational and supportive programming for youth and children, volunteer-based language bank for interpretation and translation, multicultural health care initiatives, free interpretation services for individuals needing counselling/support regarding family violence issues. Many languages are accessible.

Address: 1200, 910 – 7th Avenue SW
Calgary, AB T2P3N8

Telephone: (403) 265-1120

E-mail: info@calgaryimmigrantaid.ca

Website: www.calgaryimmigrantaid.ca

▶ **Immigrant Language and Vocational Assessment – Referral Centre (ILVARC)**

Services include language assessments, referrals and counselling regarding education, career planning, and information on accreditation and job search techniques.

Address: 1401, 910 – 7 Avenue SW
Calgary, AB T2P 3N8

Telephone: (403) 262-2656

E-mail: info@calgaryimmigrantaid.ca

▶ **Mosaic Family Resource Centre**

Address: 520, 910 – 7 Avenue SW
Calgary, AB T2P 3N8

Telephone: (403) 265-6093



Calgary Immigrant Women's Association (CIWA)

Services include support, counselling, information, referral services, networking and social support groups, cross-cultural parenting program, skills training, ESL classes, daycare program, family conflict program, youth program, and volunteer support.

Address: 200, 138- 4 Avenue SE
Calgary, AB T2G
Telephone: (403) 263-4414
Email: general@ciwa-online.com
Website: www.ciwa-online.com

► **Volunteer Program and Volunteer Cooperative**

Services include volunteer training, volunteer placement, business skills development, toy and book library, craft market, food box program and free access to computers and internet.

Address: Connaught Community
School
1121 – 12 Ave SW
Calgary, AB T2R 0J8
Telephone: (403) 517-8830
Email: volunteer@ciwa-online.com

Centre For Newcomers

Services include parenting and support groups, employment training, ESL programs for adults, collective kitchen program for women, workshops and educational programming. Parent support groups are offered in Cantonese, Arabic, Sudanese, Mandarin, Hindi, and Punjabi.

Address: 125, 920 – 36 Street NE
Calgary, AB T2A 6L8
Telephone: (403) 569-3325
Email: newcomer@cmcn.ab.ca
Website: www.cmcn.ab.ca

Calgary Bridge Foundation For Youth

Services include homework clubs, life skills programs, family assistant programs, literacy and recreation programs for youth ages 6 – 17 years.

Address: 201, 1112B – 40 Avenue NE
Calgary, AB T2E 5T8
Telephone: (403) 230-7745
Email: cbfy@telusplanet.net



Ethno-Specific Organizations

Calgary Chinese Community Services Association

Address: #1, 128- 2 Avenue SW
Calgary, AB T2P 0B9
Telephone: (403) 233-0070

Calgary Chinese Elderly Citizens' Association

Address: 111 Riverfront Avenue SW
Calgary, AB T2P 4Y8
Telephone: (403) 269-6122

Calgary Multicultural Centre

Address: 835 - 8 Avenue SW
Calgary, AB T2P 2T3
Telephone: (403) 237-5850

Muslim Families Network Society

Address: 211 Silvergrove Way NW
Calgary, AB T3B 4M3
Telephone: (403) 288-7093

There are numerous organizations that focus on social and/ or recreational activities. See OTHER section regarding the Calgary Cross Cultural Directory, where many are listed.



Mainstream Organizations with Bilingual Staff

Calgary Counselling Centre

Address: Suite 200, 940 -6 Avenue SW
Calgary, AB T2P 3T1

Telephone: (403) 265-4980

Can provide counseling in the following languages: Bosnian, Cantonese, English, Farsi, Hindi, Japanese, Mandarin, Melanesian Pidgin, Punjabi, Urdu and Spanish.

Calgary Family Services

Address: 300, 906 - 8 Avenue SW
Calgary, AB T2P 1H9

Telephone: (403) 269- 9888

Can provide counseling in the following languages: Chinese, English, French, Gujarati, Hindi, Spanish and Vietnamese.

Catholic Family Services

Address: #250, 707 - 10 Avenue SW
Calgary, AB T2R 0B3

Telephone: (403) 233-2360

Can provide counseling in the following languages: Farsi, Spanish, Hindi, Urdu, Punjabi, English, German and American Sign Language.

The following organizations may also have some capacity to provide counselling in other languages:

- ▶ Jewish Family Services
- ▶ Woods/ Eastside Family Services
- ▶ Sunrise Community Link Resource Centre
- ▶ YWCA Sherriff King
- ▶ U of C- Family Therapy Program
- ▶ Calgary Women's Emergency Shelter



Other

Through the AHS Internal Website one can also link to the following:

- ▶ **Ethnocultural Services Directory**
(Inform Alberta and click on Directories)
- ▶ **Physicians Directory**
(Click on Advanced Search and select a language).

9.0 ALBERTA HEALTH SERVICES DIVERSITY PROGRAMS



“We might have our differences, but we are one people with a common destiny in our rich variety of culture, race and tradition.”

Nelson Mandela





Healthy Diverse Populations

Diversity Services collaborates with the community and all regional portfolios to support equitable access to health services for all populations. Strategies are developed to address a wide array of aspects related to diversity including: ethno-cultural background, gender, ability, education level, age, ancestry, sexual orientation, marital status, socio-economic level and religious beliefs.

Manager: Delaine Johnson

Telephone: (403) 943-0275

Email: delaine.johnson@albertahealthservices.ca

Interpretation & Translation Services

The goal is to provide effective, coordinated, equitable and operationally efficient regional interpretation and translation services that address the communication needs of patients/clients and health care providers. Interpretation and Translation Services provide the following services: basic health care interpreter training; cross cultural communication and development of translated patient education materials. Interpretation and Translation services also collaborates with ethnic communities on an ongoing basis to address their interpretation needs.

Manager: Louise Behiel

Telephone: (403) 944-0206

Fax: (403) 736-0492

Email: louise.behile@albertahealthservices.ca



Alberta Children's Hospital/Child and Women's Health Diversity Program

Address: 2888 Shaganappi Trail NW, Calgary, AB T3B 6A8

Telephone: (403) 955-7742

Email: linda.kongnetiman@albertahealthservices.ca

Hours of operation: Monday – Friday, 8:15 a.m. – 4:00 p.m.

The role of the program is to support, enhance, and develop culturally competent services. The Program strives to facilitate and promote culturally competent care, which acknowledges and respects different cultural beliefs, values and perceptions of health and illness. There are four primary areas of focus within this program:

1. Cultural Competence Training/ Workshops

Education for staff to enhance cross-cultural sensitivity and culturally competent service delivery.

2. Clinical Consultation

Consultation regarding diagnostic, care and treatment issues as requested/ needed in situations where cross-cultural beliefs/practices are present and not well understood/appreciated by staff.

3. Access to Resources

Availability of resources to frontline staff, and physicians; specifically, translated printed information regarding medical conditions, treatment, etc.

4. Community Involvement

We link with ethno-cultural community needs in order to (i) develop and offer customized workshops which will enhance service in the areas where issues have been identified, and (ii) improve and enhancing cultural competency and our own services. We maintain and strengthen relationships which immigrant-serving agencies and ethno-cultural groups to assist families in accessing services and supports available in the community. Any employees at the Alberta Children's Hospital and within Women's Health can access this service. Referrals and inquiries are also accepted from members of the community and community organizations.

We also work closely with the Interpretation and Translation Services of the Alberta Health Services in Calgary to ensure that staff are able to access medically trained interpreters in a timely manner.



Multicultural Prenatal Community Programs

Our free service is part of the Prenatal Community Programs of Alberta Health Services (formerly known: Calgary Health Region). We provide culturally and language appropriate prenatal and childbirth classes in Spanish, Urdu, Hindi, Punjabi, Arabic and for Aboriginal women. We tailor the classes to the specific needs of the expectant families of the East Calgary communities.

Our 4 Perinatal Outreach Educators provide prenatal and childbirth classes in first languages, using alternative education strategies in a culturally sensitive way. We provide groups/classes on varied days and

hours of the week at different locations like hospitals, health centres, client's homes, temples, mosques, community agencies and resource centres.

We also work in partnership with immigrant agencies, cultural groups and other service providers in the Region and provide information about them and make the appropriate referrals.

The Perinatal Outreach Educators are located at the Sunridge Retail Space in the NE and can be reached at the following phone numbers:

Wichita Ferro
(Spanish speaking communities)
(403) 944-0219 / Cell: (403) 667-5593

Harprit Sandhu
(Punjabi, Hindi and Urdu speaking communities)
(403) 944-0220 / Cell: (403) 988-4573

Fatima Hamad
(Arabic speaking communities)
(403) 944-0220 / Cell: (403)819-3541

Joyce Flora Laprise
(Aboriginal communities)
(403) 944-0219 / Cell: (403)818-5762

For more information please, call:

Ira Heidemann, MScECON, BAA
Multicultural Program Coordinator
Prenatal Community Programs
Alberta Health Services
ira.heidemann@albertahealthservices.ca
Phone: (403) 781-1452
Cellular: (403) 819-3659

Chronic Disease Management for Diverse Populations

In the Capacity of the Program Manager, Chronic Disease Management for Diverse Populations, my main responsibility is to ensure that ethnically, culturally and socially diverse populations have access to the mainstream chronic disease management program.

Using Community Development Approach, I adopt, develop and implement targeted and outreach health programs for Calgary's diverse populations. An integral part of my position is formation of strong, meaningful and sustained

partnerships with multiple stakeholders including diverse community organizations, media, physicians and other relevant sectors.

Currently, culturally and socially sensitive chronic disease management programs are available to Calgary's two largest ethno-cultural populations: Chinese and Indo-Asians. In addition, similar programs are being developed for the Vietnamese, Filipino, Aboriginal and Calgary's homeless populations.

For more information, please contact:

Shahnaz Davachi, Ph.D, RD, RNutr.
Program Manager
Chronic Disease Management for Diverse Populations
Chronic Disease Management
Atrium, SPT
10101, Southport Road, SW
Calgary, AB, T2W, 3N2
Phone: (403) 943-1664
Fax: (403) 943-1605
shahnaz.davachi@albertahealthservices.ca



10.0 OTHER RESOURCES



“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

Margaret Mead (1901 - 1978)





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Internet Resources

<http://depts.washington.edu/pfes/CultureClues.htm>: Provides information relating to culture clues for following groups of patients: Albanians, African Americans, Chinese, Deaf patients, Korean, Latino, Russian, Somali, Vietnamese and End of Life: The Russian Culture.

http://cecp.air.org/cultural/Q_integrated.htm: Includes conceptual background for cultural competence, and to illustrate the elements of cultural competence in programs serving children with, or at risk of developing serious emotional disturbance.

<http://www.cal.org>: Fact sheets about Bosnian, Cuban, Haitian, Iraqi Kurd, Iraqi and Somali cultures, including information regarding festivities and proverbs.

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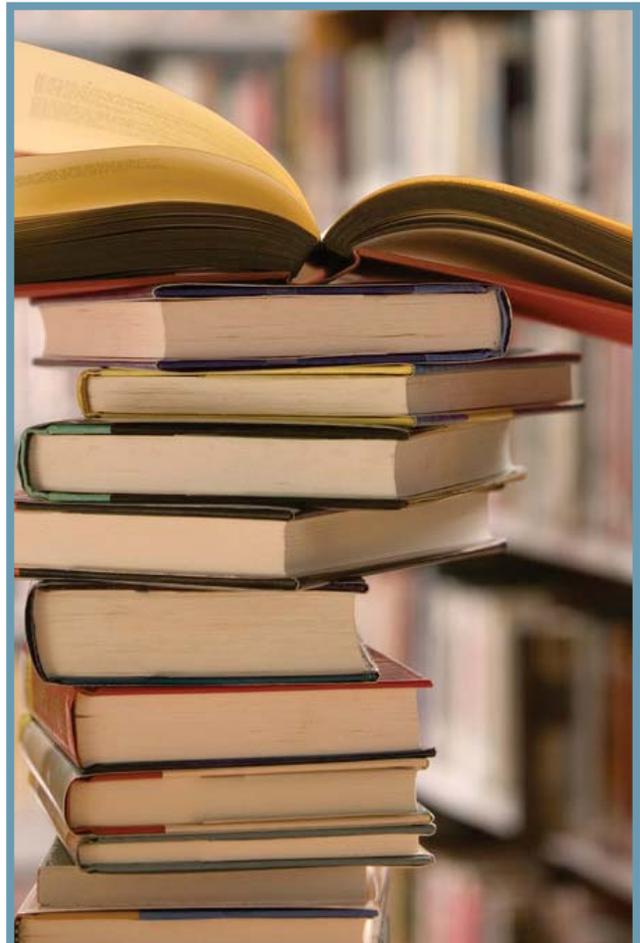
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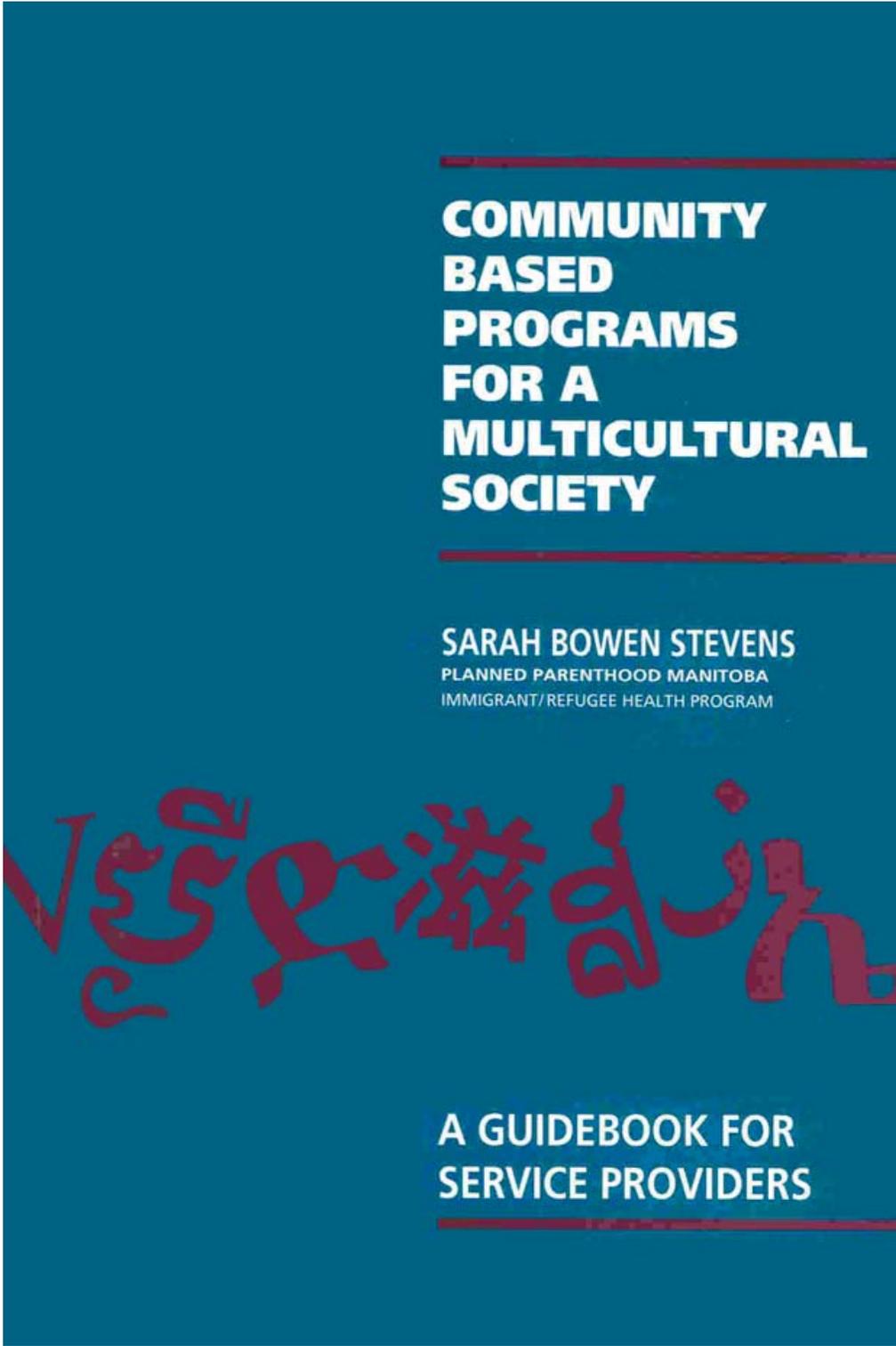
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Article



**COMMUNITY
BASED
PROGRAMS
FOR A
MULTICULTURAL
SOCIETY**

SARAH BOWEN STEVENS
PLANNED PARENTHOOD MANITOBA
IMMIGRANT/REFUGEE HEALTH PROGRAM

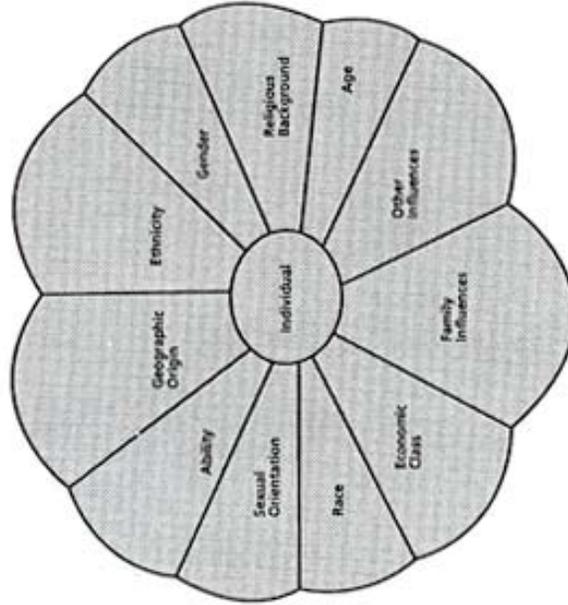


**A GUIDEBOOK FOR
SERVICE PROVIDERS**

and the former Yugoslavia may contain ethnic groups bitterly divided against one another. A large proportion of the many Vietnamese refugees in Canada is ethnic Chinese. At the same time, we may find several cultures within one ethnic group. If we look at all Salvadoran refugees in Canada, we will find an enormous range in education, socio-economic status, political orientation and religion. Even though they are all of the same ethnic group, they do not share the same ideas, beliefs, values and knowledge: in other words, they do not all share the same culture.

Enid Lee gives us a useful tool for looking at the many different cultural identities we all have:²

THE PETAL OF CULTURE



This "petal" diagram includes both those cultural factors we are born into and those we take on, involuntarily or by choice. Ethnicity is certainly one important aspect, as is race. However, there are other powerful cultural influences: gender (we speak for example of "women's culture"), the generation into which one is born, education, socio-economic class (the "culture of poverty"), and religion. Life events – such as attending nursing school, joining a political party, living in a refugee camp, or parenting a child with disabilities – can also give us a shared culture with people from different countries who have experienced similar lives.

What implication does this have for us in implementing programs in a multi-cultural context? First, it reminds us not to think of a client and her needs simply in

2. An Intercultural Approach To Service Provision

► IN THIS CHAPTER

Culture and ethnicity: Appreciating the complex range of cultural influences on individuals can help service providers avoid stereotyping.

Introducing three perspectives on multicultural services: clients' culture of origin, their transition experience, and barriers to established services.

The culture of origin is the source of a broad range of differences between newcomers and established North American services and providers.

The transition experience profoundly affects the health, behaviour, and expectations of newcomers; understanding this experience helps service providers respond appropriately.

Barriers to established services are often not recognized by service providers, but their elimination is essential to provision of effective service.

CULTURE VS. ETHNICITY

The common explanation for difficulties in providing effective services is simply to ascribe the challenges to "ethnic differences." That is, people from certain countries have different beliefs and practices and they speak different languages. However, focusing only on ethnic origin or language can lead to stereotyping, a denial of the variety and complexity within each culture.

From the outset, it is important to distinguish between culture and ethnicity.

One can define culture as the totality of ideas, beliefs, values, and knowledge of a group of individuals who share certain historical experiences.¹ An ethnic group, on the other hand, shares a common language, race, religion or national origin.

In one country there may be more than one ethnic group. Countries like Ethiopia

terms of her ethnic background. Parents of preschoolers, even though they are of many different ethnic origins, may have more of a shared culture than parents and non-parents from the same ethnic group. The primary cultural influence in any program may not be ethnic group, but marital status, gender, age, socio-economic status, education, or sexual orientation.

Two male physicians – from different countries, but both raised in an urban environment by professional parents, and both graduates of a Western-style medical school – may have much more of a shared culture than would one of these physicians and many of his female patients, even though they are from the same country. Awareness of such a model will also alert us to the very common tendency of groups to stereotype their own culture. Service providers must be alert to statements such as “The women in my community aren’t comfortable talking about sex,” or “There are no homosexuals in my country.”

ETHNO-SPECIFIC VS. INTERCULTURAL APPROACHES

An ethno-specific approach focuses on describing the characteristics, beliefs and behaviours of a specific ethnic group. It does not necessarily encourage us to take into account the diversity within each ethnic group. An intercultural approach, in contrast, gives us the tools to get beyond observations or descriptions of behaviours. With an intercultural approach, programmers can address the fundamental values and beliefs underlying behaviours. This approach also helps with appreciation of the similarities between cultures and the diversity within each.

We can use the analogy of a tree to describe culture; the visible part of culture (the branches and some of the explicitly held beliefs) correspond to the trunk and more important parts of the culture – values, thought patterns, and beliefs – which, like roots, are not explicitly observable. While each tree may appear very different, it is important to keep in mind that the root systems are similar and serve the same function. We are challenged to understand these underlying elements of the culture. The customs, rituals and practices surrounding health and family life are but the surface manifestations of a culture’s core values: as professionals we are cautioned against attempting to understand or change these practices without addressing the often hidden assumptions and values on which they are founded.

OUR OWN VALUES AND ASSUMPTIONS MAY NOT APPLY

Certain characteristics may be found more frequently in certain national cultures, and values shared by the dominant group within a society will have a profound impact on attitudes and responses to services, particularly on sensitive topics.

Societies differ, for example, in their belief in planning and control. In North America we place great value on the ability – and the responsibility – of individuals to plan their lives. Pierre Casse describes this as the Staircase Model.³ Life is like a staircase: the goal in life is to get to the top of the staircase. The staircase of life consists of three stages – learning, working and, finally, enjoying. One must work hard and sacrifice now to reach one’s reward in the future. Planning is the key. One is in control, one is responsible, one can choose.

In health promotion, for example, most western initiatives assume this model. Promotions are based on persuading the individual to take responsibility for his own health, to plan ahead, and to sacrifice when necessary. The outcome of behaviour is what is important (the top of the staircase), even if there is difficulty along the way. According to this model, children should be (and can be) “planned”; a woman can expect a healthy baby if she is responsible and does “everything right;” and this same child will turn out well if parents take the “right actions.” One result is that this model tends to blame the victim; it leads to concepts such as “innocent victims”: people who follow all the rules but don’t get their expected reward..

Not everyone shares these assumptions. Others are closer to the Roller Coaster Model. Life goes up, it goes down, you can’t control the ride. The key to life is to enjoy the ride and make the best of what comes. You can’t choose, there is no point in planning, you are not responsible. The goal in life is to adapt to the twists and turns that come your way. According to this view, babies come when they will, pregnancies just happen. (“My sister took the birth control pill every day and she got pregnant anyway.”) Luck, fate, or God are more often responsible than one’s own actions.

This view, while found in individuals from every society, may be more prevalent among those from developing countries who may have found that planning and hard work have had little impact on poverty, or among refugees whose whole lives, regardless of plans and choices, are in disarray. The belief that the individual does not have much control may be expressed by views that seem fatalistic to others.

In discussing her anxieties about an impending plane trip, one service provider (a white knuckle flier) found she had two different responses from her Canadian and many of her immigrant friends. “My Canadian friends tended to reassure me by reminding me of statistics on the relative safety of air travel as compared to car travel. It was all an intellectual argument, and it stressed the fact that I was making a ‘responsible’ decision. A common reaction from some of my Central American friends, however, was something like this: ‘If you’re going to die tomorrow, you’ll die, even if you stay here and don’t take the flight.’ They did not see my choice of behaviour having much effect on whether I lived or died.”

The Roller Coaster Model indicates that for many people the individualistic approach to health education so common in North America may not be the most effective. For if life is a roller coaster ride, we are all on the ride together, and focusing on persuading each individual to change his behaviour may not make much sense. In fact, researchers suggest that for some communities the most effective approach – although slower – is to work with community leaders to change overall community perceptions and priorities.⁴

Our society has recently begun to incorporate this approach into many health-promotion initiatives. We do this by changing the social climate to make it less acceptable to smoke or to drink and drive, for example, and by enacting concrete steps (such as banning cigarette advertising on television or increasing the penalties for driving while impaired) to make these issues a matter of community responsibility, and not only individual health.

THREE PERSPECTIVES FOR INTERCULTURAL UNDERSTANDING

In developing or adapting service programs for a culturally diverse population, it is important to consider the varieties of culture and experience clients bring with them. No matter what area of life we are dealing with, there are no “simple facts.” What we may understand as “basic information” is, in fact, the product of beliefs, priorities, and experiences.

We suggest three perspectives from which multicultural service issues can be better understood. Most of the examples given are drawn from our experience in the sensitive areas of sexuality and reproductive health. They touch not only health practices, but also the broader social context in which health must be viewed for effective programming and include such issues as family roles and responsibilities, legal rights, and communication between patient and provider.

These three perspectives can be described as follows:

- The impact of the culture of origin: how does the culture of origin affect beliefs, practices and expectations of clients?
- Issues arising from the transition experience: how do the experiences of transition and adaptation for immigrants and refugees affect health, family relations, behaviour and expectations?
- Barriers to access: what cultural, language and other barriers prevent immigrants and refugees from accessing Canadian services and getting the best service from them?

Each of these perspectives brings important insights, but each also has limitations and pitfalls on which we will expand in the following discussion. In the end, it is often useful to incorporate all these perspectives to achieve a comprehensive approach to programming.

While many of the issues included here apply also to people who undergo internal migration (for example, Aboriginal peoples from isolated reserves moving into large urban centres), the examples we give arise out of the immigrant/refugee experience.

The Impact of the Culture of Origin

A hospital is experiencing much difficulty with a Southeast Asian client. Although the birth was normal, the mother is refusing to eat, shower, or get up and care for her baby. “I just don’t know what to do,” one nurse said. “It seems like she just wants us to do everything for her. It seems she doesn’t care about the baby at all.”

SOURCE: program case files

Lack of information on differing beliefs and practices can limit our ability to provide appropriate service. In this situation, the nurse is not aware that many Southeast Asian patients base their behaviour during pregnancy and the postpartum on a very different understanding of how the body works, of how to maintain health and prevent disease than that of the western medical model in which she was trained.

This mother probably believes that health results from maintaining equilibrium between the two opposite life forces, ‘yin’ and ‘yang’ (often simply described as hot and cold). During the postpartum period, it is believed that a woman is in a ‘cold’ state, because of the loss of blood during the birth. Her responsibility is to follow prescribed guidelines for restoring equilibrium, or she will risk becoming ill in her old age. Any source of ‘cold’ or ‘wind’ must be avoided, as the woman is very vulnerable at this time. Showering, bathing, or hair washing is not allowed, the room must be kept warm and draft free, and the woman is expected to rest in bed. Food is also important, and is taken therapeutically to help restore balance. Only ‘hot’ foods⁵ such as rice, chicken, or ginger are recommended. Most fruit, vegetables, and juices are considered ‘cold’ and are therefore forbidden. As well, the nurse and patient probably do not share the same idea about who is responsible to care for the baby. It is likely that the mother believes it is her responsibility to recuperate and focus on her own health. For the first month, childcare responsibilities fall to others, most likely the infant’s grandmother.

Recognizing the differences:

A common approach to multicultural health issues is to focus, as in the case outlined above, on differing beliefs and practices (not only of those from different countries, but those from sub-cultures within our own society.) Descriptions of differences have served a valuable role in alerting us to important variations in health practices and have enabled professionals to show sensitivity and to respond appropriately to different practices. In this case, an understanding of the client's beliefs about appropriate postpartum behaviours, required and prohibited foods, and expectations of who was responsible for newborn care would have prevented much misunderstanding.

Those working with immigrants are well aware of the impact of culture on all aspects of life. Here are some particular issues of culture and experience which we found affected health and health education for our program.

Standards of health care

What do people expect in the way of health care? Was health care available to all or only to the wealthy? This will affect how newcomers interact with health professionals in Canada.

Said one health educator: "People always ask me whether newcomers are happy with the health care they receive here. I don't know what to say: The clients who could afford private hospitals are generally dissatisfied; they expect much more personalized service. But for patients who have only experienced public hospitals in their home countries - well, this is heaven. Even if mistakes are made, they wouldn't think of complaining."

Beliefs around disease causation and health maintenance

Does the culture accept western medical theory? Newcomers from China or Southeast Asia, as the example above indicates, may have a very different view of how the body works, how organs are related to each other, what causes disease, and how to maintain good health.

Patterns of help-seeking behaviours

Is help first sought within the family? Are traditional or home remedies usually tried before resorting to health professionals? Does the whole family (or mother) accompany an ill person when seeking care? Is seeking help for certain problems an admission of failure, or does it cause the family embarrassment?

Taboo topics

Is it considered "bad luck" to discuss certain health problems? Are there beliefs that talking about disease or medical complications will increase

the likelihood that they occur? Are there certain diseases that bring "shame" on the whole family? In one community served by the IRHP, it is not permitted to mention the risk of dying; not only would this be considered bad taste, it would risk provoking the event feared. This meant that when discussing certain dangers, it would be appropriate to describe the risk as "having trouble breathing," not of dying.

Expression of emotional/psychological complaints

What is the acceptance of emotional and mental illness? How are various psychological concerns expressed? Is there a "code" which links certain somatic complaints to emotional symptoms? Complaints of poor appetite or of trouble sleeping may be the expected way to raise the concern of depression or anxiety.

Death and dying

What are individual and family roles in the support and care of a dying person? Is there a stigma attached to certain illnesses? Are there beliefs – such that the death of a young person brings misfortune to the family – which may make coping with loss more complex?

Expectations of professionals

What health or social service professional roles are familiar to the client? (For example, Public Health Nurses are not familiar to many newcomers.) What are the assumptions in communicating with professionals? Is questioning or asking for more information acceptable? Does admitting one does not understand or is not happy with treatment cause the professional to "lose face"? Will the client be alienated by the non-directive style of counselling popular in North America?

Legal system

What are the laws affecting family violence, women's rights, homosexuality, quarantine for communicable diseases, abortion, and so on? What are the roles and powers of police, public health authorities, and health care providers? Does a patient have the right to refuse treatment, or to choose alternatives? Many concepts we take for granted are based on British common law and are not found in all countries.

Common diseases and conditions

For those providing health care, it is important to know what diseases and conditions – perhaps rare in North America – are common in other parts of the world. We found, for example, that clients were concerned and knowledgeable about certain sexually transmitted diseases that are not generally found in Canada.

Racial differences

Certain diseases and conditions are found more commonly in some racial groups than others. Tolerance and reactions to certain foods or drugs may also vary between races. In our area of work, the frequency of milk intolerance found in some groups made common guidelines for nutrition in pregnancy inadequate.

Traditional patterns of sex roles

Does the woman generally work outside the home? Which partner usually makes decisions about family concerns such as contraception, childrearing or finances? Are there topics (such as health education) which are considered traditionally a male or female sphere of influence? Is it acceptable for couples to discuss sexual issues?

Beliefs and practices specific to service areas

There will be specific issues related to any particular area of service delivery that require special consideration. Services working with children and families, for example, will need to investigate such issues as child-rearing patterns, family roles and responsibilities, discipline, and expectations of extended family, teachers, and neighbours. Senior-serving organizations may want to address questions such as the position and status of the elderly in society and expectations of roles of parents, grandparents and children. Because our programs focused on the areas of reproductive and maternal child health, many issues arose in the areas of sexuality. Here are some examples of how cultural assumptions, beliefs and practices affected our area of work:

Sexuality education

When does it occur, in what setting, and who does it? Must men and women learn from those of the same sex? Who are the educators – the school system, the church, the medical profession, or the family? Is a woman supposed to be innocent of all sexual matters until her marriage? Within the family, who is the appropriate educator of a young girl or boy – is it the aunt or uncle rather than the parents?

Sexual practices

What are the knowledge and beliefs around important sexual practices, such as the use of barrier protection (e.g. condoms), pre- and extra-marital intercourse, or male and female circumcision?

Sexual orientation

What is the awareness of (and attitude towards) issues of sexual orientation? Is homosexuality recognized, or is its existence denied?

What are the penalties, if any, for homosexual behaviour? How is homosexuality defined? In some cultures, for example, it may be acceptable for a man to have sex with another man if a woman is not available or “for kicks.” In some cases a man who plays the “active” role (who penetrates another man) may not be considered homosexual; or penetration of a man who is considered effeminate may not even be thought of as sex with a man. In societies where there is little tolerance of homosexual behaviour, gay men and women may marry heterosexually, but continue to have same-sex relationships. Differing patterns of bisexual activity have also been found in various cultures.

Cultural stereotypes

What stereotypes are there about certain diseases, conditions, or lifestyles? What is the status of a woman who has sexual intercourse before marriage? Who is believed, for example, to be at risk of AIDS? Some societies may hold a stereotype of AIDS as a “prostitute’s disease” rather than the commonly held North American stereotype of it as a “gay” or “drug addict’s” disease.

While it is helpful for service providers to be able to answer such questions in order to plan and deliver programs effectively, this approach has limitations of which we need to be aware. We must guard against focusing exclusively on practices, particularly on those that appear exotic compared to our own. Used in isolation, this may contribute to a “recipe book” approach where clients are understood primarily in terms of their ethnic background. As professionals we may feel we need only learn a lot of “facts” about different cultural groups in order to provide service, when it is also crucial that we analyze our own practices.⁶

There is also the very real risk that we may be unable to differentiate between cultural practices and individual problems or family dysfunction.

A public health nurse has been visiting a Southeast Asian single mother, a recent immigrant. She observes the mother placing medicine on the baby's fontanel, but accepts this as a common and harmless practice. The Vietnamese health educator who also visits the new family is more concerned. This is not the kind of medicine acceptable for use with newborns, and on further investigation she identifies the mother as having little knowledge and great anxiety about parenting.

SOURCE: program case files

It is cases such as these that alert us to the need to look beyond a simplistic explanation based on cultural differences.

The Impact of the Transition Experience

The mother of a two-day-old baby discharges herself early from the hospital. Two days later she ends up back at the emergency department with complications. Why did she leave the hospital early? "The Canadian mother complained every time my baby cried. She would call the nurses and they would try to take my baby to the nursery. They kept trying to take my baby. I stayed up all night in the lounge holding my baby. Then I went home." Hospital staff described this mother, who spoke no English, as "hysterical." "We could see that she was exhausted, and the other mother in the room felt she needed some support. We offered to take the baby so she could get some rest but she refused." They didn't know that in her country people could be taken from hospital by the military, and family members of those under suspicion could "disappear." They had no way of knowing she had recently arrived in Canada to escape death threats to her family.

A pregnant woman receiving prenatal information from a health educator asks the educator to talk to her 15-year-old son. He is having nightmares. Several months ago in their home village, the extended family was having a party. Soldiers came and demanded food and drink. The mother asked her son to come with her to the river to get water. On the way back they heard shots and screaming. All of their family was killed; they were the only survivors. They escaped by hiding in the forest, then walking to safety. Shortly after this the mother found she was pregnant. They were accepted as refugees in Canada.

SOURCE: program case files.

One perspective often overlooked in health education is the impact of the transition experience. As the preceding examples indicate, the refugee experience can have profound physical, emotional and psychological effects, both immediately and in the long-term.

Questions to be considered from this perspective include:

Conditions in transit

What were health and social conditions for refugees when they reached countries of first asylum? What were the conditions in camps or while in transit regarding nutrition, basic sanitation, personal safety, employment? The time of being in transit can range from a few days to many years.

Service contacts while in transit

What preventive measures have people been exposed to while in transit? (To use an example from the field of AIDS education, some thorough

AIDS education initiatives have recently been undertaken in refugee camps, and new arrivals may in fact be much more knowledgeable than immigrants who have been in Canada for some time.) Have there been prior problems with access to health and social services? Before coming to Canada, many immigrants experienced poor or discriminatory care, which may affect their confidence in and use of Canadian health or other resources. Coercive or insensitive care may cause distrust of the motives of caregivers. One health educator related the following story about one of her clients:

"A client came to me with a concern about obtaining contraception. I took her to a community clinic, where she had an interview with a very supportive family planning counsellor. She decided to take the birth control pill. Because she was starting the pill a couple of days late in her cycle, she was told to take two pills for each of the first two days. She agreed. Three months later she was pregnant. I discovered she had never taken the pills. When I asked her why, she said that she felt it was dangerous, that western medicine was 'too strong' for the body. She recalled how in the refugee camps, family planning workers had promoted abortion and the use of Depp-Provera for contraception (a drug not approved for contraceptive use in Canada because of side effects). In fact, the camp residents called these workers 'the people who kill babies.'"

SOURCE: program case files

So the helpfulness of the counsellor in assisting her to start a birth control method she had chosen was interpreted by the client as quite something else. ("These people who kill babies are giving me twice as much of that dangerous medicine. It is not safe. They don't care about me.")

Views of government initiatives

Because of experiences in their home country, many newcomers (particularly refugees) may distrust government health education campaigns. Family planning initiatives, for example, are often perceived as population control programs, focused on certain racial, political, or economic minorities. Any perception that a program is "government propaganda" may work against behaviour change. Said one AIDS educator, "It's not that people don't have correct information. The problem is, they don't believe it."

Family disruption

It is almost a given that family disruption is part of the immigrant or refugee experience, and this has profound implications for any health

promotion programming. In many societies, it is traditionally the role of older women to act as guardians of the family's health and as health educators for the younger generation. This link is lost in communities where the older generation is left behind. There is evidence that young people who arrive in a new country without family have special health and social concerns.⁷

Perceptions of Canadian standards

Immigrants commonly express shock at some of our social practices. Child rearing practices and care (or lack of care) for older family members are among the areas in which we differ widely from many other cultures. Many immigrants perceive Canadians as lax in their standards of sexual behaviour. Often isolated, perhaps not socializing with all segments of society, but widely exposed to popular media, newcomers are particularly vulnerable to this perception. Some newcomers may also misunderstand behaviours: a woman who talks freely with both sexes, for example, is sexually "available."

Sex role changes

Changes in the role, rights and responsibilities of women in moving to a new society may affect their relationships. Some of the changes newcomers experience are: working outside the home, greater access to information, and more freedom to date and associate with friends. In addition, many immigrant women will be experiencing for the first time legal protection from spousal assault and other rights as individuals under the law.

We should not assume that these changes are entirely positive. Although additional responsibilities are often added – such as employment outside the home – traditional responsibilities usually remain. And new legal rights may not offer protection as reliable as the norms and support of the traditional extended family.

Torture and abuse

The abuse suffered by many refugees is difficult for Canadians to comprehend. Forced to flee their homes, often losing family and friends to violence, many have also suffered personal persecution and torture. Refugees were at risk not only in their own country, but also while fleeing to safety (as in the case of the "boat people" of Southeast Asia). What implications such experiences will have on service needs within Canadian programs will vary. Our program works in the area of reproductive and maternal child health, and so it has been necessary for us to know that, while it is difficult to accurately estimate the incidence

of rape and other sexual abuse, a Canadian study found 15% of refugees who had been tortured reported also being raped. More common were reports of other forms of sexual abuse.⁸ Another study found that 80% of female detainees who were tortured were subject to sexual assault.⁹

It is important to keep in mind, especially when dealing with mental health or reproductive health issues, that most survivors of such events have not received counselling. Many have not shared their ordeals with anyone. Appropriate counselling services are not even available in many cities.

How these experiences influence individual behaviours will vary. Counsellors working with Central American refugees, for example, report that clients may exhibit behaviour that could be interpreted as "paranoid." They may be unable to relax in a setting where they are forced to sit with their back exposed to a window or door, or they may react with deep suspicion to questions about family or previous activity. It is important not to confuse such behaviours with different cultural beliefs and practices, but to see them instead as coping techniques for surviving persecution and trauma.

Unrealistic expectations of a new society

To those from less developed parts of the world, a country like Canada may appear immeasurably wealthy. If before immigrating a newcomer has been partly supported by relatives in Canada, the small amounts of money "sent home" may seem like huge sums, supporting the family in relative luxury. This may lead to unrealistic expectations of standards of living in Canada. One immigrant who sponsored his mother and brothers to Canada complained: "They just don't understand. When I sent them \$100, back home it would support all of them for a month. They just don't believe that I am not wealthy here; they think I am hiding money from them. They don't want to work, they just want me to support them."

Expectations of the health care system may also be unrealistic. Many newcomers – especially if they have been at great personal risk, or if they have suffered with poor or non-existent medical care in the past – have enormous faith in the powers of modern medical care. They may find it hard to believe that, having suffered so much danger, they could possibly fall prey to an incurable disease or accident here.

Looking at newcomers from the perspective of their transition experience reminds us that not all "different" behaviours can be understood as customs or beliefs.

When we see behaviours which are actually the result of either the stresses of forced relocation or of adaptation to a new environment, we must guard against attributing these behaviours to cultural beliefs or practices.

The Impact of Barriers to Access

A Cambodian mother, now eight months pregnant, has never been for prenatal care. She has heard that Canadian doctors will do an internal examination, a practice unheard of in her country.

A health educator is contacted by a new mother for information about infant feeding. Upon investigation, the educator discovers that the public health nurse has already provided information on this topic, but the client didn't understand her.

An outreach worker discovers a young family with a very sick infant. They were very worried about the baby's health but didn't know who to contact for help.

Parents in one community contact the health educator to request family life education for their adolescents. In talking to the teens, the educator discovers that they have received Family Life Education in the school. Even though they speak English, they still have a lot of questions. They are not comfortable asking such questions in a mixed group, and they also want to deal with their special concerns about adaptation.

SOURCE: program case notes

Barriers to access are obstacles that work to prevent or discourage people from utilizing services, or which prevent the services from being as appropriate or effective as they might be. Identifying the barriers is the first step to addressing them.

In our experience, this is one aspect of multicultural service provision that providers and programmers often overlook, but one of greatest concern to newcomers themselves. The barriers are numerous, and they can be described in five categories:

Information and knowledge barriers

Newcomers often lack specific health information, but more importantly, they may not know where to get information or even whom to ask for referral. This lack of information extends well beyond any particular health concern to the basic workings of the health and social service systems.

At the Immigrant/Refugee Health Program, for example, it is commonly found that newcomers' needs for contraceptive information are only discovered after an unplanned pregnancy. Although the women were in touch with settlement workers, they often did not feel it was appropriate (or they found it too embarrassing, especially if the worker was male) to raise their concerns. They were never informed about what contraceptive methods are available, where they could go for information, or where they could get birth control supplies.

Cultural barriers

While many of those working with immigrants are aware of cultural "differences," they may be less aware that differences create obstacles. These barriers are varied and far-reaching.

There is little in the way of professional preparation in intercultural understanding for service providers, and many may be unaware that certain practices are unknown or considered inappropriate in the client's culture. Some key cultural issues have been discussed under the heading "The Impact of the Culture of Origin." Consider, for example, how this constellation of cultural issues affects even the simplest interaction with our health and social service system: an appointment. An immigrant client may ask herself:

Do you need to phone ahead to make an appointment? How do you raise your concern? Can you make an appointment yourself or must you be referred? What will happen in an appointment? (Imagine the shock of a client who goes to request birth control and is requested to undress and submit to an internal examination, a procedure unheard of in her country.) If the appointment is for ten o'clock, what time should you get there? What if you change your mind?

At the same time the service provider is often unaware that his assumptions are not shared by the client. If the client does not ask questions or appears to agree with everything the professional says, there may be no way of discovering that it may be perceived as inappropriate to question or disagree. We should also always keep in mind the particular sensitivity of issues around sexuality, reproduction, family relationships and mental/emotional health.

Communication barriers

It is impossible to overemphasize the importance of communication barriers in any health or social service area, but especially in the areas

such as sexuality, reproductive health, mental health or family relationships which are intensely private and value laden. These barriers are perhaps the most readily identifiable of all barriers faced by immigrants and refugees, but health and social services have taken relatively little responsibility in addressing them.

Many assume that access problems rooted in communications can be solved by an interpreter, defined simply as an individual who speaks both languages required. Interpretation appears straightforward: the interpreter rewords the message into another language and understanding is achieved. This view, however, does not recognize either the complexity of the task of linguistic interpreting nor the crucial need for the role of cultural interpretation and advocacy.

The lack of trained interpreters poses serious risks for many new arrivals. The many issues in selecting and working with interpreters are outlined in Chapter 7, when we discuss the key components of comprehensive service provision for newcomers.

Circumstantial barriers

Hours of service, an unfamiliar climate, and lack of transportation or child care may make it difficult for newcomers to access services. Even the physical setting of services may be intimidating.

Administrative & systemic barriers

The categories of barriers discussed thus far incorporate the aspects of access described by the Social Planning Council of Toronto as:

CLIENT ACCESS: The extent to which consumers are able to secure needed services.

As important as these issues are, there cannot be full and meaningful access until we address problems of:

ORGANIZATIONAL ACCESS: the extent to which consumers are represented and/or participate in the planning, development, delivery and administration of services.¹⁰

Addressing barriers in this category will be a substantial challenge for any organization or agency, for these barriers go to the heart of our own cultural assumptions. The tendency may be to make only superficial changes. For instance, it is not enough to make minor adjustments in client accessibility while continuing to rely on strict linguistic translation by the all-too-common use of untrained volunteers. If the services

themselves are not designed for newcomers or at least sensitive to them, these changes will not be adequate and newcomers will often not receive the same quality of care or service as other Canadians.

In order to be truly responsive to multicultural concerns, we must ask ourselves, for example: Are interpretation services perceived to be the responsibility of the client rather than the service provider? Are most information sources (individual counselling services, pamphlets, information lines, videos, or radio and television programs) available only in English or French? Do professionals have the intercultural training to provide culturally sensitive care? Responding to barriers at this level requires changes in how our programs and organizations are structured, how service needs are prioritized, and who is involved in planning and administering services.

The first two chapters have attempted to give readers some sense of the need to reassess our health and social services in light of an increasingly multicultural society, as well as some appreciation for the complexities of intercultural service provision. Beginning with the next chapter, we discuss how to plan, develop, implement, and evaluate services for a multicultural society, and how this often challenging process will affect the organization delivering services.

- ¹ Lee, Enid, **Letters to Marcia: A Teacher's Guide to Anti-Racist Education**, Cross-Cultural Communication Centre, Toronto, 1985.
- ² Adapted from Enid Lee, **Letters to Marcia: A Teacher's Guide to Anti-Racist Education**, with permission.
- ³ Casse, Pierre, **Training for the Cross-Cultural Mind**, The Society for Intercultural Education, Training, and Research, Washington, 1981
- ⁴ Connor, R.F., "A Cross-Cultural Assessment of Health Promotion/Disease Prevention Programs," **Evaluation and Program Planning Vol. II**, 1988
- ⁵ 'Hot' and 'cold' in this context refer to the inherent properties of food, not temperature or spiciness.
- ⁶ This point is well made by Patricia A. Kaufert, "The 'Box-ification' of Culture: The Role of the Social Scientist," **Sante Culture Health: Culture and Health Services: A Challenge to Canadian Society**, Numero special Volume VII (2-3) 1990. pp. 139-148: "The use of culture as a way of accounting for whatever is seen as emotional, irrational, or illogical in the behaviour of the patient is commonplace in the literature on multiculturalism and health. The problem is that the focus becomes the patient and his or her cultural identity. Attention is diverted from other actors and other factors, and references to culture become simply another way of blaming the victim."
- ⁷ The Canadian Task Force on Mental Health Issues Affecting Immigrants and Refugees, **After the Door Has Been Opened: Mental Health Issues Affecting Immigrants and Refugees in Canada**, Health and Welfare Canada, 1988.
- ⁸ F. Allodi and G. Cowgill, "Ethical and Psychiatric Aspects of Torture", **Canadian Journal of Psychiatry**, Vol 27, No. 2, pp. 98-112, 1982.
- ⁹ Ole Vedel Rasmussen, "Medical Aspects of Torture", **Danish Medical Bulletin**, Vol. 37, Supp. No. 1, January 1990.
- ¹⁰ Doyle, R., Visano, L., **A Time for Action: Access to Health and Social Services for Members of Diverse Cultural and Racial Groups**, Social Planning Council of Toronto, 1987, p. 201



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Ten Years in Review: 10th Anniversary Report of the City of Saskatoon. Race Relations Committee – 1989-1999.

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Human Rights and Diversity Initiatives in Alberta. Tools for Transformation. Alberta Human Rights & Citizen's Committee. Government of Alberta, May 2000.

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"Anti Racism Social Work: The Time is Now." A report on the March 24, 1994 Forum. Prepared by the Multicultural and Race Relations Division. 1995. Municipality of Metro Toronto.

Perception of Racism and Hate Activities Among Youth in Calgary. Effects on the lived experience. Community Strategies City of Calgary 2002. Researchers: Valerie Pruegger and Jerilynn Kiely.

Racist Discourse in Canada English Print Media. Canadian Race Relations Foundation March 2000. By Francis Henry and Carol Tatro.

Recent Immigrants in the Calgary Metro Area. A Comparative Portrait Based on 1996 Census. Sept 2000 Research Unit. Citizenship and Immigration Canada.

Facts and Figures 1999. Immigration Overview. Citizenship and Immigration Canada.



Your Guide to the Canadian Charter of Rights and Freedoms. Canadian Heritage. 1997.

Employment Equity. Excerpt from the 1999 Annual Report. Canadian Human Rights Commission.

Videos

The Culture of Emotions . VHS 9-7359.
Canadian Learning Company.

Walk a Mile, The Immigrant Experience in Canada, A multimedia training package.

Communicating Effectively Through an Interpreter, Barriers to Communicate. An instructional video for health care providers. The cross cultural health care program.

Cross-Cultural Health Care Program, “Can you hear me? Arab Communities, VHS.

Through the Eyes of Others, Unitake productions available for Somali, Ethiopian, Hispanic and Native American communities.

Mental Health Interpreting. A mentored curriculum.

Couleur Coeur, le racisme chez les jeunes au niveau elementaire.

French languages health services, Everyone Benefits.

Cultural Assessment, University of Lethbridge School of Nursing, 1993.

APPENDIX







Appendix A

Translated Patient/Client Education Materials Available

Translation materials are available for order by Alberta Health Services in Calgary health care professionals. Please order by using the on-line ordering system. Go to:
http://www.calgaryhealthregion.ca/healthinfo/library/translated_materials.htm.

Translation Request Form

Additional forms are available on the Alberta Health Services website:
http://www.calgaryhealthregion.ca/programs/diversity/int_and_trans_services/how_do_i_arrange_int.htm

Please fax or email your request to Interpretation and Translation Services:
Booking clerks booking_clerk@albertahealthservices.ca

Telephone: (403) 944-9033 or Fax: (403) 943-9044



Email - REQUEST FOR AN INTERPRETER FORM (ONE BOOKING)

*****If this appointment is needed within 48 hours please call 403-944-0202

Request Information

** Indicates a required field*

* Required Date: _____ * Language: _____
mm/dd/yy

* Start Time: _____ * Estimate Duration (in hours) _____
0000 24 hour time 0000 24 hour time

Alternate Date (If possible) _____ Interpreter Gender: _____
mm/dd/yy If important to the situation

Contact Information

Used to call back to confirm appointment date, time you and issue you an assignment number

* Your First AND Last Name: _____

* Your Phone / Pager: _____ * Your Alternate Phone / Pager: _____

Name of Health Care Professional Attending Appointment: _____

*Your Department: _____ * Your Site: _____

Your Portfolio: _____ * Appointment Room: _____

On Site Interpretation Home Visit Telephone Interpretation

Appointment Address: _____
(if outside hospitals and community health centres)

Patient Information

* Patient First Name: _____

* Patient Last Name: _____

* Patient Telephone: _____ Alternate Telephone: _____

* Alberta Health Care Number: _____ * Postal Code: _____

Purpose of Appointment

Admission History Assessment/Testing Consultation Counselling

Diagnosis Emotionally Difficult Content Legal Issues

Procedure/treatment/surgery Site translation Consent

Explanation/Update of Condition Patient or Family Teaching PPD Screen

Vaccination Other (please explain) _____

Notes to Interpreter

Indicate any additional information the interpreter needs to know. If you want an interpreter to contact the patient to inform them about the appointment, please check this box

Health Care Provider informed of the status on _____ By Email By Phone
mm/dd/yy

In-house Interpreter informed on: _____
mm/dd/yy

Assignment Number _____

Date Entered in Database: _____ Entered by: _____
mm/dd/yy

