

HIV, diversity and cultural competence

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Cross-cultural issues are a reality and a challenge for public sector agencies seeking to meet their responsibilities in an increasingly diverse Australia. 'Cross-cultural training' of various kinds has been part of the 'tool box' to address these challenges. Here we report briefly on the more comprehensive framework of 'cultural competence'.

Why cultural competence?

Australia is one of the most culturally and linguistically diverse countries in the world. People from culturally and linguistically diverse (CALD) backgrounds made up 22% of new HIV notifications nationally from 2003 to 2007 (NCHECR, 2008) and are now recognised as a priority population by national, state and other HIV/AIDS strategies. This presents both challenges and opportunities for HIV/AIDS agencies in reorienting and targeting their health promotion, treatment and care services to reach CALD communities.

'Cultural competence' can be regarded as a framework as well as a process to ensure equitable health outcomes for all, regardless of ethnicity or cultural background. Related terms with slightly different meanings and implications include 'cultural awareness', 'cultural sensitivity' and 'cultural responsiveness'. Our interpretation of the term 'cultural competence' here is consistent with its use in recent Australian and international literature (NHMRC, 2005; NCCC, 2006).

What is cultural competence?

Cross et al. (1998) (see Summary 3) define cultural competence as:

A set of congruent behaviours, attitudes, and policies which come together in a system, agency, or among professionals and enable that system, agency, or those professionals to work effectively in cross-cultural situations.

Following Cross, cultural competence within the health system is more than awareness of cultural differences; rather, it implies the capacity to improve health and well-being by integrating culture into service delivery (NHMRC, 2005). It is best viewed as a developmental process for the individual worker and for the agency and system in which that person works. Rather than denoting mere compliance with legislation or the meeting of minimum standards of practice, cultural competence may be considered an ongoing process, an ideal towards which to strive (Diller, 2004).

The National Health and Medical Research Council (NHMRC, 2005)

and the US National Center for Cultural Competence (NCCC, 2006) describe five progressive steps of cultural competence:

- **valuing cultural diversity** whereby policies, programs and services respect diversity and whereby individuals, as members of a cultural group, are recognised to have both cultural and individual needs
- **capacity for cultural assessment** whereby an organisation is aware of its own community and culture, and assumptions and biases, and identifies actions to reduce such biases
- **managing the dynamics of difference** whereby there is the ability to proactively improve interaction between different cultures
- **institutionalising cultural knowledge** whereby the understanding of different cultures has been integrated into service delivery and practice
- **adapting to diversity and cultural contexts** whereby cultural knowledge is embedded throughout the hierarchy of the organisation, and policy, practices, service delivery and behaviours are adapted to the cultural diversity of the engaged communities.

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Do we need cultural competence?

Early in 2007, as part of the National Cultural Competency Project, the Multicultural HIV/AIDS and Hepatitis C Service (MHAHS) undertook a national assessment of learning needs among HIV/AIDS agencies to determine gaps in awareness, attitudes and skills when working with people from CALD backgrounds. The overall goal of the project was to provide a framework for increasing the capacity of the HIV/AIDS sector to work effectively with CALD communities.

The key findings of the needs assessment, which surveyed more than 300 workers, included that:

- most respondents reported that people from CALD backgrounds frequently accessed their programs and services
- while many respondents felt they had some level of understanding of CALD issues, they also felt that they lacked the skills to work effectively with CALD populations
- a third of respondents stated that they did not understand the specific

cultural needs of their clients from CALD communities and over half did not have the confidence to develop programs or services that would cater specifically to particular CALD communities.

The assessment confirmed the need for cultural competence training in the HIV/AIDS sector and contributed to the development of a cultural competence program.

The cultural competence program

Using the Cross (1998) and NHMRC (2005) framework, the MHAHS developed a set of three cultural competence modules to be delivered as a program to HIV/AIDS agencies. The goal of the modules was to develop the capacity of agencies rather than of individual workers.

The three modules, the *individual, population and organisational*, were based on the need for a developmental process to occur at each of these three interconnected levels for an agency to effectively enhance cultural competence. Each module was developed independently but their

purpose was cumulative. Each module contained information, reflection, case studies, group discussion and small-group exercises.

The individual module focuses on recognising, understanding and valuing cultural diversity, in particular recognising how culture—beliefs and behaviours—influences health and how we, as service providers, interact with individual CALD clients.

The population module focuses on developing the key skills that enable a service to identify, access and work with CALD populations. This includes how to 'go out to' populations and communities; how to identify, make contact and build links with them; and how to develop strategies to increase access to these populations and communities through media work, education and resources.

The organisational module focuses on how to embed cultural competence in an organisation through planning, policy and procedures, infrastructure, systems, recruitment, induction and workforce development. It provides the opportunity for an organisation to assess itself and identify strategies and activities to increase cultural competence

ARTICLE SUMMARY 1 HIV issues for CALD populations

A culturally competent approach to people with HIV/AIDS from CALD communities is based on an understanding of issues specific to them and an integrated response to these issues in the course of service delivery.

There is significant Australian research on the experiences of people living with HIV/AIDS but relatively little on the experiences of those with HIV/AIDS from CALD backgrounds. However, overseas studies have consistently documented poorer knowledge about HIV and its prevention, less access to services, lower rates of HIV testing and later presentation with HIV/AIDS among people from CALD backgrounds who are living with HIV/AIDS.

This first Australian study of people with HIV/AIDS from CALD backgrounds was a collaboration between the National Centre in HIV Social Research and the MHAHS.

The key findings included that:

- most participants were diagnosed with HIV after being tested as part of their application for permanent residency or when seeking treatment for symptomatic infection
- HIV infection was perceived as a 'death sentence' and most participants did not differentiate between having HIV and having AIDS

- information in the mother tongue was crucial for their understanding of HIV as a chronic condition rather than a terminal illness
- access to health care was affected by immigration status; the visas of some participants made them ineligible for Medicare
- disclosure to family and the ethnic community was not automatic but purposeful. Participants sought both to protect themselves and their families from stigma/discrimination and to get the support they needed
- confidentiality was vital to people's willingness to disclose their HIV status
- support from the bilingual/bicultural MHAHS co-workers represented both 'closeness', in the sense of receiving one-to-one support from someone of the same cultural background and in the mother tongue, and 'distance' in the sense of being outside usual social networks. The participant could confide in the co-worker while maintaining silence with ethnic family/friends.

■ Körner, H., Petrohilos, M., & Madeddu, D. (2005). *Living with HIV and cultural diversity in Sydney* (Monograph 4/2005). Sydney: National Centre in HIV Social Research, The University of New South Wales.

at all levels—individual, population and organisational—in the short, medium and long term.

The three modules were co-presented as a program by two MHAHS facilitators. Six agencies in various states and territories participated in the program from December 2007 to May 2008. All agency staff members were encouraged to attend all three modules and almost 50 people participated. Most agencies were involved either in direct client work or in health promotion/community development, or in a mixture of both. Every agency that participated received a confidential feedback report suggesting areas for further development and the opportunity of six hours consultancy/ follow-up from the MHAHS.

Does cultural competence training work?

An evaluation of the cultural competence modules to assess their relevance and efficacy was undertaken externally by means of participant evaluation surveys and in-depth interviews with a manager and staff member from each agency.

The evaluation found high levels of satisfaction with the modules on the part

of almost all participants; the relevance and usefulness of the modules were also rated highly. The organisational module was viewed particularly favourably.

The modules achieved their aim in that most participants reported increased cultural competence in terms of knowledge, self-efficacy and skills to work with people from CALD backgrounds.

The content and training methods of the modules were also well received. Feedback from the in-depth interviews supported feedback from the participant evaluations in three key areas:

- Where staff felt they and their agency were already culturally competent, the training allowed them to reflect on their progress and prompted them to consider future strategies.
- The attendance of managers at the training was considered extremely important, particularly when examining how the agency as a whole could respond to the needs of people from CALD backgrounds.
- Participants valued the primary focus of the training on the cultural competence of their agency as

a whole rather than on that of individual workers.

To see the full *National assessment of learning needs* report, go to: www.multiculturalhivhepc.net.au

References

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- Ethnic Communities Council of Victoria. (2006). *Cultural competence guidelines and protocols*. Melbourne: Ethnic Communities Council of Victoria.
- National Centre for Cultural Competence [NCCC]. (2006). *Conceptual frameworks/ models, guiding values and principles*. Washington, DC: Georgetown University Child Development Center.
- National Centre in HIV Epidemiology and Clinical Research [NCHECR]. (2008). *HIV/ AIDS, viral hepatitis and sexually transmissible infections in Australia annual surveillance report 2008*. Sydney: National Centre in HIV Epidemiology and Clinical Research, The University of New South Wales.
- National Health and Medical Research Council [NHMRC]. (2005). *Cultural competence in health: A guide for policy, partnerships and participation*. Canberra: Commonwealth of Australia.

2 Late HIV diagnosis in CALD communities

This paper focuses on the circumstances of late HIV diagnosis among people from CALD communities in Sydney, the meaning of the diagnosis and their perceptions of risk. It considers in depth the contribution of culture and community to the experience of HIV/AIDS among people from CALD communities in Australia.

The key findings include that:

- HIV testing and diagnosis were usually outcomes of a serious health crisis; regular HIV testing was an exception
- HIV testing was not usually self-initiated but prompted in hospital or by a GP following symptomatic illness
- HIV testing for women occurred only when a partner was seriously ill
- late HIV diagnosis compounded the trauma of illness
- the meaning of the diagnosis was interpreted in terms of people's knowledge and experience of HIV/AIDS both in their country of origin and within their ethnic community in Australia
- the meaning of HIV/AIDS was unclear; HIV and AIDS were often not connected, or HIV was equated with AIDS and death
- risk was understood stereotypically in terms of membership of a 'risk group' (e.g. injecting drug user, prostitute), not in terms of risk behaviour. HIV was perceived to happen only to others.

The findings reiterate those of other studies of CALD populations in developed countries. The author argues that the pattern of HIV testing and the meaning of the diagnosis among CALD populations differ significantly from those of the general community in Australia. In particular, if people from CALD communities are to be

continued overleaf

Points of note

- 'Culture' includes the customs, beliefs, values and behaviours of a group.
- 'Cultural competence' is more than cultural awareness or cross-cultural communication.
- Cultural competence is displayed in behaviours, attitudes and policies that enable people and organisations to work effectively in cross-cultural situations.
- Integrating culture into the delivery of services involves putting in place strategies at the individual, population and organisational levels of any agency.
- Cultural competence is an ongoing developmental process for the individual worker, and for the agency and system in which the individual works.

tested early, health promotion must be modelled on a non-individualist framework to take account of the role of family and community in their experience.

Körner, H. (2007). Late HIV diagnosis of people from culturally and linguistically diverse backgrounds in Sydney: The role of culture and community. *AIDS Care*, 19, 168–178.

3 What is cultural competence?

The most quoted recent definition of 'cultural competence' comes from Cross et al. in a monograph on mental health services for children from 'minority' backgrounds. It defines 'cultural competence' as a continuum, describes the parameters of any culturally competent system of care, outlines how to develop cultural competence in several steps/levels, identifies the adaptations services need to make to be culturally competent and argues for focused planning to achieve cultural competence.

The philosophy underpinning the monograph emphasises the following:

- Everyone has or is part of a culture.
- 'Minority' is probably a misnomer since, globally, non-Caucasian people constitute a majority of the population.
- People think differently and make different choices based partly on their cultural background. However, stereotyping of any group of people is counterproductive.
- Cultural knowledge about specific groups is not the same as an understanding of culture and its function in human behaviour. It is not 'cultural competence'.
- Becoming culturally competent is a developmental process. It does not happen because one reads a book, attends a workshop or is a member of a minority group.

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care: A monograph on effective services for minority children who are severely emotionally disturbed*. Washington, DC: Georgetown University Child Development Center.

4 Cultural 'gate-keepers'

This is a small exploratory study of how 'gate-keepers' in the Chinese and South Asian immigrant communities in New York may affect the outcome of public health efforts regarding HIV/AIDS. The 'gate-keepers' identified were progressive paradigm shifters: for instance, arts, media and charitable organisations; professional organisations, including health care bodies; and less progressive, but influential, religious, business and ethnic organisations which acted as community sentinels. Recognising that immigrant community institutions influence discourse regarding traditions and values is important in planning programs to address 'sensitive' or stigmatised issues such as HIV. While this paper is not explicitly on cultural competence, it is significant in underlining that identifying and engaging with community institutions is a major strategy in culturally competent HIV practice with CALD communities.

Chin, J. J., Neilands, T. B., Weiss, L., & Mantell, J. E. (2008). Paradigm shifters, professionals, and community sentinels: Immigrant community institutions' roles in shaping places and implications for stigmatized public health initiatives. *Health & Place* [doi:10.1016/j.healthplace.2008.01.006].

5 Strategies for culturally competent intervention

This is a review of HIV intervention studies in the US from 1985 to 2001 in which the concept of culture was central to the design of the intervention. The review identifies two major strategies, 'attending to intervention presentation' and 'attending to intervention content', by means of which culture was integrated into the design of the intervention. **Presentation strategies**, strategies for making interventions culturally specific, were used to present the intervention to a particular cultural group, presuming that people were more likely to accept information from other members of their ethnic group. **Content strategies** were used to identify cultural concepts and then integrate these into the design of the intervention so that it was grounded in the experiences, values and norms of the target group.

Wilson, B. D. M., & Miller, R. L. (2003). Examining strategies for culturally grounded HIV prevention: A review. *AIDS Education and Prevention*, 15, 184–202.



For further information

- For more information about the MHAHS or to find information about HIV or hepatitis C in a range of community languages: www.multiculturalhivhepc.net.au
- To download the publications by Henrike Körner on HIV issues for CALD populations: http://nchsr.arts.unsw.edu.au/nchsr_library/
These include:
Körner, H. (2007). 'If I had my residency I wouldn't worry': Negotiating migration and HIV in Sydney, Australia. *Ethnicity and Health*, 12, 205–225.
Körner, H. (2007). Negotiating cultures: Disclosure of HIV-positive status among people from ethnic minorities in Sydney. *Culture, Health & Sexuality*, 9, 137–152.
- For further information on cultural competence:
National Centre for Cultural Competence
<http://www11.georgetown.edu/research/gucchd/nccc>
Multicultural Disability Advocacy Association
www.mdaa.org.au