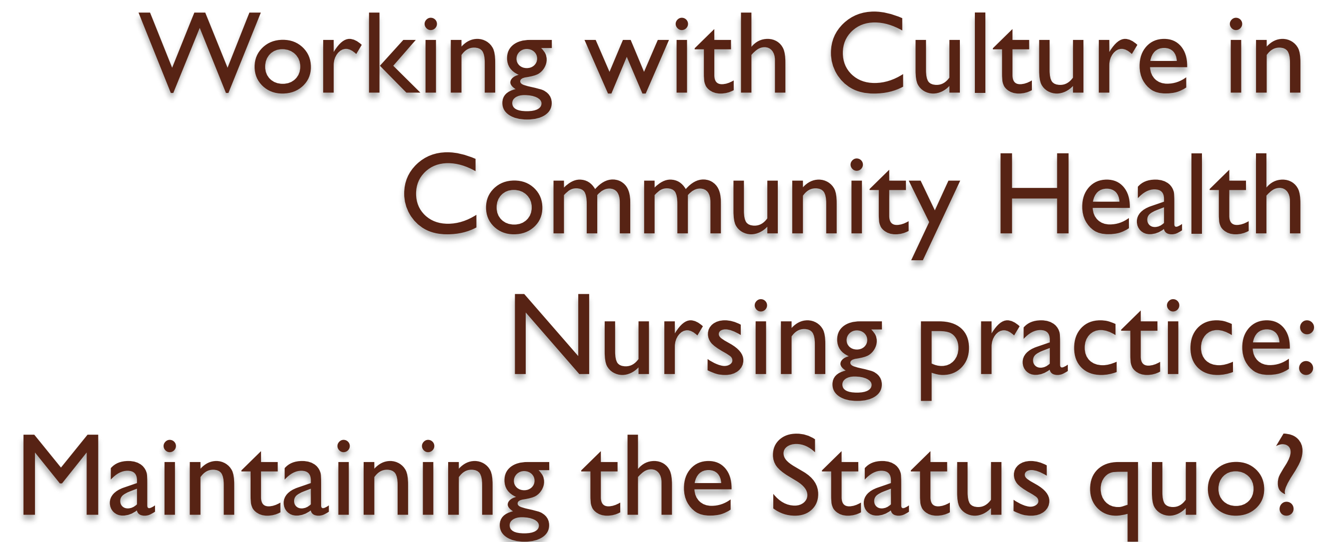

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Support

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- Dr. Cheryl Forchuk
    - University of Western Ontario
- Dr. Tanya Basok
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" is one of the two or three most complicated words in the English language"
(Williams, 1981)

Purpose

- To describe the ways in which culture is currently conceptualized and utilized in community health nursing practice
- To identify and explore the resulting intended and unintended consequences for clients and nurses

Introduction

- Since the 1970's there has been major attention to integrating and utilizing the concept of culture in nursing
  - Congruent with nursing's holistic emphasis on understanding the person in context
  - Congruent with client as person, family, community and society
  - Attention to immigration, diversity and multiculturalism
  - Attention to role of culture in health

Culture

- Leininger's definition:
  - "the learned, shared, and transmitted values, beliefs, norms, and lifeways of a particular culture that guides thinking, decisions, and actions in patterned ways and often intergenerationally" (Leininger, 2006, p. 13)

- Strengths of Leininger's theoretical approach include:
  - The emphases on in-depth assessment, meaning and care within the context of culture
  - The inclusion of diverse health contexts
  - The generation of nursing knowledge and interventions (Andrews, 2008)

Critiques

- Broadly defined concept of culture that is narrowly applied
- Culture of origin is accentuated and often perceived to be static
- Reinforces difference rather than transforms
- Lack of attention to the culture of the nurse
- Lack of theorization about power
- Assumption that knowledge and understanding of other cultures leads to tolerance, respect and changes in discriminatory behaviours
  (Andrews, 2008; Gray & Thomas, 2005; Gustafson, 2005)

Cultural Competency

- The mechanism to address culturally specific health needs
  - Integrates the knowledge, attitudes and skills that the nurse would utilize in order to plan effective and appropriate interventions
- Current conceptualizations - a life-long process of approaching relationships with openness and humility rather than focusing on "knowing" specific cultures (Racher & Annis, 2008)
  - The course of culturally competent care emerges from the interaction between providers and recipients (Schim et al., 2007)

Critiques

- Complexities are minimized,
  - focus is on facts,
  - negotiating multiple identities is obscured
  - distance from the dominant groups is emphasized
- Individual nurse working with an individual client
- Little guidance for working with communities
- Mostly providers defining cultural competence
  - Leading to the focus on the attributes of providers in many current evaluation tools rather than a focus on client outcomes (Schim et al., 2007)

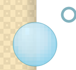
Culture as a Determinant of Health

- Underlying Premises:
  - Some persons or groups may face additional health risks due to a socio-economic environment, which is largely determined by dominant cultural values that contribute to the perpetuation of conditions such as marginalization, stigmatization, loss or devaluation of language and culture and lack of access to culturally appropriate health care and services.

    (Health Canada, 2009)

Health & Culture in Health Promotion

- HP defined by WHO as "enabling people to increase control over, and to improve, their health" (1986)
- Ottawa Charter explicitly broadened health promotive strategies
- Yet there remains a focus on disease prevention and health protection in public health approaches
- There is no clear definition of culture
- Culture is often equated with behaviour and results in a 'deficit model' requiring change (Airhihenbuwa & Liburd, 2006)



INTENDED CONSEQUENCES

Intended Consequences

- Meaningful to the client
- Tailored to specific groups
- Corrective of deficiencies in service provision
- Efficient for the organization

Care that is Meaningful

- Nurses intend to provide care that is appropriate and culturally sensitive
- Meaningful assistance and support to clients can be provided by cultural explanations that guide nursing practice (Johnson et al., 2004)
- *However, when discovered meaning is essentialized in and through an assigned framework of culture, the question needs to be asked – meaningful to whom?*

Care for Specific Groups

- If culture is the label to distinguish between groups, and becomes the way in which differences are assumed, then care can be provided based on culture
- Efforts are made by providers to become culturally competent
- *Is the primary motivation in providing such services to help clients adapt to the dominant system or for the system to adapt to the clients?*

Corrective of Deficiencies

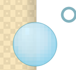
- Culture provides the structure to frame and then correct deficiencies of service

- Equality of care is seen in terms of increased access and reduced barriers to existing systems

- *Services are often implemented in a restricted, partial manner, and with insecure funding*
- *Adapted programs remain based on benchmarks and indicators determined by professionals, institutions and governments*

Efficient for the Organization

- It is efficient to adapt/add-on to existing programs
- Nurses assume the role of cultural brokers – translating the client's culture to the organization and vice versa
- *Targeted services are minimally disruptive in that the underlying arrangement of the organizational systems and larger social, political and economic structures remain unquestioned* (Gray & Thomas, 2005)



UNINTENDED CONSEQUENCES

Unintended Consequences

- Culture is conflated with ethnicity and race
- The sole focus is on the culture of the client
- Intersecting factors are discounted
- Constraints arise from the clearly designated social locations for all concerned

Conflation of Culture with Ethnicity and Race

- Culture becomes the status of being different (from the dominant majority)
- Reinforced by attention to visible differences in dress, skin colour, religion and language
- Culture then becomes equated with ethnicity and race, based on those markers of visible difference
- Fixed categories undermine real and potential human agency and negate multiple and fluid identities

Sole Focus is on the Culture of the Client

- Lack of attention to the assumptions, values, and cultures of nurses, organizations and society
- Can become a mechanism to preserve the status quo
- Cultural descriptions and attributes often become equated with personal characteristics
- Culture becomes problematic and the responsibility of the client

Intersectionality

- Intersectionality "recognizes that [multiple] influences come together in distinct ways, leading to different health outcomes for individuals and groups" (Guruge & Khanlou, 2004, p. 34)
- The discounting of intersectionality occurs on two levels:
  - effects of economic, social, political and ideological systems on the health care system
  - effects of social determinants of health on people's meanings and experiences

Structures & Systems

Agency, Advocacy and Resistance

Constraints

- When the culture of clients become the marker of difference and the focus…
  - This leads to clearly designated, restrictive and boundaried social locations for all
  - If nurse are the cultural brokers interacting with clients in need of brokering services, the direction remains one of helper to helpee in need of assistance (Van Ryan & Fu, 2003)
  - The nurse is assumed to be unchanged
- Limiting opportunities for discovery, humility and relational community health nursing

Reflections

- What do the current conceptualizations of culture and cultural competence accomplish?
- Whose purposes are being served?
  - Professionals and institutions create the framework that sustains the status quo and then invite individuals and groups into the structures responsible for maintaining boundaries of exclusion (Labonte, 2004)
- Tensions between intended and unintended consequences?

Conclusions

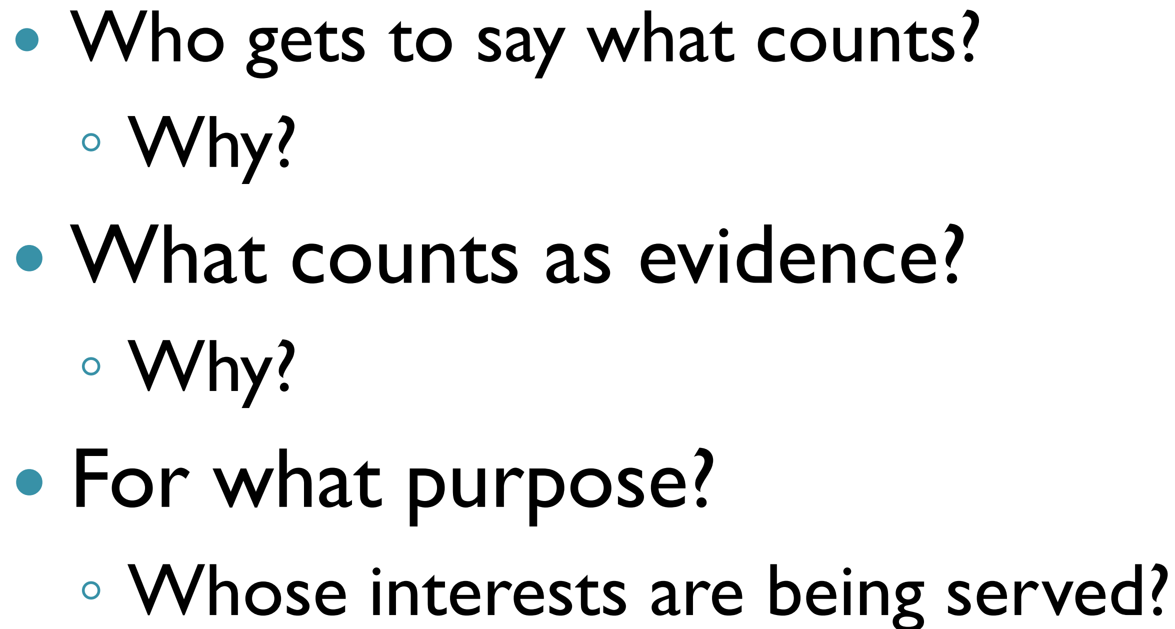
- The ways in which nurses promote the health of those who are identified as having a culture, and therefore "cultural needs", often essentializes both culture and needs.
  - Inhibits relationships between nurses and clients
  - Reduces the potential for healthy outcomes
  - Often serves the purposes of professionals and institutions to reinforce a limited (and limiting) understanding of culture

Conclusions

- Current enactments of cultural inclusion and exclusion occur at all levels of nursing and health care
- Connecting across difference requires reflection in order to engage in relational inquiry with others (Hartrick Doane & Varcoe, 2006)
- What is needed is the creation of space for a more layered and flexible expression of difference, and the development of nurse-client relationships in larger contexts (Gustafson, 2005)

What Now?

- Critically review
  - Assessment forms & outcome indicators
  - Standards – nursing and sector
  - Social justice, advocacy, empowerment, equity
- "Keep the faith" with the Ottawa Charter and PHC principles
- What is the larger context for your practice?
  - What are the cultural values of globalization?
  - WHO reports
- Need for analytical frameworks
  - Complexities and context


Who gets to say what counts?
Why?
What counts as evidence?
Why?
For what purpose?
Whose interests are being served?

How is culture enacted in your nursing practice?