Cultural competence and diversity responsiveness: how to make a difference in healthcare?

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4 Cultural competence among nurse practitioners working with asylum seekers
Abstract

Asylum seekers often have complex medical needs. Little is known about the cultural competences health care providers should have in their contact with asylum seekers in order to meet their needs. Cultural competence is generally defined as a combination of knowledge about certain cultural groups, as well as attitudes towards and skills for dealing with cultural diversity. Given asylum seekers' specific care needs, it may be asked whether this set of general competences is adequate for the medical contact with asylum seekers. We explored the cultural competences that nurse practitioners working with asylum seekers thought were important. A purposive sample of 89 nurse practitioners in the Netherlands completed a questionnaire. In addition, six group interviews with nurse practitioners were also conducted. A framework analysis was used to analyse the data of the questionnaires and the interviews. From the analysis, several specific competences emerged, which were required for the medical contact with asylum seekers: knowledge of the political situation in the country of origin; knowledge with regard to diseases common in the country of origin; knowledge of the effects of refugeehood on health; awareness of the juridical context in the host country; ability to deal with asylum seekers' traumatic experiences; and skills to explain the host country's health care system. Apart from these cultural competences specific for the situation of asylum seekers, general cultural competences were also seen as important, such as the ability to use interpretation services. We conclude that insight into these cultural competences may help to develop related education and training for health care providers working with asylum seekers.
Introduction

Asylum seekers are a heterogeneous and culturally diverse population living under specific conditions in a host country while awaiting the decision on their request for asylum. It is a population with a high prevalence of both physical and mental health problems (1). The medical needs of asylum seekers are often complex because of multiple medical problems, language and cultural barriers, lack of familiarity with the health care system, and general health illiteracy (2). Furthermore, the relatively poor health care systems in countries of origin, the war-related chaos and subsequent hardships, the difficulties associated with the flight (3), and the impact of a long asylum procedure (4) may all contribute to asylum seekers having different health needs compared to other immigrants.

Health care professionals often do not feel competent to deal with these needs (5) because they feel they lack adequate skills (6) or a comprehensive knowledge of health conditions unique to refugees (2). It is also noted that health care providers working with asylum seekers apply strategies that are developed individually rather than professionally (7), and that much is left to professionals to discover through trial and error. Even though studies exist that highlight the importance of cultural competence in several areas, such as the skill to develop a trustful relationship with asylum seekers (8,9) or the ability to explain the host country's system of health care (10,11), cultural competence has not been studied in a systematic and integral way in relation to this specific patient group. To date, no research exists that describes cultural competences — which will be explained in the next section — specific for the medical contact with asylum seekers. Yet, a systematic description of cultural competences may facilitate the development of training and education for care providers. On the basis of questionnaires and interviews, we explore in this paper those particular cultural competences that nurse practitioners working with asylum seekers consider important. A nurse practitioner is a registered nurse who has completed specific advanced nursing education (generally a master's or doctoral degree) and training in the diagnosis and management of common as well as a few complex medical conditions. Nurse practitioners are common in the Netherlands, but also in the United States, Canada, Australia, and the UK.

Cultural competence

In societies that are rapidly becoming multicultural, nurses deal increasingly with patients from various ethnic backgrounds. Hence, ‘cultural competence’ has been suggested by scholars to be an instrument that can be used to prepare care providers and to support them in dealing with issues of ethnic diversity (e.g. 12-15). The idea is
that with culturally competent health care providers, health care for patients of different ethnic backgrounds will improve and health disparities may decrease (5,16-18).

Cultural competence has been a concept of interest in nursing for the past forty years, and has been addressed internationally in the United States, Canada, New Zealand, the United Kingdom, and Korea (19). It is assumed that with culturally competent health care providers, health care for patients of different ethnic backgrounds will improve and disparities will decrease (generally, models of cultural competence include a combination of awareness, knowledge, and skills to deal with ethnic diversity). Awareness refers to self-examination and to an in-depth exploration of one's own cultural and professional background, including one's own biases. Knowledge is the process of seeking and obtaining a sound educational foundation about diverse cultural and ethnic groups, such as disease incidence or prevalence and treatment efficacy. Skill refers to the ability to collect relevant cultural data regarding the client's presenting problem, such as the ability to elicit the patient's perspective or to use interpreter services effectively. The three concepts of awareness, knowledge, and skills have an interdependent relationship with each other (13), and each of them needs to be addressed by the care provider. It is the integration of these concepts that makes up a competence (20), and it is therefore described by Betancourt (14) as a three-legged stool.

Despite the popularity of the concept of cultural competence, two important criticisms exist. Firstly, it is assumed that the concepts of ‘ethnicity’ and ‘culture’ are interchangeable (21). However, this does not do justice to the complex sociocultural context in which patients live (22), and which needs to be acknowledged in the care for an ethnically diverse patient population. Hence, a broad conceptualisation of cultural competence needs to be applied, which relates not only to cultural issues but also to other elements that pertain to care for patients from various ethnic backgrounds; this includes epidemiological differences, patients' social contexts, and prejudice and stereotyping (15). Secondly, the concept of cultural competence tends to focus on the ‘otherness’ of patients as the cause of experienced problems, and suggests that care providers are culturally neutral human beings (21). Therefore, models of cultural competence need to acknowledge that not only patients but also care providers and health care systems are culturally influenced.

Cultural competence is said to be relevant in all areas of medical practice (13), but given asylum seekers' specific care needs, it may be asked whether this set of general competences is adequate for the medical contact with asylum seekers. Asylum seekers and refugees may confront care providers with all kinds of challenges, demanding not only a sufficient level of cultural competence (23,24) but perhaps also different kinds.
Methods

Questionnaires were used to collect general data on the intake experiences of nurse practitioners, but questions about cultural competences were also included. In addition, semi-structured group interviews were conducted to obtain a more detailed insight into the daily experiences of nurse practitioners. Thus data from different sources were synthesized, a method called ‘triangulation,’ as a way to improve the likelihood that qualitative findings would be found credible (25).

Setting

Asylum seekers stream to the Netherlands from different parts of the world, and in 2007, the largest groups had come from Iraq, Somalia, Afghanistan, and Iran (26). While awaiting the decision on their application for refugee status, they live here in asylum seeker centres. At the time of the study, nurse practitioners were working at these centres, and the health care was organised as follows: 1) to assess the health needs, within six weeks after the asylum seekers’ arrival, nurse practitioners undertook an intake procedure in which main health issues were discussed. This was usually the first contact between an asylum seeker and a nurse practitioner; and 2) to deal with asylum seekers’ medical and mental problems, nurse practitioners provided daily care, and referred as necessary to mainstream service professionals such as GPs, social workers, or dentists. An interpretation service, in all languages and generally by telephone, was available. At the time of the study, there were approximately fifty different asylum seeker centres divided into six clusters throughout the Netherlands. For about 40% of the applications for asylum, the Naturalisation Service Agency (the Organisation for entry into the Netherlands) takes a decision within three to five days. For some 60% of the applications, however, more time is needed, and in these instances the Naturalisation Service Agency strives towards taking a decision within about a six-month period, during which the asylum seeker stays temporarily in an asylum seeker centre (www.ind.nl).

Participants

In each cluster, a coordinator was approached who distributed the questionnaires to nurse practitioners in different asylum seeker centres. Nurse practitioners could fill in the questionnaire at their own convenience, and they returned it by post to the researchers.

For the group interviews, coordinators in all six clusters were asked to approach nurse practitioners, from one centre per cluster, who were willing to participate in a group interview. Thus, we conducted a purposive sampling of nurse practitioners from centres in the different clusters, to ensure representation from all clusters and to maximise variation in experience with asylum seekers.
Data collection

Data from the questionnaires and group interviews were collected over a four-month period in 2007. In total, 89 questionnaires were returned, but because it is not known how many questionnaires were distributed we are not able to give a response rate. Four open-ended explorative questions with regard to cultural competences were asked: 1) Did you receive specific education or training with respect to cultural competences and, if so, what is your educational background? 2) Do you feel culturally competent: why or why not? 3) What kind of cultural competences are important for the intake? 4) How may cultural competences be improved? In addition, personal information about years of experience in providing health care to asylum seekers was requested. As an introduction to these questions, we provided a broad and generally accepted definition of the concept: ‘Cultural competence can be defined as a composite of knowledge, awareness, and skills necessary to provide adequate care to an ethnically diverse patient population.’ This definition was included in order to give all respondents the same general idea about what we understand cultural competences to be.

Subsequent to the questionnaires, a group interview with nurse practitioners was planned in all six clusters: in total, seven group interviews were conducted, and were held either after a professional meeting or were organised separately. All together, 36 nurse practitioners were interviewed in groups of between two and nine persons. In the interviews, a topic list was used that contained items such as problems experienced with providing medical care, the specific role of the nurse practitioner in the system of medical care, perceived expectations of asylum seekers, and what was seen as an ideal situation in which to provide high-quality care. No specific questions about cultural competences were asked, but participants spontaneously considered it while discussing the above-mentioned topics. Questions were open-ended and efforts were made to engage all present in the group. The interviews were conducted by two researchers (IR and CS) who took turns interviewing and making notes. All interviews — which took about 1.5–2h each — were recorded on tape and transcribed.

Ethical considerations

According to the Medical Research Involving Human Subjects Act, medical–ethical approval of this study was not required in the Netherlands. Firstly, only care providers and no patients were involved. Secondly, this was not an intervention study, and respondents were only interviewed. Nevertheless, we made a great effort to deal adequately with ethical considerations such as anonymity of all the collected data and informed consent of the involved care providers. The anonymity of respondents was guaranteed by using codes to designate them. Information about the study was given in the form of a flyer as well as in a letter accompanying the questionnaire, in which the
researchers also guaranteed anonymity. Group-interview participants were assured of confidentiality, informed consent was obtained and this was tape-recorded a priori. Finally, approval was obtained from the Community Health Services for Asylum Seekers, the employer of the nurse practitioners.

**Data analysis**

A framework approach was used to analyse data from the questionnaires (27,28), and after familiarisation with the data, a coding framework was identified. The questionnaires were then systematically coded using this framework. Data were subsequently charted (29) and three major charts were constructed: educational background (combining questions 1 and 2), important cultural competences in connection with asylum seekers, and ideas about how cultural competences may be improved. The group interviews were not developed to collect data on cultural competences, although interesting related themes arose from the interviews. It was therefore decided to include the group interviews data in the study, albeit merely to illustrate further what was found in the questionnaires. The transcription of each group interview was read carefully to gain an overall impression before being coded and analysed. One chart was designed on the basis of different cultural competences that were mentioned in the interviews. Using this chart, patterns and connections could be described (30).

The questionnaires as well as the interviews were qualitatively analysed. This means that we were interested in exploring how nurse practitioners understood or managed their day-to-day competences in relation to asylum seekers (29). Rather than to quantify this process and answer questions such as “how often” or “how many,” we wanted to understand what was going on, in order to provide a comprehensive description of cultural competences.

**Results**

**Training and education in cultural competence**

Nurse practitioners had an average of nine years' work experience in health care for asylum seekers. In the questionnaires, a majority of the nurse practitioners explained they had received some form of training or education in cultural competences (Table 4.1). This was generally during their study period, such as doing a master's degree in transcultural nursing and/or in special courses organised by the employer or previous employers (e.g. a course regarding intercultural communication skills or sexually transmitted diseases and PTSS). Most nurse practitioners answered that they felt culturally competent, and added that this was largely because of their experience
working in the asylum seeker centre or because of their training or education. In Box 4.1, the cultural competences that nurse practitioners described in the questionnaires are presented. Mainly these are competences specific for the contact with asylum seekers, whereas a few competences can be seen as general competences useful in all intercultural medical contacts. In the following paragraphs, each competence specific for the medical contact with asylum seekers is further illustrated with information from the interviews. The excerpts show how these competences are put into practice, and occasionally demonstrate how difficult they may be to apply. We leave the general cultural competences unexplained in this paper because they have already been addressed elsewhere in more detail (e.g. 12-15).

Table 4.1 Education in cultural competence and feeling culturally competent.

| Educational background with respect to cultural competence | 88% |
| Education/training during study (e.g. intercultural nursing) or specific courses (e.g. in intercultural communication skills, knowledge of sexually transmitted diseases and PTSS) | 81% |
| Education/training because of former experience (e.g. working in an asylum seeker centre; working in a developing country) | 34% |
| Nurse practitioners feeling culturally competent | 88% |
| Feeling culturally competent because of previous work in an asylum seeker centre | 15% |
| Feeling culturally competent due to education or training | 11% |

Percentages do not add up to 100%, as it was possible to give more than one answer to these questions and an answer was not always provided.

Box 4.1 Cultural competencies for nurse practitioners working with asylum seekers.

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<tr>
<th>Knowledge</th>
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<tr>
<td>Knowledge of the political and humanitarian situation in countries of origin.</td>
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<tr>
<td>Knowledge of epidemiology and the manifestation of diseases in asylum seekers’ countries of origin.</td>
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<tr>
<td>Knowledge of effects of refugeehood on health.</td>
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<table>
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<tr>
<th>Attitudes</th>
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<tr>
<td>Awareness of the juridical context of the host country in which asylum seekers live.</td>
</tr>
<tr>
<td>Awareness of how culture shapes individual behaviour and thinking (related to being respectful, open-minded, empathic, and so on).</td>
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<tr>
<td>Awareness of one’s own prejudices and tendency to stereotype (related to being open-minded, respectful, and so on).</td>
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<tr>
<th>Skills</th>
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<tr>
<td>Ability to develop a trustful relationship with an asylum seeker.</td>
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<tr>
<td>Ability to ask delicate questions about traumatic events, personal problems.</td>
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<tr>
<td>Ability to explain what can be expected from health care (in order to develop a trustful relationship).</td>
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Knowledge of the political and humanitarian situation in the country of origin

Most nurse practitioners saw it as essential to be aware of the political situation in the patients' home countries, and to have an insight into the way medical problems may be a direct result of the political situation. A nurse practitioner has to decide which specific information is relevant for groups of asylum seekers coming from different political situations. As a nurse practitioner explained in an interview:

'It is different, for example, if you were part of the army of Saddam Hussein, and you are a young Iraqi man, who, oh well, had to do awful things, and were abused with rifle butts or something like that. Or that for a long time you had very little to eat and were wandering through the desert of Sudan [...] and have become very skinny, yes, had very limited food.' [R1]

Knowledge of epidemiology and the manifestation of diseases in asylum seekers' countries of origin

Nurse practitioners mentioned that it was useful to have knowledge of the prevalence of diseases such as malaria, worms, infectious diseases including HIV and other sexually transmittable diseases, dental problems, chronic diseases, vaccinations, and haemopathologies such as sickle cell disease or thalassemia. Knowledge concerning the prevalence of female circumcision and possible medical complications was also seen as relevant.

Knowledge of the effects of refugeehood on health

Nurse practitioners generally made a difference between health issues with regard to different stages of the refugee's flight. It was important to know about health issues that had existed before the flight (e.g. knowing that bone fractures may be the result of torture), that emerged during the flight (e.g. knowing that there may be health differences between someone who had arrived by plane or after a long and arduous journey), or after the flight (e.g. knowing that the asylum-seeking procedure and living conditions in the centres may influence asylum seekers' mental health).

Awareness of the juridical context in which asylum seekers live

Several nurse practitioners stressed the importance of explaining very clearly that the medical staff had nothing to do with officially organising entry to the Netherlands. For instance, they pointed out to asylum seekers that all information would remain
confidential and would not be used in the application procedure for a residence permit. Or they told asylum seekers that they would like to know the story with regard to the flight in order to assess their health condition, but stressed that they were not interested in every detail. Thus, they strove to avoid causing the asylum seekers to feel they were being interrogated in connection with their refugee status. Nurse practitioners took great pains to make it clear that this was not the case, because if asylum seekers erroneously believed it to be so, it was seen as highly disruptive in the development of a trustful relationship.

Skills to develop a trustful relationship with an asylum seeker

Building a trustful relationship was generally seen as pivotal, and should be initiated as early as possible in the contact with asylum seekers, as is explained in the following excerpt:

‘I think it is a trustful relationship. Because people need a long time before they will disclose things. Especially painful things. And the fact that someone has been seen in the intake creates a bond, a starting point from which to continue. I myself think this is often neglected. It is so important to see the same faces, the same people, a familiar face.’ [R5]

Having a trustful relationship helped the asylum seeker to talk about mental problems, but it also enabled the nurse practitioner to ask sensitive questions about traumatic events or about personal problems. Good communication skills, such as listening, were seen as crucial.

Ability to ask delicate questions about traumatic events and personal problems

Although nurse practitioners considered it important to detect whether asylum seekers suffered from mental problems or psychological trauma, the topic was experienced as a difficult one to raise.

Some nurse practitioners tried to sense whether the asylum seeker wanted to talk about traumatic experiences. For example, they prefaced questions with a remark such as ‘I am going to ask some questions that may be painful.’ However, even the ‘neutral’ administrative questions that nurse practitioners also have to ask — such as ‘Are you married’ or ‘Do you have children,’ when the partner and/or children may be dead or left behind — may result in the asylum seeker feeling loss and pain. Several nurse practitioners added that the presence of an interpreter also made it more difficult to ask these kinds of questions of someone you had never seen before.

Furthermore, nurse practitioners stressed the importance of referring in good time to other professionals when they felt they themselves were not capable of dealing adequately with mental problems presented by asylum seekers.
Ability to explain what can be expected from health care

This skill has to do with explaining the Dutch health care system. On the one hand, it was seen as important because nurse practitioners saw it as their job to explain to asylum seekers what they could expect from the medical care, in order to do away with any unrealistic expectations about the medical care in the host country (e.g. thinking that a leg crippled by polio would be healed) [R5]. On the other hand, the medical system was explained because it is known to be different from many systems in the rest of the world (e.g. thinking one could buy antibiotics in a shop or could go to a paediatrician whenever one felt like it) [R4]. Nurse practitioners acknowledged that not only for asylum seekers but for all newcomers to the Netherlands the health care system is new and needs to be explained. Nevertheless, it was seen as particularly important for the contact with asylum seekers, mainly because if the system was not explained well, asylum seekers may have felt excluded from care, and this was seen as disruptive in the development of a trustful relationship.

Improving cultural competence

Finally, from the analysis of the questionnaires, it emerged that nurse practitioners believe cultural competence can be improved. The majority thought more education was needed (40%). For example, skills such as listening, being able to construct a confidential relationship, and knowledge of the countries of origin, of body language, and of differences in the presentation of complaints were seen as important cultural competences that need regular attention in education and training. Other nurse practitioners believed that cultural competences can be improved through the concrete experience of working in an asylum seeker centre (24%). For instance, discussing complex cases with colleagues, talking to asylum seekers about what they feel is important, or working with interpretation services were all seen as valuable experiences and as ways to improve cultural competence.

Discussion

According to nurse practitioners in this study, the following areas of competence are important: knowledge of the political situation in the country of origin; knowledge of how refugeehood influences health; specific knowledge with regard to diseases common in the countries of origin; awareness of the juridical context; and specific skills such as the ability to ask delicate questions about traumatic events and to explain the health care system. Even though we explored cultural competences of a specific group of care providers — namely, nurse practitioners — we believe that our results are relevant for other care providers who work with asylum seekers.
These results add more specific competences to the cultural competences that have been described in other studies (e.g. 12-15). The future education of nurse practitioners or other care providers may be focused on acquiring this set of specific knowledge, attitudes, and learning skills in specific courses. However, this study also shows that it is not merely education or training that helps nurse practitioners feel culturally competent. Equally significant is the concrete experience of working with asylum seekers. This suggests that ‘learning in action’ (31) by way of adequate supervision, mutual peer supervision, and systematic feedback on the work floor may also be a key teaching instrument. Thus, experiential and didactic learning may be integrated in order to develop relevant cultural competences (32).

We believe that the care providers' cultural competences may benefit the quality of medical care to asylum seekers. However, care providers do not work in a juridical and social vacuum, but in a context of policies and politics, which to a large extent are beyond their control. For example, care providers may experience feelings of powerlessness after having to terminate contact with an asylum seeker whose application is rejected and who will be deported to the country of origin. Thus, even if care providers are very culturally competent, they have to work with restrictions to their possibilities of providing medical care. Care providers from different countries have to deal differently with the juridical and social context of their own country, as every country has its own asylum seeker policies and policies of medical care (33). This may demand country-specific non-medical competences, such as the ability to work within a certain juridical context.

Finally, cultural competences should not be seen as a list of skills that are acquired and ticked off one at a time, resulting in a person who is culturally competent. Acquiring cultural competence is an ongoing process, driven by the practitioners' self-reflection (13,34). This is perhaps especially true for nurse practitioners working with asylum seekers, a group of patients that by definition changes due to new wars and conflicts in home countries, or due to a change in host-country politics with regard to refugees.

**Study limitations**

Although the interviews revealed interesting topics that could be used to illustrate the questionnaire data, more information may have been revealed if we had asked specifically about cultural competences in the interviews. Another limitation is that we only asked about cultural competences in relation to the intake and not to regular contacts. Thus, specific cultural competences necessary for the contact with asylum seekers who have already been a long time in the asylum seeker centre may not have been found. Still, because the intake is seen as an important starting point for the
relationship with asylum seekers, we believe that cultural competences relevant for the intake will also apply for subsequent contacts.

Conclusion

As far as we know, this is the first empirical study that describes cultural competences with regard to the contact between care providers and asylum seekers. The results of our study can be used for the training and education of different health care professionals, describing as it does cultural competences unique to the contact with asylum seekers.

Acknowledgement

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