SESSION 4: WORKING WITH CULTURALLY DIVERSE POPULATIONS

INTRODUCTION

Increasingly, the population of TB patients in the United States is culturally diverse. In this 2½- to 3-hour session, participants will explore the important impact that culture can have upon the patient-provider relationship. The meaning of "culture" and "cultural competence" will be defined and discussed. Participants will learn specific ways that they can become more culturally competent. Guidelines for working with interpreters and for dealing with situations in which an interpreter is not available will be reviewed.

LEARNING OBJECTIVES

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

1. List five ways that people may culturally identify themselves
2. State four ways to learn more about a specific patient's culture and health beliefs
3. List three guidelines for how to best use an interpreter when providing DOT to non-English-speaking patients
4. Describe three guidelines for providing DOT to non-English-speaking patients without the assistance of an interpreter

WHY A SESSION ON CULTURAL DIVERSITY?

1. TB affects a very diverse population.
2. U.S. statistics: approximately half of all new cases are among the foreign-born
3. Local statistics

_____

_____

_____

4. "Diversity" refers not only to race or ethnicity. In many communities, a large number of patients are among groups with special challenges, such as the homeless and substance users. Each group has their subcultures, differing from the American "mainstream" (dominant) culture.
5. Health workers need skills to be able to communicate effectively with people from many different cultural backgrounds.
6. Health workers need to identify the many factors that affect culture and determine a group's values and rules.

Material in this session is adapted from:

- *Effective Tuberculosis Interviews Course, Part II: Targeting Special Populations*. Presented by the Francis J. Curry National Tuberculosis Center on June 26 – 28, 1995, in Stockton, California.
- Noel Day, *Definition of Culture*. San Francisco: Polaris Institute
- *Self-Study Modules on Tuberculosis: Module 9, Patient Adherence to Tuberculosis Treatment.* Atlanta: Centers for Disease Control and Prevention; 1999.
- *Tuberculosis Outreach Worker's Course*. Presented by the Francis J. Curry National Tuberculosis Center on July 20 – 21, 2000, in San Francisco, California.

► ACTIVITY

Cultural Comfort Exercise

Please rate your comfort level with the statements that follow. Use the rating scale shown below.

1	2	3	4	5
extremely uncomfortable	somewhat uncomfortable	somewhat comfortable	comfortable	extremely comfortable

1. _____ When I have a new patient who doesn't speak English very well, I'm comfortable "winging it" with the person—pointing, using sign or body language, or finding someone from the patient's circle to interpret. I don't wait for an interpreter.

2. _____ I'll eat my lunch in front of a patient if that's the only time I have to do it.

3. _____ Sometimes I arrive at a patient's house around dinnertime because I know that's the only time I'll be able to find anyone at home.

4. _____ If a patient smells so bad I can hardly stay in the room, I will gently suggest that he/she make use of the "shower resources" in the neighborhood and the free clothes bins.

5. _____ When I do home visits and a patient uses an illegal substance in front of me, I don't say anything.

6. _____ If I don't know the ethnicity of a patient, I won't ask until I do my paperwork.

7. _____ If I'm in a patient's dirty and messy room and the only place to sit is a chair that is piled with things, I will move these things so I can sit down and concentrate on the work.

8. _____ When a patient's kids are around, I will offer them gum or candy.

9. _____ If I'm trying to find a patient who is a sex worker, I will go to the area where he/she usually works. If the patient is busy with a transaction, I will stand there and wait for him/her to finish.

10. _____ When I suspect that a patient is keeping information from me, I will make "small talk" or conversation, hoping to hear something new. I'll talk about the weather, sports, news, my family, and will even reveal something personal about myself.

I. DEFINITION OF CULTURE

(adapted from Noel Day, Polaris Institute, San Francisco)

Culture is a group's design for living. It is the group's assumptions about the world, about other people, about the goals and the meanings of life. It is the group's assumptions about what is right and what is wrong – and its beliefs about how to behave and how to expect other people to behave in all of life's situations.

Culture is the integrated pattern of human behavior that includes thought, speech, action, and artifacts (objects or things). It depends on the capacity of humans for learning and transmitting knowledge and values to succeeding generations. It takes into account the customary beliefs, social norms, and material traits of a racial, religious, or social group.

We look at other people through our own cultural lens. This means we often make assumptions about people on the basis of one or two characteristics. These assumptions are often culturally specific and come along with judgments.

Once we have made a judgment (positive or negative) about someone, it will show in the way we communicate with that person. If our view is negative, this can interfere with building a positive relationship and trust. As health workers, we are often put into positions of power over our clients which impacts individuals from different cultures differently.

Culture gives you all of the answers—even when you don't know what the questions are!

II. ELEMENTS OF CULTURE

A. Culture and behavior

Remember: There is an explicit relationship between culture and behavior, which can be stated as follows:

Culture determines values; values shape behaviors; behavior is the explicit language of culture.

All individuals are composites of their thoughts, their knowledge, their feelings, their values and attitudes, their body, their behaviors, and their soul, or spirit, or ethics, or whatever term is most relevant to the person.

Since none of us lives in a vacuum, the factors outside of an individual and the environment in which the person lives significantly impact his/her life. Environmental elements such as family, physical environment, peers, media, school, economics, and other social institutions also contribute to the whole person.

B. Culture and race

In addition to these elements, it is important to understand the difference between racial traits and cultural traits. A racial trait is an inherited physical characteristic or feature that occurs with more frequency in one population than another. A cultural trait is a learned behavior.

C. Cultural universals

Then we have to remember that there are certain human activities that are universal, that are a part of every culture. This does not mean, however, that they are practiced in the same way, have the same value or meaning, or are not subject to change by forces outside the culture. All people eat, sleep, build shelters, mate, raise their young, celebrate, and pass on their beliefs and values to the next generations. Knowing and understanding that there are many rich and diverse customs for all of these activities will help you to become more culturally competent.

D. Cultural competence

How do we become culturally competent? Does taking a course such as this mean we as health care professionals can advertise ourselves as "certified culturally competent workers?" Of course not; taking a course, seeing a movie, reading a book, or even being a member of a minority group does not certify anyone. Our experiences, our willingness to risk making mistakes, our commitment to deliver quality service, and our ability to empathize with others are factors that determine our level of cultural competence. The processes we go through as we personally and professionally develop these skills arise from our desire to care about the well–being of a community, a group of people, and the individuals in it.

E. Common denominators or cultural universals

Common denominators of cultures are basic life practices performed by members of every society. On page 4–6 of the *Participant's Workbook*, there is a list of these common denominators of culture. Can you think of any more?

F. Cultural identification

Individual characteristics that people are born with, and experiences that they have as infants and children, cannot be changed. These form what is called the primary cultural identity or dimension. The secondary cultural identity consists of characteristics over which individuals may have some choice as young people and adults. They may decide whether or not they identify with these characteristics. The tertiary characteristics are more unique and are not shared by all populations.

Common Denominators of Culture – "Cultural Universals"

The following is a list of basic life practices and characteristics found in or performed by members of all cultures.

- age-grading
- art: theatre, drama, visual arts, music
- bodily adornment
- child rearing
- cooperative labor
- courtship and dating
- dancing
- death and dying
- education
- ethics
- etiquette
- family feasts and celebrations
- folklore
- food: customs, taboos, meal times
- funeral rites
- games
- gender roles
- gestures
- greetings
- hospitality
- holidays
- housing
- hygiene, health, cleanliness
- joking
- kinship: relations among relatives
- language, slang
- law, authority, punishment, prison terms
- literacy: aural and written
- marriage
- medicine, medical providers, healers
- mind-altering substances
- modesty; privacy about the body
- music
- personal and family names
- pregnancy and labor
- pre- and postnatal care
- problem-solving
- property rights
- puberty customs
- religious beliefs and rituals
- sexual customs, roles, and restrictions
- social organizations
- sports
- status differentiation, prestige, credibility
- trade, economics, money, barter
- visiting, socializing

Can you think of any more?

CULTURAL IDENTIFICATION

Primary cultural identity

The first way we can identify ourselves consists of individual characteristics that people are born with, and experiences that they have as infants and children. These are characteristics that we cannot change.

1. Age
2. Ethnicity/race
3. Gender
4. Language
5. Physical abilities and qualities
6. Sexual and affectional orientation
7. Childhood experiences and family factors (family religion, place of birth and household location, family social class, parents' occupations, and so forth)

Secondary cultural identity

The second way we can identify ourselves consists of characteristics or experiences over which individuals may have some control or choice; however, the level of control or choice can vary widely for each characteristic.

1. Education
2. Geographic location
3. Income
4. Marital/relationship status and history
5. Military experience
6. Parental status and history
7. Religion
8. Work experience
9. Current social class and class status history
10. Political affiliation and perspective

Tertiary characteristics

The third way we can identify ourselves is through characteristics that are most unique among individuals and are not shared by all populations.

1. Experiences with immigration, exile, refugees, and so forth
2. Lifestyle (e.g., gay culture, new age)
3. Degree of acculturation/assimilation
4. Degree of recovery
5. Recreational drug use
6. Health consciousness
7. Gender identification; change in gender

► **ACTIVITY**

Cultural Identification

Refer to page 4–7, *Cultural Identification*. Within the three dimensions, select 6 or 7 different items and describe your cultural identity in the space below.

Item	Your cultural identification
Example: religion	*Catholic*

III. WHAT IS CULTURAL COMPETENCE?

Similar to developing any set of skills, becoming culturally competent is a process. We can view this process along a continuum. On one end of the continuum, when cultural competence is completely lacking, individuals or institutions can hold attitudes or practice policies that are harmful to clients. Along the way, as individuals or institutions gain awareness and understanding about cultural dynamics, competence increases. Full cultural competence is achieved when individuals or institutions not only accept and respect cultural differences, but also continuously seek new knowledge and strive to improve their approaches with clients.

A. How can health workers develop cultural competence?

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

► **ACTIVITY**

Health Beliefs among the _____

name of cultural group

Notes:

IV. USING AN INTERPRETER

A. Potential problems with interpreters

1. Interpreters may not state accurately what the health care worker and/or the patient have said
2. Interpreters might add their own ideas of what has been said
3. Interpreters may have difficulty finding correct words in English or interpreting medical terms into the patient's language
4. The patient might be uncomfortable talking about personal information that he/she does not want the interpreter to know

B. Guidelines for interpreters

1. Ask for the patient's permission to use an interpreter
2. Meet with the interpreter before seeing the patient to give instructions and guidance and to make sure the interpreter is comfortable with the questions and topics that will be discussed
3. Remind the interpreter that all information discussed is confidential
4. Ask the interpreter to refrain from adding his/her own comments
5. Ask the interpreter to interpret the patient's and the health care worker's words as exactly as possible: add nothing, omit nothing, change nothing
6. Arrange to sit or stand so the health care worker is facing and talking to the patient, not the interpreter
7. Ask the interpreter to explain questions or answers that are not clear
8. Keep messages simple and factual; use short phrases and focus on one topic at a time
9. Give the interpreter time to interpret each phrase before continuing; do not interrupt the interpreter
10. Give the patient enough time to answer questions
11. Ask the interpreter to be sure to use the first person. For example, if a patient answers a question about her family members by saying, "I live with my husband and three daughters," the interpreter should not say, "*She* lives with *her* husband and three daughters." The interpreter should say it exactly as the patient did: "*I* live with *my* husband…"

C. Who should interpret? (listed in order of preference)

1. Trained medical interpreters
2. Other health care workers who speak the patient's language
3. A community member or family member of the patient
   - Potential problems with confidentiality and unfamiliarity with medical terms
   - If a family member must be used to interpret, do not use children; they will hear personal information and may be asked to interpret things that the family believes children should not discuss

D. Guidelines for providing DOT when an interpreter is not available

1. Call the office for interpretation over the telephone
2. If available and approved by program management, use a commercial telephone interpretation service
3. Learn and use a few greetings and key TB words in the patient's language
4. Use materials/instructions written in the patient's language
5. Other ideas

REVIEW QUESTIONS

1) What are five ways that people can culturally identify themselves?

   a. _____

   b. _____

   c. _____

   d. _____

   e. _____

2) What are four ways to learn more about a patient's culture and health beliefs?

   a. _____

   b. _____

   c. _____

   d. _____

3) What are three guidelines for using an interpreter when providing DOT to a non-English-speaking patient?

   a. _____

   b. _____

   c. _____

4) What are three guidelines for providing DOT to non-English-speaking patients without the assistance of an interpreter?

   a. _____

   b. _____

   c. _____

ADDITIONAL RESOURCES

- http://www.aapcho.org
  Association of Asian Pacific Community Health Organizations

- http://ahec.msu.montana.edu/students/culture.html
  Culturally Competent Health Care, Montana Area Health Center, Montana State University

- http://healthlinks.washington.edu/clinical/ethnomed
  EthnoMed – Ethnic Medicine Guide, Harborview Medical Center, University of Washington

- http://www.omhrc.gov/omhrc/index.htm
  Office of Minority Health Resource Center

- http://www.health.qld.gov.au/hssb.cultdiv/cultdiv/home.htm
  Queensland Health Information Network (profiles of ethnic groups in Australia)

SESSION EVALUATION FORM

Your feedback about this training session is important. Please read each statement and circle one number to indicate the level of your agreement/disagreement. Include any comments on the lines provided below.

Name _____ Session # _____

Topic _____ Instructor _____

1 = Strongly disagree 2 = Disagree 3 = Neither agree nor disagree 4 = Agree 5 = Strongly agree

1.	The topics are covered comprehensively	1	2	3	4	5
2.	The session meets its objectives	1	2	3	4	5
3.	The session length is appropriate	1	2	3	4	5
4.	The information is well organized	1	2	3	4	5
5.	The session maintained my interest	1	2	3	4	5
6.	The level of the material is appropriate	1	2	3	4	5
7.	The printed materials are useful	1	2	3	4	5
8.	The delivery of the material was effective	1	2	3	4	5
9.	I now feel more prepared to perform my DOT duties	1	2	3	4	5
10.	Overall, the session was excellent	1	2	3	4	5

What do you recommend to improve this session? _____

What additional tuberculosis training do you need? _____

Other comments: