Leading article / Uvodnik

Developing cross-cultural competences: opportunity for ensuring health and healthcare equality and equity

Razvijanje medkulturnih kompetenc: priložnost za zagotavljanje enakosti in pravičnosti v zdravju in zdravstveni oskrbi

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Nurses, midwives and other healthcare professionals are increasingly challenged by the complex changes generated by the dynamic cultural diversity of the present times. The roots of these changes lie in the worldwide globalisation processes and some societal circumstances, which led to great waves of migration, especially noticeable in the last decade. Although this phenomenon is not new to the mankind, the current migration trends are characterised by rapidly changing and unpredictable patterns. Migrations occur for various reasons, including the 'push' or 'pull' factors (Prosen, et al., 2017). At first sight, it would seem that in the clinical practice in Slovenia such a diverse population of patients has never been treated, but the patient cultural diversity has always been present, albeit in a different form. It was probably not acknowledged or more likely not even apperceived, possibly because the concept of cross-cultural competency was not included in nursing and midwifery education. But, are we fully aware of cultural differences and do we provide culturally congruent care? The latter should not be the privilege granted to a selected population, but a fundamental human right to which all healthcare consumers within the healthcare system are entitled.

In view of a relatively small number of foreign citizens, Slovenia could be defined as culturally homogenous, however, no culture is entirely homogeneous. Assigning cultural diversity solely to different nationalities, citizenship status, the race and religion is a too narrow perception of the phenomenon, which can create stereotypes, prejudices and discrimination. A specific cultural group is distinguished by diverse and closely intertwined cultural features. The list of these culturally distinctive features is not restricted only to the groups' ethnicity, race and religion. Their diversity is additionally defined by the geographical place of origin; language and dialect; common historical background, tradition, values and symbols; cultural legacy in oral and written form; nutritional patterns; lodging and employment opportunities; political conviction and worldview; the institutions that serve and support a particular group as well as the internal and external perception of distinctiveness (Rittle, 2015). These cultural features are manifested also in the attitude towards an individual and/or group regarding their health and illness and have a significant impact on their healthcare. This cultural diversity, also from the viewpoint of heath and illness, is even more expressed in the subcultures of the same culture group, building up their distinct culture. According to Jeffreys (2014), groups belonging to these subcultures are and will remain the most vulnerable populations. One of the key aspects in understanding cultural diversity is the division of the world and its population into different social categories, e.g. men – women, children – adults, higher – lower social class, healthy – diseased, and other. All the societies have developed systems of moving people from one social category to another (e.g. from the 'patient status' into a 'healthy status') and allocating them, often against their will, into a specific social category (e.g. psychiatric patients, people with disabilities, the elderly). Each of these categories has its own norms, rules and worldviews (Helman, 2007), which are manifested in their attitudes towards health and illness. Cultural diversity of patients daily entering the healthcare system should be readily recognised not only in the most salient cultural groups depicted in mass media, such as ethnic minorities or migrants. There are also other cultural and subcultural groups encountered in clinical practice (e.g. people with disabilities, the elderly, unemployed, patients with immigrant background, immigrant workers, etc.) the cultural diversity of which should not be ignored.

It is worth noting that cultural diversity is present not only in patients but also in nurses, midwives

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and other healthcare team members, whose cultural uniqueness affects the work of the team and help shape their distinct professional subculture. Team work requires the awareness and recognition of the members' cultural diversity as well as the consideration and tolerance of their worldviews. The professionals entering practice can introduce important changes into clinical practice where the respect for cultural background is self-determined and intentional and not merely an obligation mandated by the profession. It is through the process of socialisation or enculturation that they accept the concepts, rules, organisation and values of a specific professional subculture. The provision of holistic care requires the recognition of cultural diversity of patients as well the respect for cultural diversity of other healthcare professionals.

Cross-cultural competence, in the Anglo-Saxon world also known as cultural competence, is an essential component in nursing and midwifery care necessary to ensure effective and culturally responsive healthcare services, to reduce inequalities in health and healthcare disparities, to overcome the racism and discrimination, as well as to improve patient satisfaction and treatment outcomes (Repo, et al., 2017). In short, cross-cultural competence can be defined as the ability of a nurse or a midwife to provide the patient, family or community culturally sensitive and competent care, taking into consideration their values, convictions, customs and habits and incorporate them into the treatment planning. The care providers should accept and respect cultural diversity, the awareness of which is acquired through knowledge and development of professional skills.

Madeleine Leininger, a pioneer in the field of development of transcultural nursing care, developed the so-called Sunrise model, showing the ways in which the patients' culture can be considered in nursing practice. This model is based on the concept of transcultural nursing, which focuses on three aspects of nurses' action or decision-making. It includes (1) cultural care preservation, also known as maintenance, (2) cultural care accommodation, also known as negotiation and (3) cultural care re-patterning or restructuring. In delivering nursing care, the choice of the most adequate mode or modes requires unconditional mutual participation in the nurse-patient relationship and decision-making (Leininger, 2002). The model can be applied also in the midwifery practice.

The need for culturally competent care may be illustrated by the example of an elderly man who, due to his customs, values or convictions, has not developed the basic personal hygienic habits that his current health condition necessitates. In order to induce a long-term change in his hygienic regime, a healthcare provider may decide to impact the patient's behaviour by negotiation and restructuring of his behavioural patterns, and later also by cultural care preservation or maintenance. As any change is a process, not an event, any form of rapid, one-sided pressure of health and nursing interventions on the principle 'because it is the right thing to do', may cause the patients' negative response or a cultural conflict, only worsening the situation.

The development of cross-cultural competences is a dynamic, continuous and life-long process. While some people acquire cross-cultural competence with no difficulty, others need more time, and in some cases, this process will never even commence. The factors that pose barriers for healthcare providers to develop cross-cultural competence is the failure to understand sociocultural differences/the lack of cultural knowledge, inadequate professional skills, avoidance of contacts with people with different cultures, and personal prejudices. This in turn may lead to intolerance, injustice, health inequity and healthcare disparities, non-holistic healthcare provision and unsatisfactory teamwork. In order to capacitate the nursing professionals to provide culturally competent care, it is necessary to incorporate the contents on cultural diversity into nursing education, where cross-cultural competence can begin to develop (Prosen, 2015; Prosen, et al., 2017). Similar views on nursing education responsive to the needs of multicultural society can be found also in the works of other Slovenian authors (Hvalič Touzery, et al., 2016).

Several attempts have been made to integrate components of cultural diversity into the nursing curriculum, either as a separate course or across existing courses. The pedagogical approaches and strategies in cultural diversity training are diverse, aiming primarily to enhance the cultural awareness and to some level equip the new nurses and midwives with the relevant knowledge. In some foreign countries, cultural diversity contents are an obligatory constituent part of nursing curricula (Sagar, 2014; Prosen, et al., 2017), gradually becoming also part of midwifery study programmes (Jesse & Kirkpatrick, 2013). Evidence-based research and past experience, especially in the United States of America, suggest that the concepts of transcultural nursing should be integrated in the nursing curricula either as a separate, formal course or integrated in the existing courses in undergraduate or post-graduate study programmes (Sagar, 2014). If these contents are included into the curricula across the existing courses, there is a danger that different theoretical concepts and practical models, as well as non-appliance of some new approaches to cross-cultural education (e.g. simulations, experience-based learning) may result in dispersed, unstructured and inconsistent teaching and training, yielding non-integrated and fragmented knowledge. On the other hand, transcultural nursing taught as a separate course may overlook some specifics of nursing specialties. The challenges of transcultural nursing teaching are, however, too complex and diverse to be fully discussed in this article.

In view of further professional development of nursing and midwifery care, responsive to the needs of patients and communities in modern times, it is necessary to reconsider the nature and the body of professional knowledge consequential in the provision of humane and quality care (Skela-Savič, 2017). Continuing education of all nurses and midwives should follow the latest advancement in the respective professional field, including not only knowledge and skills, but also greater awareness of the clinical significance of culturally responsive care. The limited knowledge on cultural diversity acquired during formal education is usually not sufficient to successfully develop and acquire cross-cultural competences. Clinical practice often requires the application of different strategies and approaches to address multicultural and diversity issues in healthcare.

As nurses and midwives spend more time with patients than any other healthcare providers, they are expected to be the first to recognise the patients' complexity of needs, the injustice and health disparities and to provide quality and culturally responsive care. Intrinsic motivation is crucial in increasing the efficiency of learning and knowledge acquisition. Cross-cultural competence is based on the individual's personal and professional values and their worldview. Educational institutions and professional associations should actively support the development of cross-cultural competence by integrating this aspect of care into formal and continuing education, and applying it into clinical practice.

In order to provide culturally congruent care, the healthcare providers should respect and accept the patients' cultural diversity by which health disparity can be reduced or eliminated. Health is a fundamental human right, but in this regard, access to healthcare services and healthcare provided are an equivalent part of this right.

Slovenian translation / Prevod v slovenščino

Medicinske sestre, babice in drugi zdravstveni delavci se dandanes soočajo z novimi in kompleksnimi spremembami, še bolj pa izzivi, ki jih prinaša kulturno raznolik in dinamičen svet, v katerem živimo. Vzroke za te spremembe pogosto prepoznamo v globalizacijskih procesih in nekaterih družbenih dogodkih, ki so zlasti v zadnjem desetletju privedli do množičnih migracij. Čeprav slednje v zgodovini človeštva niso novodoben pojav, se prvič srečujemo s takšnimi migracijskimi trendi, za katere so značilni hitri in nepredvidljivi vzorci in vzroki zanje (t. i. dejavniki »push and pull«) (Prosen, et al., 2017). Morda se na prvi pogled zdi, da se v Sloveniji s tako raznoliko populacijo pacientov še nismo srečali, vendar je bila njihova kulturna raznolikost v naši klinični praksi vedno prisotna, samo v drugačni obliki. Le videli je morda nismo ali pa še verjetneje, te kulturne raznolikosti se nismo zavedali, saj se učni načrti izobraževanja za poklice v zdravstveni in babiški negi tovrstne tematike niso dotikali oz. se o tem preprosto ni govorilo. Ob tem se postavlja vprašanje, ali se je v celoti zavedamo danes, vsaj z vidika opažanja, če že ne z vidika potrebe po zagotavljanju kulturno dovzetne zdravstvene oskrbe. Zagotavljanje le-te ni in ne more biti privilegij le nekaterih, ampak osnovna človekova pravica slehernega posameznika v zdravstvenem sistemu.

Slovenijo bi resda lahko z vidika manjše zastopanosti tujih državljanov, ki živijo pri nas, opredelili kot homogeno kulturo, vendar nobena kultura pravzaprav ni homogena. Povezovanje kulturne raznolikosti zgolj z narodnostjo oz. državljanstvom, raso ali pripadnostjo religiji je zelo ozkogledno in vodi v ustvarjanje stereotipov, predsodkov in diskriminacijo. Kulturne značilnosti neke kulturne skupine so številne in med seboj zelo prepletene. Poleg naštetih – etnična pripadnost, rasa in religija – kulturne skupine opredeljujejo tudi geografsko območje; jezik in dialekt; skupna zgodovina, tradicija, vrednote in simboli; ustno in pisno izročilo; prehranske navade; nastanitvene in zaposlitvene značilnosti; politično prepričanje in pripadnost; institucije, ki služijo skupini in jo ohranjajo; notranja in zunanja percepcija razlikovanja (Rittle, 2015). Te kulturne značilnosti se odražajo tudi v odnosu posameznika ali skupine do zdravja in bolezni in pomembno vplivajo na zdravstveno oskrbo. Še bolj se kulturna raznolikost, tudi z vidika zdravja in bolezni, kaže znotraj posameznih subkultur iste kulturne skupine, ki gradijo povsem svojstveno kulturo, in prav subkulture, ugotavlja Jeffreys (2014), so danes in bodo tudi v bodoče najranljivejši del populacije. Eden ključnih vidikov razumevanja kulturne raznolikosti je namreč delitev sveta in ljudi v različne družbene kategorije, kot npr. moški – ženske, otroci – odrasli, višji razred – nižji razred, zdravi – bolni itd. Vse družbe imajo izdelane načine, kako pomikati ljudi iz ene v drugo družbeno kategorijo (npr. iz »statusa bolnika« v »status zdravega«) in umeščati ljudi – včasih tudi proti njihovi volji – v določeno družbeno kategorijo (npr. psihiatrični pacienti, invalidi, starejši). Vsaka od teh družbenih kategorij ima svoje norme, pravila in poglede na svet (Helman, 2007), kar se kaže tudi v njihovem odnosu do zdravja in bolezni. Kulturno raznolikost pacientov, ki vstopajo v zdravstveni sistem, moramo tako prepoznati ne le v morda najočitnejših, pod vplivom medijskih podob izpostavljenih kulturnih skupinah, kot so etnične manjšine ali migranti, temveč tudi v drugih kulturnih skupinah oz. subkulturah, s katerimi se srečujemo v klinični praksi vsakodnevno – invalidi, starejši, brezposelni, osebe s priseljenskim ozadjem, delavci migranti itd.

Kulturna raznolikost pa ni prisotna samo med pacienti, za katere skrbimo. Kulturno raznoliki smo tudi izvajalci v zdravstveni in babiški negi oz. zdravstveni delavci in sodelavci, s katerimi sodelujemo v zdravstvenem

timu. Kulture, ki jim pripadajo naši kolegi in kolegice, s svojo edinstvenostjo tako zaznamujejo tudi naše delo in obenem vsi skupaj sooblikujemo, vsak v svojem poklicu, lastno profesionalno subkulturo. Delati v timu, v pravem pomenu besede, skupaj s sodelavci iz različnih kulturnih sredin zahteva poznavanje njihove kulture, spoštovanje različnih pogledov na svet in strpnost. Kandidati in kandidatke, ki šele vstopajo v poklic, zato predstavljajo odličen mejnik uveljavljanja sprememb v klinični praksi, v kateri je spoštovanje kulturnega porekla prepoznano kot hoteno dejanje, in ne le poklicna obveza, saj skozi proces socializacije oz. inkulturacije sprejemajo koncepte, pravila, organizacijo in vrednote profesionalne subkulture. Med temi mora mesto najti ne samo spoštovanje kulturne raznolikosti pacientov v nudenju holistične zdravstvene oskrbe, marveč tudi spoštovanje kulturne raznolikosti med sodelavci.

Medkulturne kompetence v zdravstveni in babiški negi ali kulturne kompetence, kot je to poimenovano v anglosaškem svetu, so ključne za nudenje učinkovitih in kulturno odzivnih zdravstvenih storitev, preprečevanje neenakosti v zdravju, zatiranje rasizma v zdravstveni oskrbi ter tudi za izboljševanje zadovoljstva pacientov in izidov zdravljenja (Repo, et al., 2017). Medkulturne kompetence lahko preprosto opredelimo kot sposobnost medicinske sestre ali babice, da ob lastnem zavedanju pomembnosti in razumevanju kulture v nudenju zdravstvene ali babiške nege s pridobljenim znanjem in veščinami pacientu/-ki, družini ali skupnosti zagotavlja kulturno dovzetno zdravstveno ali babiško nego, tj. takšno obliko zdravstvene ali babiške nege, ki ne zanika vrednot, prepričanj, običajev in navad pacienta/-ke, ampak jih vključuje v načrtovanje njegove / njene oskrbe.

Madeleine Leininger, pionirka na področju razvijanja transkulturne zdravstvene nege, je kot prva tovrstni način upoštevanja kulture pacienta v zdravstveni negi prikazala na svojem t. i. modelu sončnega vzhoda (angl. *Sunrise model*). Slednjega Leininger (2002) utemeljuje na konceptu kulturne skrbi (oskrbe), pri čemer izpostavi tri osrednje načine ravnanja medicinske sestre, ki naj bi vodili njeno presojo in aktivnosti v zagotavljanju kulturno dovzetne zdravstvene nege, tj. skrbi (oskrbe), ki je koristna in pomenljiva ljudem za katere skrbimo. Opredeljeni trije načini ravnanja oz. odločanja medicinske sestre (ali babice, op. avt.) so (1) ohranjanje kulturne skrbi (oskrbe) in/ali njeno vzdrževanje, (2) prilagajanje kulturne skrbi (oskrbe) in/ali pogajanje ter (3) restrukturiranje kulturne skrbi (oskrbe) in/ali vzpostavljanje novih vzorcev. Izbor ustreznega in najprimernejšega načina oz. načinov, saj so lahko izbrani vsi trije, brezpogojno zahteva medsebojno sodelovanje med pacientom in medicinsko sestro (ali babico, op. avt.) (Leininger, 2002). Npr. pri starejšem pacientu, ki zaradi svojih običajev, vrednot ali prepričanj nima razvitih za njegovo zdravje potrebnih osnovnih higienskih navad in bi le-te dolgoročno želeli spremeniti, lahko kot načine ravnanja izberemo pogajanje in vzpostavljanje novih vzorcev ter kasneje tudi ohranjanje oz. vzdrževanje kulturne skrbi. V omenjenem primeru gre lahko za dolgotrajen proces, saj bi vsakršno hitro, enostransko vsiljevanje zdravstvenonegovalnih intervencij, »ker je to pač treba narediti«, povzročilo negativen odziv pacienta oz. kulturni konflikt, s katerim bi situacijo samo poslabšali.

Razvijanje medkulturnih kompetenc je dinamičen, dolgotrajen in vseživljenjski proces. Nekateri jih lahko osvojijo zelo hitro, nekateri za to potrebujejo več časa, pri nekaterih pa se pravi proces ne bo nikoli pričel. Največja ovira so nepoznavanje druge kulture, nezadostno razvite veščine, izogibanje interakcijam s posamezniki iz drugih kultur in lastni predsodki. Vse to lahko privede do nestrpnosti, nepravičnosti in neenakosti obravnave oz. nezmožnosti zagotavljanja holistične zdravstvene oskrbe ali celo neučinkovitega timskega sodelovanja, če govorimo o izvajalcih zdravstvenega tima. Nujno moramo torej vsebine o medkulturnosti vključiti v kurikulume izobraževanja za poklice v zdravstveni ali babiški negi, če želimo doseči ali pa vsaj omogočiti zgodnji pričetek razvoja medkulturnih kompetenc (Prosen, 2015; Prosen, et al., 2017), kar v našem prostoru ugotavljajo tudi drugi avtorji (Hvalič Touzery, et al., 2016).

Narejeni so bili že številni poskusi umestitve vsebin o medkulturnosti v kurikulum izobraževanja za zdravstveno nego. Bile so bodisi vključene v samostojni predmet ali kot del vsebin pri drugih predmetih. Strategije poučevanja in učenja o medkulturnosti so namreč zelo raznolike in poskušajo najprej vzbuditi kulturno zavedanje ter vsaj do neke mere na tem področju usposobiti kandidate in kandidatke, ki pričenjajo z delom v zdravstveni ali babiški negi. V tujini so te vsebine pogosto del obveznega formalnega izobraževanja v zdravstveni negi (Sagar, 2014; Prosen, et al., 2017), postopoma pa postajajo tudi del izobraževanja v babiški negi (Jesse & Kirkpatrick, 2013). Dosedanje ugotovitve, zlasti v Združenih državah Amerike, kažejo na raznolike izkušnje bodisi v prid samostojnemu predmetu bodisi vključevanju vsebin medkulturnosti v druge predmete na dodiplomskem ali podiplomskem izobraževanju zdravstvene nege (Sagar, 2014). Pri vključevanju vsebin medkulturnosti v druge predmete seveda obstaja nevarnost, da bo zaradi številnih teoretičnih konceptov in praktičnih modelov ter neupoštevanja nekaterih novih metod poučevanja medkulturnosti, kot so simulacije in izkustveno učenje, poučevanje neenotno, razpršeno in znanje nepovezano. Po drugi strani pa lahko samostojni predmet spregleda nekatere specifičnosti posameznih strokovnih področij zdravstvene nege. Izzivi, ki jih zato postavlja učenje medkulturnosti pred učitelje zdravstvene ali babiške nege, so mnogi in tudi preobsežni za ta uvodnik.

Z vidika nadaljnjega profesionalnega razvoja zdravstvene in babiške nege in potreb, ki jih imajo pacienti danes, je treba razmisliti, kakšno bi moralo biti naše znanje, da bi bilo naše delo humano in kakovostno (Skela-Savič, 2017). Kontinuirano izobraževanje slehernega v zdravstveni in babiški negi, tudi za potrebe pridobivanja oz. obnavljanja licence, bi zato nujno moralo po poti profesionalnega razvoja, katerega cilj je povečevanje znanja, veščin in osebnega zavedanja za nudenje kulturno dovzetne zdravstvene nege. Omejeno izobraževanje s področja medkulturnosti v času šolanja, če že je vzpostavljeno, ne zadošča za uspešno razvijanje in pridobivanje medkulturnih kompetenc. Kasneje se namreč zaposleni v kliničnem okolju srečujejo z veliko bolj konkretnimi in specifičnimi situacijami, ki zahtevajo morda drugačen pristop razreševanja, usmerjenega v praktične napotke in rešitve.

Zaradi narave dela medicinske sestre in babice največ časa preživijo ob pacientu/-ki, zato se pričakuje, da bodo prve, ki bodo prepoznale celovite potrebe pacienta/-ke, zaznale nepravice in neenakosti v zdravju (ali zdravstveni oskrbi) ter nudile kakovostno zdravstveno ali babiško nego, za kar so medkulturne kompetence ključne. Želja po učenju mora izhajati predvsem iz vsakega posameznika. Medkulturne kompetence naposled temeljijo na posameznikovih etičnih oz. poklicnih vrednotah in njegovem pogledu na svet. Za izobraževalne ustanove in profesionalna združenja je podporna vloga v tem procesu prav tako odločujoča, saj morajo z ustrezno strategijo izobraževanja in usmerjanja dela v klinični praksi (npr. vzpostavitev kliničnih smernic in kontinuiranega izobraževanja oz. izobraževanja z elementi medkulturnosti) aktivno podpirati razvijanje in udejanjanje medkulturnih kompetenc v kliničnem okolju.

Z namenom zagotavljanja kulturno dovzetne zdravstvene oskrbe morajo zdravstveni delavci in sodelavci spoštovati in sprejemati kulturno raznolikost pacientov ter s tem prispevati k zmanjševanju ali izkoreninjenju neenakosti v zdravju. Zdravje je resda osnovna človekova pravica, a v tem pogledu sta tudi dostop do zdravstvenih storitev in zdravstvena obravnava enakovreden del te pravice.

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