

Cultural Competence Beyond Culturally Sensitive Care for Childbearing Black Women

As racial and cultural diversity increase in Canadian society, health care professionals face challenges in providing appropriate care for all clients. Gaps in health status information, and disproportionately low access to health care for racially visible minority groups, exemplify these challenges. Identifying and understanding the influence of culture on health and health seeking behavior can address some of the challenges in meaningful ways. This paper will discuss the findings of a study that examined Black women's childbirth experiences in one of the Atlantic provinces. The study was guided by the tenets of feminist Participatory Action Research (PAR) methodology. Women's narratives can serve as a fundamental component of research knowledge for policy development. Data was collected mainly through in-depth individual interviews and focus group discussions with Black women from Nova Scotia. Thematic analysis facilitated the categorization of key themes.

Although five themes emerged from the data for this study, this paper focuses on one of these themes: lack of cultural competence and its implications for perinatal health care. In exploring Black women's perinatal health care experiences, this study has explicated some of the manifestations of insensitive and incompetent perinatal care services. Developing skills in cultural competence allows health care professionals to improve the quality of perinatal health care provided to clients from diverse cultural backgrounds. The paper proposes the use of cultural competence as a process that will enable health care providers to work effectively across cultures and ultimately, to address health disparities along racial and cultural lines.

Introduction

Childbirth has been described in health literature as a cultural phenomenon (Davis-Floyd and Sargent, 1997). Nowhere in a culture are there more prescribed rituals and ways of behaving as occur around childbearing (Finn,

1993; Enang, 1999). Kathryn A. May and Laura R. Mahlmeister (1990) note that “cultural beliefs dictate how women and their families view childbearing and care for their newborn” (263). The relatively simple act of what is to be done with the placenta, for example, is affected by cultural mores: some dispose of it in the hospital while others take it home to plant a memorial tree for the child. Culture has impact on the various dimensions of childbirth including methods of prenatal care, choice of caregivers, the birthing process, use of pain relief measures, breastfeeding patterns and diet (Finn, 1993). Factors influencing these dimensions can range from the scientific medicine of the dominant cultures of Western societies such as Canada, to the indigenous childbearing traditions of the developing world (Mauricette, 1997). Given that the majority of health care providers are White and middle class (Sue *et al*, 1998; McNaughton Dunn, 2002), an important step to foster effective cross-cultural care should involve recognizing and acknowledging their own Eurocentric values, which are often seen as superior to others (Higham, 1988).

The lack of culturally responsive health care services to people of African descent living in Nova Scotia has been a long-standing barrier to health care (Enang, 2002). The purpose of this paper is to explicate this lack of cultural competence in perinatal health care based on the finding of a study of women of African descent from one of the Atlantic Canadian Provinces. The paper also proposes a cultural competence model to guide effective health care across cultural boundaries. The following topics are addressed in the paper: background to establish the significance of the study; the research process; key findings related to cultural competence at the institutional and individual levels; implications of study findings for cross-cultural care; and specific strategies to foster cultural competence among health care professionals including proposing a model for culturally competent health care.

From a socio-cultural viewpoint, human childbirth is a unique process involving highly systematized patterns of care that may be found in any culture. The diversity and patterns are so great that members of one culture might not recognize care in another one as care. Thus, if one cultural group confronts the practices of another, they may be left wondering how women even survive the childbirth process (DeVries, 1989; Sue *et al*, 1998: 82). Culture specifies the care available to the perinatal family. Culture also socializes and educates thereby eliciting the desire for a particular style of care (Enang, 1999: 2). The discourse surrounding culture and childbirth in any society reflects its social meaning and is a contribution to understanding the reality of childbirth as an event experienced by people within a particular society (Hewison, 1993). In recent times, there has been an increased realization and demand for respect by caregivers (Kitzinger, 1993). This respect is requested by individuals including childbearing women, their families and other stakeholders who are engaged in, and committed to, the responsibilities of perinatal and childbirth care.

Cultural differences amongst diverse populations influence perceptions

of quality of care during the childbearing period (Reid and Garcia, 1989). The reality of cultural differences and the effect of these differences on the needs of diverse populations accessing the public health care system require attention especially given the current demographic of Canada's population. Approximately 44 percent of Canada's population report origins other than British, French or Canadian (Statistics Canada, 2005). Of this figure, 13.4 percent are reported to be members of visible minority groups (Statistics Canada, 2005). Over 100 different ethno-cultural groups live in Nova Scotia. Approximately 19,000 Black people live in the province (Statistics Canada, 2005). This number is about five times the total for Blacks in the other four Atlantic provinces of Canada.

The arrival of Nova Scotians of African descent to the province dates back to the early seventeenth century. Indigenous Blacks constitute the largest visible minority group in the province, comprising fifty-seven percent (57 percent) of the total population of visible minorities in the province (Nova Scotia Department of Health, 2003). In relative and actual numbers, they represent a significant sub-population, which affects daily life in general and work life in particular throughout the province. In a local needs assessment, less than 50 percent of African Nova Scotian women ranked their satisfaction level with perinatal care as a 2.6 out of 5.0 (Black Learners Advisory Committee, 1994). Such findings call for more research in this area as limited evidence of health care experiences of African Nova Scotians exists.

The research process

The purpose of this study was to examine the childbirth experiences of African Nova Scotia women with a goal of generating knowledge that will inform health services for this population. Feminist Participatory Action Research (PAR) methodology formed the guiding tenets for the study. The main sources of data collection were audio taped semi-structured interviews and Focus Group Discussions. All tapes were transcribed word for word and thematic analysis was used to identify major themes and their sub-themes from the transcripts.

Eight African Canadian women between the ages of 18 and 40, who gave birth in the Nova Scotia perinatal health care system, took part in individual interviews. Over 30 women participated in the focus group discussions. All participants in the interviews were African Nova Scotians who had their babies within two years of the study. In-depth individual interviews took place mostly in the women's homes. The Black Women Health Project: An initiative of the Inner City Community Health Centre served as a forum for these group discussions, data analysis and the initiation of social action projects, which were integral part of this participatory action research. Preliminary data analysis was validated and further enhanced through the use of several focus group discussions. Thematic analysis was used to capture the concerns and issues identified by study participants.

Findings

This examination of the childbirth experiences of African Nova Scotia women revealed “lack of culturally appropriate care” as a major theme. Other emerging themes included: meaning of the childbirth experience; access to health care; racism in health care; and value of support networks. This paper will focus on the lack of culturally appropriate care; other themes are addressed in a separate manuscript.

To provide culturally appropriate and competent care, it is important for nurses to remember that each individual is culturally unique and, as such, is a product of past experiences and cultural beliefs. These women identified a number of cross-cultural care issues that impacted on the health care experiences. These include limited cultural knowledge and education of health care professionals, and others which have been described under two sub-themes; 1) Cultural competence at the institutional level; and 2) Cultural competence at individual level.

Cultural Competence at the Institutional Level

Most women in the study expressed their perception that some of the cultural insensitivity they experienced occurs due to lack of the organizational commitment to multiculturalism. In validating the lack of cultural competence at institutional level, Joan A. Anderson (1998) notes that, health care institutions should emphasize the strengths of minority populations they serve. Professionals in leadership roles within health care institutions should identify ways of incorporating learning, knowledge and expertise from these communities in addressing the complex issues inherent in multiculturalism. The following are excerpts of what the women in this study had to say:

I think everybody is different in their own way ... I find that everybody have a different background, culture, or race. But it seems like when you go into the hospitals, everything you see is just White White babies' pictures, cards, magazines and stuff.

Organizations should strive to provide posters, magazines and additional audio-visual resources that reflect the diversity of the clients they serve. This provides a welcoming setting, reassuring clients that their cultures are accepted and valued in the health care environment (McNaughton Dunn, 2002). One participant spoke on the need for more representation of visible minorities in the health professions:

You know, some people have different religions. I think there should be more awareness in the hospital to be nice to people of African, Chinese, or Indian descents. A lot of people that live here now, do things differently in their country so there should be people of their culture in the hospital, that they could talk to, can relate to and share religious beliefs.

Another woman related this need for increased representation to the potential information resource that diverse staff would be:

It would be beneficial for women from different races to be able to have the information they need. If one nurse doesn't have the information, it would be nice to say, "well, we have someone else on staff from your culture that could help answer your questions better than I can."

Cultural representation among staff in the health care setting not only provides reassurance to the clients but serves as a readily available information source to health care professionals as well. Working closely with ethno-cultural groups allows health care professionals from the dominant culture to constantly assess their attitudes and biases based on their behaviour towards colleagues. Human resource departments in organizations should review hiring policies to determine whether they are conducive to staff from diverse cultural backgrounds (ACHA, 2000). Some women in the study observed that cultural sensitivity alone was not sufficient. Health care professionals require cultural knowledge about the communities they served:

To make sure they are sensitive to the people's needs, they should know a bit about our culture, a bit about us. And if they don't know ... There are ways to find out. There probably have some of the nursing staff or other staff that could answer our questions.

Similarly, another participant asserted, "we need more cultural diversity awareness. I think it will be helpful for everyone to see the different cultures because not everybody is Black and White."

Based on the perceived lack of cultural awareness, one woman suggested that perinatal health care institutions needed to integrate diverse perspectives into prenatal class content, she noted "Whites, Blacks, Native Indians, etc.... So that they can hear everyone's opinion and not just what one group wants." She also recommended that information on cultural issues should be made available to women and their families in accessible locations such as the libraries in their communities. Another woman expressed a similar need to recognize diverse needs:

Different babies require different things because Black people have different needs from White people. For example, skin and hair care. Everybody can't use the same kind of lotion, make-up or hairdo. It's different.

Another woman expressed the need to recognize minority people's needs in terms of diet planning in the hospital:

I was disappointed with the food. I found that they didn't come by to see if

some people can't eat certain things. When I was in the hospital, I had to get people to bring me food because I hardly ate any of the hospital food. I know they can't change their diet for everybody but there are certain things that certain people can't eat. And they didn't come by to say "could you eat the food today? Is there anything you didn't like? Is there anything else that you would like to have or substitute?" A lot of times they would send me my breakfast, dinner and then supper, and I would usually send it back.

The limited cultural knowledge and skill of health care professionals was a common thread in the narratives of many of the study participants. For example, one woman noted, "I think everybody is different, and everybody's childbearing experience is different. And so nurses should assess the needs of each individual person, not treat every person exactly the same." The following narrative from another woman further supported the lack of cultural competence by health care providers:

If our family comes in, they shouldn't get frustrated because we have extra one or two family members around. That is just the way we are. And if they are finding that they are having problems understanding our culture or understanding our needs then they need to first of all attack their administration to get some workshops or sessions. There are people that can come in and to do sessions with them—both patients and other professionals. And then they can also attack the training institutions that they came from ... and say, "well, you didn't tell me this. What are you doing for people that are coming through now?" Because you've got to stop the cycle somehow.

One of the participants recommended an educational process on interpersonal relationships for the health care providers. In response to the question on whether anything in her care could be changed, she said:

Actually, there is one thing that could change. Educate [the staff] on interpersonal relationships. Maybe even do some role playing so that they can get some idea to be nice. Not that they were bad. It's just the fact that you could feel something when they come in. And it wasn't "If I smile, she'll smile back" A couple of times, I said, "Hi," and they didn't even answer. They just kept right on about their business. So I didn't bother saying anything.

Cultural competence at the organizational (institutional) level is an effective strategy to address the health needs of diverse communities (Culley, 2000; ACHA, 2000; Kim-Godwin, Clarke and Barton, 2001). However, from the stories for these women, it is obvious that there are some gaps in the professional services and organizational culture of health care institutions. Unfortunately, there are currently no multicultural health care policies at Provincial

and Institutional levels. As a result, there are limited cultural resources in the health care institutions in the province.

Cultural Competence at the Individual Level

The women involved with this study identified a number of issues related to lack of cultural competence at the practitioner level. The women spoke of inappropriate care by a variety of providers such as physicians and nurses. These include treatment of family members, being insensitive to client's needs and displaying judgemental attitude towards some Black women. For example, one woman commented that,

One nurse kind of just dropped me off and left me. Like, "This is what you have to do." I had a bad labour, and I had trouble like trying to bath myself. I thought that they would at least send someone to help.

Another noted that her need to have family members around while in hospital was not respected:

I know I was sick. I had high blood pressure, but they used to come in and just kick my family and friends out. I never had a lot of friends down there. They used to just come in and kick anybody out. Those are my friends. I mean they are not more important than me having a stroke or something like that. But they came down to see me. They took their time and now you're just going to kick them out?

She went on to explain how the situation affected her, "I felt like a little kid ... Yes, 'Oh, you're sick'. You don't know what you are talking about." Another woman described a similar experience regarding her family members not being allowed to stay with her in the delivery room. She recalled,

My family was gone ... They didn't come back until after I was showered, and sent to my room to have my nap after supper. And it was so because my doctor said, "Well, you're not going to be bringing your whole in because I know you are from a large family."

She also explained how she missed the support of her family in the absence of sufficient professional support:

They [her family] were warned not to be there. So there was no family ... And the nurse called her and she came and broke my water. Then she [the physician] went and sat on the chair back there. Meanwhile, I'm just there gritting my teeth and saying, "What did you come here for?" You know, I believe it's totally different attitude from Ontario ... A totally different system. And I believe it's so because there you have everyone and

every culture. Both minority and Whites are treated well. I can picture the situation to this day. And I was saying, "What is she getting paid for ... ? And every contraction, I throw up. The nurse was standing there helping me. And she is still sitting in the chair. She says "well, get another bowl" and the nurse is standing by me and the nurse goes "Oh, Dr. X, I think the baby ... the head is out" So she says, "The baby is out?." And she jumps up off her chair. She attends to me. It's just me, her and the nurse in the room. All my family was gone.

One woman had similar concerns while deciding which of her family members and her *doula* she could take with her to the operating room. She felt pressured to choose between her sister who was videotaping the birth and her *doula* who was her main support as a single parent throughout her pregnancy:

And when I had to go in the OR, they said "who do you want to take?" I said "I want my sister and my doula there." They were saying, "You can only have one person." I said, "No, that is my doula. She has been with me throughout my whole pregnancy and through labour ... And I want my sister there so she could tape." I was really upset by this because I thought that they should tell you these things before so you could tell them your own plan especially if you have a doula.

Some participants felt that they were rushed to leave and return to their homes:

The worst thing was the hospital process. You are in there and you have to go home. You want to be pampered. You just left home. I'm a person with two kids already at home. I just left home with the kids. Why shuffle me out of the hospital? "You have to leave. Oh, you have to leave." "Will you be staying for supper?" That's the worst thing.

One woman recalled feeling frustrated at repeatedly being asked when she would be going home:

Constantly nurses are asking you "when will you be leaving?" It was so horrible for them to tell you, "Well, will you be staying for lunch? When will you be leaving?" But I said I still need a break from home. And it's like, "Oh, no, that bed has got to be used by somebody else."

Another participant felt that there were a lot of assumptions regarding her preferences when it came to options for care:

Sometimes I find they just assume without finding out your needs first ...

They shouldn't be so judgmental. It's their job so they should be personable about it ... They have to put themselves in the people's shoes. It's like a business. You have to treat the customers with respect.

As illustrated by these narratives, health care professionals need to understand, accept and adapt to cultural diversity. These are essential elements of cultural competence that should form a part of curricula for health professions training institutions. Yet, it has been determined that institutions of higher learning are not active in incorporating cultural content as an integral part of professional preparations (Papadopoulos and Lees, 2002). Some proponents of anti-racism argue that nursing (and indeed all other health professions) must challenge racism and avoid opting for a 'politically soft option' which embraces curricula issues that merely reify culture (Alleyne, Papadopoulos and Tilki, 1994); without discussing the various ways that cultural intolerance are borne out in the health care setting. Such an approach denies the centrality or existence of racism and pays "superficial attention to cultural rites and rituals" (Papadopoulos, Tilki and Alleyne, 1994: 583) of patients from diverse cultural backgrounds.

Discussion

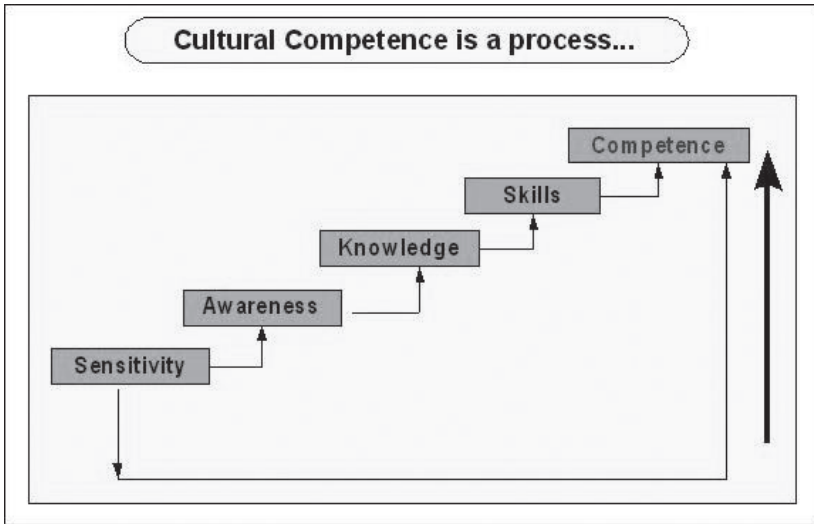
As Canadian society becomes more racially and culturally diverse, health care professionals face the challenge of identifying and exploring issues of diversity in meaningful ways that would improve the quality of care for all clients (Enang, 1999: viii). Whilst there are vibrant, diverse communities, the health system is perceived to overlook and to be unresponsive to their diverse culture-based needs. It is essential for the health care system in Nova Scotia to embrace the task of enhancing perinatal health care through the process of cultural competence.

Erin Skinner (1998) identified the lack of research and culturally relevant health resources as health issues of concern in the African Nova Scotian community. Participants in this study have identified individual (personal level) barriers to access encountered by ethnic minorities including: lack of knowledge, respect, understanding, and insensitivity of health professionals caring for clients from diverse cultures. Their narratives also illustrate an individual bias amongst some health care professionals expressed as a lack of accommodation of culture-specific needs of the clients they serve. A fundamental feature of effective cross-cultural interaction is the basic appreciation of cultural norms, values and beliefs that even health care professionals carry within. These women's narratives suggest a need for health care professionals to develop awareness, sensitivity and knowledge about the needs of the clients from different cultural backgrounds.

In addition, adapting to diversity and recognizing personal biases are also important aspects of working effectively across cultures. The process of developing cultural competence as illustrated in the figure below is essential for

health care professionals seeking to effectively work across cultural boundaries. Cultural competence is not a goal but a journey; a continual process requiring constant learning, reflection and self-assessment.

A Model for Developing Cultural Competence



In this illustration, cultural sensitivity, defined as a “desire and effort to develop programs and services in a manner that respects diversity” (Kim-Godwin, Clarke, and Barton, 2001: 922) is positioned at the start of the continuum.

Sensitivity precedes awareness, which involves recognition leading to knowledge and more informed understanding of the influence that culture has on behaviour of providers and recipients of care. The knowledge allows an acquisition of skills to improve self-assessment, acceptance and adaptation to diversity, which are all essential components of cultural competence.

However, competence in one area for a specific cultural group may not be transferable. Health professionals should be willing to engage in the process of developing cultural competence in a variety of health care settings for diverse cultural groups.

Cultural competence can be described as a set of behavior, attitudes, and policies that enable a system and individual health care professionals to work effectively with culturally diverse families and communities. Cultural competence includes: sensitivity, awareness, knowledge and skills (Kim-Godwin, Clarke and Barton, 2001; McNaughton Dunn, 2002; Papadopoulos and Lees, 2002; Rounds, Weil and Bishop, 1994; Shapiro, Hollingshead and Morrison, 2002). Differences between a health care providers’ and a recipients’ interpretations of a given situation will affect the perceptions of clients, especially if the care provided is incongruent with his or her needs and expectations (Sue *et al*, 1998; Kim-Godwin, 2001). Thus, it is imperative for health care providers to

develop a knowledge base that incorporates an awareness of their own culture, preferences and prejudices. Cultural assumptions are so implicit to our behavior that we are usually not aware of them. The health care provider's ability to recognize personal culture-based preferences is vital to the provision culturally competent health care. An awareness of the influence of one's culture-based beliefs is essential to providing culturally competent care. Without awareness, "western values of individualism, autonomy, independence, self-reliance..." (Kim-Godwin, Clarke and Barton, 2001: 919) results in conflict and miscommunication with clients from cultures having dissimilar values.

Acquiring cultural knowledge and skills involves understanding that concepts of culture are central to the delivery of effective care. Culture-specific knowledge is an essential component of cross-cultural care but focusing on culture-specific information is not desirable because, among other things, it encourages a superficial approach to care, which reduces multicultural issues to the level of a recipe (Geiger, 2001; Papadopoulos and Lees, 2002). Adapting to diversity requires a willingness to work within the client's cultural framework; to be flexible when using professional skills to address health needs (Kim-Godwin, Clarke and Barton, 2001; Shapiro, Hollingshead and Morrison, 2002).

At the institutional level, cultural competence is demonstrated in various ways including clearly articulating an organization's commitment to multicultural care in its vision and mission statement (ACHA, 2000). It is evident in a culturally diverse workforce including diversity among those in leadership positions. Institutional budgets of such organizations would be set out in ways that include multicultural resources along with other priority areas. Professional development opportunities such as workshops and seminars would include cultural education.

Conclusions

Culture provides us with a way of viewing our world and represents the assumptions we make about our everyday life or the situations we face. Nurses should be aware of their own cultural values because when these values are at odds with those of their clients, conflict may occur (Miller, 1995). Health care providers should not try to impose their beliefs on the patient—especially if no harm is created from the patients' way of relieving health problem (McNaughton Dunn, 2002). Understanding the dynamic of difference and how these differences may influence health care services utilization, may inform the development of policies to address the health disparities observed among racially visible minority groups. Recognizing the ways in which these differences affect the establishment of rapport and therapeutic interaction is essential to sustaining equitable access to care. Learning about clients' values, beliefs and practices is an ongoing process. Thus, working effectively across cultures is not about knowing everything there is to know about another culture, instead it is about an eagerness to learn and openness to understanding the many ways of viewing the world.

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