Cultural health assessment

Singapore is well known multicultural society due to its unique demographic composition. Singapore population has become increasingly diverse through immigration. According to the Monthly Digest of Statistics Singapore on February 2011, the overall population figure for Singapore in 2005 was 4. 26 million. Approximately 81% of the population is Singapore citizens and permanent residents. The remaining 19% of the populations are foreigners. The latest demographic statistics for 2010 reported that the overall population increased to 5. 08 million.

Singapore citizens and permanent residents population accounted for 74%; while foreigners accounted for 26% of the total population in Singapore. In addition, among the Singapore citizens and permanent residents population group, Chinese form 74%, Malays from 14%, Indians form 9. 2%, while others forms 2.

8% (Department of Statistics Singapore, 2011). Within this increasingly multicultural society, healthcare professionals encounter patients from diverse ethnic and cultural backgrounds. The patients may own different culture values and beliefs. Healthcare providers can no longer assume that patients will always share a common moral perspective (Carter & Klugman, 2001). Culture defines as ??? the lifeways of a particular group with its values, beliefs, norms, patterns, and transmitted intergenerationally??? (Leininger as citied in Leininger, 1996, p. 73). Galanti (as cited in Turner, 1996) defined culture as beliefs and behaviors that are shared by a particular group and that influence how the individual perceives and shapes his or her world. For example, perceiving, expressing and controlling pain is one of learned behaviors which is culture-specific.

From perspective of physiology, stimulation of pain and transmitting nerve signals to tell the brain that something is happening is the same among all human beings; however, the perceptions and control of pain vary from culture to culture (Free, 2002). Patients describe and express pain sensations differently and have different tolerance level for pain (Leininger, 2002). Healthcare professionals need to develop a cultural insight and a deeper appreciation and respect for the rights of culturally diverse individuals. When cultural beliefs and practices are not appropriately identified, the significance of behavior may confuse the healthcare professionals and result in the delivery of inappropriate care or inequity care. (Pergert, Ekblad, Enskar, & Bjork, 2008; Narayanasamy, 2003; Narayanasamy, & White, 2005; Leininger, 1996, 2002).

The goal of the health care system is to provide optimal care for all patients. Healthcare professionals should understand and aware of diversity of beliefs and the norms of how the patients react from different cultures so that damage to healthcare profession-patient relationship caused by conflicting value system can be prevented. When healthcare profession-patient relationship was damaged, frequently leads to frustrations, anger and stereotyping. Patients satisfaction does not exist and not surprise that patients will become uncooperative and non-responsive during treatment or healthcare planning (Klessig, 1992; Leininger, 1996; Narayanasamy, & White, 2005). In order to achieve the goal of providing congruent and effective care without disparities to all patients, healthcare providers need to develop and practice cultural specific care for each of the individual patient (Leininger, 1996, 2002). By integrating cultural practices into healthcare care

plan irrespective of patients cultural origins or social situation, we improve the probability of achieving positive health outcomes and meeting the objective of attainment of highest possible level of health for peoples (Douglas, & Lipson, 2008). Transcultural care, which defined as ??? a formal area of study and practice focused on comparative holistic culture care, health, and illness patterns of people with respect to differences and similarities in their cultural values, beliefs, and lifeways with the goal to provide culturally congruent, competent and compassionate care??? (Leininger as citied in Narayanasamy, 2003, p. 182), is one of the useful tools to remove obstacles for patients to access or healthcare professions to provide equal quality health care.

Racial discrimination or ethnocentric views proved to be one of the significant obstacles to access health equity opportunities by ethnic minority groups (Beach et al. as citied in Deatrick, 2009; Narayanasamy as citied in Narayanasamy, 2003, p. 185; Parfitt as citied in Narayanasamy & White, 2005, p. 104). With the evidences mentioned by literatures above which support the importance of transcultural care in routine healthcare planning practice. However, awareness and sensitivity to cultural differences do not means we can identify the patient??™s cultural needs (Tripp-Reimer, Brink, & Saunders, 1984). Therefore, cultural health assessment of healthcare planning is extremely important step in interethnic relationships between patients and healthcare professionals so that transcultural care can be delivered to patients. The purpose of cultural health assessment is to identify a person??™s cultural needs, beliefs, religion, values, worldviews, life experiences, environmental context, language, dietary practices and social

structure that related to health care and behaviors towards treatments (Leininger, 2002; Andrews & Boyle as cited in Anderson et al.

, 2010). Cultural health assessment enables healthcare professionals and patients shared beliefs, values and customs that related to health behaviors. By identifying the specific pattern, patients feel being respected for their different cultural practices and healthcare providers are able to deliver more effective care according to their cultural specific needs; in result of promoting positive outcome (Maier-Lorentz, 2008). No doubt that a concise cultural health assessment will assist healthcare professionals to practice good transcultural care. The contents of cultural assessment are curial which determine the effectiveness of identifying a particular person??™s culture pattern. Giger and Davidhizar cultural assessment model (as citied in Davidhizar, & Bechtel, 1998) proposed six cultural assessment criteria that healthcare professionals must understand to provide effective care for all patients: Communication, Space, Social Organizations, Time, Environment Control, and Biological Variation. ??? Communication is a continuous process by which people interact through written or oral language, gestures, facial expressions, body language, space, or other symbols. Communication and culture are closely intertwined and communication transmits and preserves culture over time??? (Giger and Davidhizar as cited in Davidhizar, & Bechtel, 1998, p.

2). Miscommunication is frequent problem in hospitals. When the patient and healthcare professional do not speak the same language, language become a significant barrier to access equity care. More subtle problems are those that result from cultural differences in meanings of non verbal behavior.

For example, a common signs of fear, such as fleeting changes in facial expression and quick eye movements. However, eye behaviors may vary among cultures. Indian patients may avoid direct eye contact with persons in higher or lower socioeconomic groups and often healthcare professionals considered as superior socioeconomic group so they may not look at them directly (Sue, as cited in Davidhizar, & Bechtel, 1998, p. 3). Healthcare professionals should perform a concise assessment on communication aspect to identify the most appropriate method to communicate with their patients such as preferred choice of language, nonverbal communication style and use of interpreter (Andrews, & Boyle as cited in Anderson et al., 2010, p.

315s). Individual from different cultural groups may require differ need of space. Each of individual group may feel different comfortable level related to personal space such as conversation, proximity to others, body movement, touch and perception of space (Hall as cited in Anderson et al., 2010, p. 308s). For example, ask for permission before any touch include hand shake as some culture do not like personal touch even as simple as hand shaking. Social Organizations contribute to enculturation of a person such as geography, age, religion, gender, sexual orientation, educational background, family background and socioeconomic status (Davidhizar, & Bechtel, 1998; Andrews, & Boyle as cited in Anderson et al.

, 2010, p. 316s). Family is the basic social unit and the most important social organization for most patients as they learn their own culture values via family setting (Maier-Lorentz, 2008). Thus, healthcare professionals should identify the dominant family members, identify major decisions person for

the family, access interaction relationship between patient and his family members. If the family is the decision maker, family should be involved in understanding the illness and in the process of determining the options of treatment (Clark as cited in Davidhizar, & Bechtel, 1998, p. 4).

Time is a very familiar concept to most of peoples; however, perception of time can be very different among different cultures. Time can be appear as absolute or flexible (Wessman, & Gorman as cited in Davidhizar, & Bechtel, 1998, p. 5). Some peoples from particular culture background may have strong preference for appointment time or treatment time.

They see time as qualitative rather than quantitative (Davidhizar, & Bechtel, 1998). Traditional Chinese believe that certain timing or day is considered as ??? good time??? to do surgery or ??? bad time??? to go hospital. In such cases, quality timing will be the preference for this group of peoples and directly affect when they will seek for consultation and treatment as well as the compliance for their healthcare appointment. Environmental control refers to abilities of persons to control nature, such as their health and illness (Giger ,& Davidhizar as cited in Davidhizar, & Bechtel, 1998, p. 5). Some peoples feel that they are in control of their own life. While others believe that their life and illness was determined by fate or ??? god will???.

In the worldview of this group people, human beings cannot do everything to change their designated fate by god and they choose accept the final outcome (Randall_David as cited in Davidhizar, & Bechtel, 1998, p. 6). Healthcare professionals need to identify the reasons and causes of their

illness that the patients believe; as well as any particular treatments that patients think can resolve their problems, e. g.

??? folk healers???. Biological variations refer to people from vary cultures who may contain different psychological characteristics, skin color, hair texture, genetic variations, nutritional preferences, disease prevalence and resistance to disease (Davidhizar, & Bechtel, 1998). Some studies reported that some particular diseases such as diabetes, cardiovascular diseases and sickle anemia are more prevalence in specific cultural group (Andrews, & Boyle as cited in Anderson et al.

, 2010, p. 315s). Therefore, assessments such as skin color, hair type, preferences of food, family history of diseases should be included in the health cultural assessment. Case StudyA 33 years old married Arabian women who came from Saudi Arabia together with her husband and both of them speak little English. Her chest X-ray showed a shallow in her left lung that most probably indicated a tumor.

Her clinician suggested that she needed a C. T. guided biopsy to confirm the nature of the tumor. When she and her husband turned up for the procedure appointment, a male CT radiographer informed her to change into the operating patient??™s gown. However, she refused to remove her bra and resisted to change into the patient??™s gown. The male radiologist required to obtain the written consent of the intervention by explaining the risks of the complications.

During the consent taking, although the Arabian female patient could speak English, she kept silence and avoided eyes contact at all time. She did not

responded to any questions from the radiologist. All questions and enquiries addressed to her were done by her husband. He was a bit agitated and not willing to disclose her medical history to the radiologist.

Besides, he was very particular concerned about what kinds of medicine will be used during the procedure. He also demanded to accompany her wife during the procedure; however, he was not allowed to stay with his wife during procedure due to radiation safety issue. The case above illustrating the differences of culture and health practices of people from Middle Eastern community. In fact, the female Muslim patient does not feel comfortable to get change to patients grown and to remove her underwear is due to their specific religion and core values. The same reason applies for the husband demanded to stay with his wife during the procedure even he need to exposed to large amount of unnecessary radiation.

Modesty and purity are the most important Islamic values especially for Saudi Muslim ladies. Muslim women very concern about gender segregation issue, they need to dress traditionally like wearing black cloak, head scarf and most of them will also covering their faces (Hiba Wehbe-Alamah, 2008; Mebrouk J. (2008). Female shyly resist to expose or under covering of the body as a man who is not the spouse is not allowed to see an Arabic woman uncovered in Saudi Arabia (Pirotta, 1994 as cited in Mohammad Zafir al-Shahri, 2002, p. 136). The health care providers need to understand their religion concern and try to get a female staff to guide and explain to patients. Avoidance of unnecessary body exposure during procedure is recommended. If female staff is not available, the male health professionals

should speak to the point and try to avoid any unnecessary touch and eye contact (Mohammad Zafir al-Shahri, 2002).

Use of chaperone, a family member or involving a female healthcare provider during the procedure is recommended. If possible, do allow the female Muslim patients wear their head scarf and let them cover up their faces during procedures. By practicing the cultural specific and flexible protocol, can help to relief the uncomfortable level for female Muslim patients. It is important to identify the appropriated communication channel to Middle Eastern Islamic patients. Identify who is the dominant decision maker and understand the gender-specific considerations in Muslim culture.

The husband answered all the questions addressed to her wife, because men are considered to be protectors of women and the family leader in Islamic culture. The family leader normally is spokesperson and ultimate decision maker. Men have high social respected status in Muslim society (Hiba Wehbe-Alamah, 2008; Mohammad Zafir al-Shahri, 2002). Therefore, female tend to delegate the task of signing consents to close male relatives despite they are legally independent on making medical decision (Al-Shanqiti, 1993 as cited in Mohammad Zafir al-Shahri, 2002, p.

137). In addition, interpreters are strongly recommended if healthcare professionals realized that language is one of the barriers in their communication. Selecting the interpreter of the patient??™s gender is likely to obtain a more comfortable and efficient interpretation process (Aitken, 1994; Sheikh, & Dhami, 2000 as cited in Mohammad Zafir al-Shahri, 2002, p. 136).

Health related beliefs/ practices of Middle Eastern Islamic culture do not believe disclosure of family medical history is necessary. In fact, Arabian people believe such disclosure is private. They expect physicians and other healthcare providers, because of their expertise, to select appropriate treatments for them (Purnell, Larry, D., Paulanka, & Betty, J., 1998). To tackle with this cultural practice, it is important to make the couple feel comfortable with the healthcare providers first and develop trust relationship between each other. Take time to explain the importance and purpose of obtaining such information and be careful that not to give any cues of being in hurry.

However, sometimes education level of the patient is also a curial factor that contributes to the compliance of being cooperative in such scenario. In view of their cultural and religious beliefs, alcohol is categorized as prohibited substance by the Islamic law (Mohammad Zafir al-Shahri, 2002). Consume or use of alcohol and alcohol-based medications considered as unlawful and users of this substance are liable to trail (Rashidi, & Rajaram, 2001 as cited in Hiba Wehbe-Alamah , 2008, p. 88). Therefore, is it important that the healthcare providers should try to avoid use of alcohol-based medications to Middle Eastern Muslim patients unless when there is no alternative. In the event of no other alternatives, they should be informed and permission of usage should be obtained from them. From the discussion above, it is no doubt that healthcare to patients should be culturally sensitive and specific. However, to achieve cultural competent require a culturally competent health care system that working at different levels include organization level, profession level and last individual level (Blackford, 2005).

Organization need to act politically and strategically to match the development for cultural competency; for example, setting up appropriate policies, financial budget, resources, transcultural training programs, recruitment and management direction. Practicing transcultural care is a time consuming procedure, thus increasing human resources and running costs. These become the major challenges for the organization. Most of organizations need to take a balance between cultural competent and high expenditure. However, recruitment and management direction sometimes may able to help the organization to become more ??? cultural competent???. By recruiting wider range of different races healthcare staffs, employees will be more culturally exposed. Increase cultural exposure opportunities appear to be an effective way of learning about different cultures (Jones, & Bond as cited in Kardong-Edgren, Schlosser, & Jones, 2005).

More efforts and resources should be put under the training of cultural competence on professions level is recommended. Traditionally, most of the allied health professions education or medical schools over focus on their respective clinical professional??™s knowledge but not that much emphasize on the training of cultural awareness and transcultural care. Nursing schools acting as the pioneer in this aspect and had setup a successful example in developing cultural competent students. Other professions should also integrate this aspect of training in their respective modules. To be a culturally competent practitioner in view of individual level, healthcare professionals first need to aware of their own cultures and values.

Learn to respect your own culture before move on to the others. Always put yourself into the patient??™s shoes, in the other words, respect and treat every patient, regardless of culture origin, as how you want to be treated. To be respectful and tolerant of views that are different from yours. Be patient and do spend adequate time to listen to patient??™s concerns. However, time appears to be the biggest challenge in real life situation and that may need to get management level to involve and to support such practice.

In addition, individual healthcare professional needs to be proactive in participating continue education programs throughout the whole career life. Even the organization provides few days course in cultural competence for all employees, this do not transform everyone into cultural competent practitioners immediately. It is impossible for a course to meet every trainee??™s expectations and needs.

Actively seek for information on Internet that provide knowledge to have better understanding on specific culture??™s illness beliefs and health practices as well as the unique needs of particular culture. In conclusion, to provide equity in health care as well as improve healthcare outcome and patient satisfaction, healthcare professionals and organizations need to collaborate seamlessly together. Desired result will not happen with individual effort but only with combined efforts focused on the same goal of being cultural competent.