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Culture-Focused Frameworks for Service Delivery

This chapter examines a variety of frameworks used to understand and address cultural issues in healthcare and human services. Frameworks in which to consider culture in the delivery of healthcare and human services have grown as culture is increasingly recognized as a determinant of health.

Cultural safety, as the focus, is discussed in more detail throughout the rest of this book. Other frameworks to gain prominence include cultural awareness, cultural sensitivity, cultural competence, cultural responsiveness and cultural humility. We provide a brief description of each framework as well as readings, activities, and case studies to apply from a professional practice standpoint.

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Chapter Objectives

After completing this chapter, you should be able to:

- describe various frameworks for intercultural health and human service
- define and apply various frameworks to scenarios
- compare and contrast cultural safety with other approaches
- examine the relevance of cultural frameworks to your own practice.

Culture and Health

Far from being prescriptive and fixed, culture can include variables such as gender, age, religion, socio-economic status, ability, sexuality, and the ones mostly associated with cultural difference—those of ethnicity or race. So, what is the link between culture and health? Well, the link is significant.

Literature suggests that:

> Racial and ethnic minorities have higher morbidity and mortality from chronic diseases … Among older adults, a higher proportion of African Americans and Latinos, compared to Whites, report that they have at least one of seven chronic conditions — asthma, cancer, heart disease, diabetes, high blood pressure, obesity, or anxiety/ depression. … African Americans and American Indians/Alaska Natives are more likely to be limited in an activity (e.g., work, walking, bathing, or dressing) due to chronic conditions. (Ihara, n.d.)

But race or ethnicity alone does not explain disparities. Increasingly, psychologists and other health and human service professionals have recognized the importance of culture as an influence on health and social outcomes and by implication, on professional practice and service delivery.

Cultural awareness, cultural sensitivity, cultural competence, and cultural safety are some of the more established frameworks to influence services and health professional education. However, there is ongoing

development and new modes of thinking as these concepts are applied and scrutinized. More recent frameworks arising from the U.S. include cultural responsiveness and cultural humility. A review of cultural safety in the U.S. found that while the term 'cultural safety' is not often used in the U.S., the tenets of cultural safety are practiced (Darroch et al., 2017). What is important always, is to find out about any local frameworks used within services and critique how well these can help meet the needs of local populations.

As cultures are diverse, so too are views about health and what it means to be healthy. The recent COVID-19 pandemic has illustrated this across a range of cultural groups. Health systems and human services that privilege a certain way of thinking unfortunately do this at the expense of others' ways of thinking and therefore at the expense of some people's health. With increasing emphasis on the rights of individuals to maintain their individual culture(s), providers and systems need to recognize that there is more than one way to do things and more than one belief system—there are many 'cultures', models, concepts, or frameworks.

In this chapter, we explore a number of these concepts and set the tone for how the rest of the book will unfold—firmly based within the framework of *cultural safety.* Of course, readers may have their own preferred or mandated frameworks for their work environment and that is fine. Before looking at the development of cultural safety and other rationales for its adoption, it may be useful to examine the historic developments that have led to what we have today.

Trans-cultural or Multicultural Practice

Although psychology has long acknowledged the importance of culture, it was the nursing profession in the U.S. that first firmly set its gaze on culture in practice. With the influx of European immigrants post World War II, differences between professionals and clients became more obvious.

The influence of anthropology was prominent in the 1960s with the ground-breaking work of nurse-anthropologist Madeleine Leininger, who pioneered the first real model of healthcare practice to incorporate

cultural considerations. Trans-cultural nursing at that time focused on the importance of the healthcare professional to learn *about* cultural differences. Culture in this context, was a limited concept that related to ethnicity or race. Trans-cultural nursing practice involved developing the knowledge base of the nurse to incorporate certain cultural protocols toward clients of different ethnic or religious backgrounds.

Multicultural or cross-cultural psychology have had a similar history. Multicultural psychology has been defined as 'the systematic study of behavior, cognition, and affect in settings where people of different backgrounds interact' (Mio et al., 2020). Many textbooks for multicultural or cross-cultural psychology include chapters comparing racial or ethnic groups in terms of behavior, cognition, or affect (i.e., emotions) and even providing checklists of cultural differences for various groups such as Native Americans, Hispanics, Asian-Americans, Black Americans, Jewish-Americans, etc. Generally, those embracing the field of multicultural psychology or multiculturalism advocate for the maintenance and honoring of cultural differences between groups of people rather than assimilation, which we will learn about more in later chapters. Cross-cultural psychology often compares differences in psychological areas of interest between 'cultural' groups using statistical methods. Unfortunately, this approach tends to oversimplify both cultural variations, as well as psychological topics resulting in stereotyped oversimplifications that can potentially be more harmful than helpful.

One problem with trans-cultural nursing theory or multicultural or cross-cultural psychology, however, is the potential reliance on stereotyped notions of how an individual might behave based on ethnicity. Little attention is paid to life experiences and diversity within cultures, let al.one across cultures or, importantly, cultures that have been affected through colonization, dispossession, or forced migration. Imagine the usefulness of having care based on stereotypes of so-called 'American culture'. What exactly is American culture? If an American were in a hospital overseas, could they expect perhaps to be greeted with 'Hi y'all', or served a hot dog for lunch or would that be a very narrow stereotype with little relevance to yourself?

Trans-cultural, cross-cultural, or multicultural theories have been valuable in shifting from a homogenized mentality to one that is *regardful* of

the individual needs of clients and communities. Trans-cultural nursing today, however, has grown and expanded, as evidenced by journals and professional societies related to this field. Other health disciplines and the broader field of human services are similarly responding to the recognition of the role of culture and cultural difference in professional practice.

Reading
Guilherme, M., & Dietz, G. (2015). Difference in diversity: Multiple perspectives on multicultural, intercultural, and transcultural conceptual complexities. *Journal of Multicultural Discourses, 10*(1), 1–21. https://doi.org/10.1080/17447143.2015.1015539.

Cultural Safety

Cultural safety will be discussed in more detail in the following and subsequent chapters. However, we need to establish an early understanding of this concept in order to compare and contrast other frameworks for intercultural practice. First, let's revisit the Nursing Council of New Zealand (2011, p. 7) definition of cultural safety, or *kawa whakaruruhau*:

> The effective (nursing) practice of a person or family from another culture, and is determined by that person or family. Culture includes, but is not restricted to, age or generation; gender; sexual orientation; occupation and socioeconomic status; ethnic origin or migrant experience; religious or spiritual belief; and disability.
>
> The (nurse) delivering the (nursing) service will have undertaken a process of reflection on his or her own cultural identity and will recognise the impact that his or her personal culture has on his or her professional practice. Unsafe cultural practice comprises any action, which diminishes, demeans or disempowers the cultural identity and well-being of an individual.

In short, the recipient of care determines whether the health professional or their service is culturally safe. Importantly, culture is defined broadly. It requires professionals to reflect on their own cultural identity and on their relative power as professionals.

Various approaches to health have viewed culture as a key determinant that can be 'managed' with increased cultural awareness or cultural competence on the part of providers. *Cultural safety* is one concept that the authors believe holds the greatest opportunity for transforming health practice in the U.S. and globally as it is one of the few frameworks that recognizes colonization, racism and discrimination as significant influences on health and social outcomes today.

We are not suggesting that an approach from New Zealand can simply be transferred to the U.S. context. The reason for considering its value in the U.S., is that it puts the onus for change on the service provider and system rather than on the client. It is an undertaking to think about the things that make us unique and to provide care that takes account of these differences. It is based on principles of professional practice rather than acquiring blocks of knowledge about cultures, which in a multicultural country such as the U.S., is expansive.

However, not everyone is ready to embrace the necessary elements of such a philosophy. We will discuss this further in later chapters that explore resistances to cultural safety.

Other Cultural Frameworks

We will now explore other frameworks that have focused on the issue of culture in healthcare and human services. Some of these overlap with cultural safety, and some have distinctly different goals. Various frameworks are not always well defined or have been defined differently by various writers. Overall, however, it is important to recognize that there are different terms and frameworks, and it is important to examine the aims and foci of the various approaches and their implementation in practice.

Cultural Awareness

Cultural awareness may be a framework that many have heard of or even participated in training. Cultural awareness training has been around for decades. It stems from anthropological studies of culture, which largely focused on racial or ethnic cultures, but more recently has included other forms of cultural difference. Cultural awareness is simply that—awareness of elements of culture—dress, foods, music, religious practices, rituals, social protocols, and so on. It's an important step for anyone working in an intercultural setting, but one which usually asks participants to look at 'the other'. It can lead to essentializing culture as something fixed and prescribed.

Cultural Sensitivity

Cultural sensitivity is perhaps less well-known as a framework, but more as a developmental consequence of cultural awareness training. Cultural sensitivity asks us to recognize our differences and accept others' right to those differences. In a sense, it requires us to accept that there are multiple worldviews, beliefs, and practices that everyone is entitled to hold and no one cultural group should be privileged above another. This is of course, easier said than done, as there are times when cultural practices and beliefs may clash with the current laws under which health professionals operate and this is the challenge of culturally safe practice to navigate these tensions.

Cultural Competence

Cultural competence originally developed in the U.S. and although in use across the country, it has been defined in many ways and used in many disciplines. Some definitions make it difficult to tease out the differences between cultural competence and cultural safety.

One definition of cultural competence is the ability of providers and organizations to effectively deliver health care services that meet

the social, cultural, and linguistic needs of patients (Betancourt et al., 2002). A culturally competent healthcare system can help improve health outcomes and quality of care and can contribute to the elimination of *racial and ethnic* (emphasis added) health disparities (Ihara, n.d.). Strategies that may help achieve these goals include providing relevant training on cultural competence and cross-cultural issues to health professionals and creating policies that reduce administrative and linguistic barriers to patient care, including access to interpreters and increasing diversity in the workforce.

Another definition of cultural competence is 'the ability of systems to provide care to patients with diverse values, beliefs and behaviors, including tailoring delivery to meet patients' social, cultural and linguistic needs' (Betancourt et al., 2002, p. v). Campinha-Bacote (2002) defined cultural competence as a 'process, not an endpoint, in which the (nurse) continuously strives to achieve the ability to work within the cultural context of an individual, family, or community from a diverse cultural/ethnic background' (pp. 1–2). Cultural competence in some instances has been broken down to include clinical, organizational, and systemic cultural competence (DeSouza, 2008).

While there seems to be widespread adoption of cultural competence as a framework it has also come under much scrutiny and critique. It is often defined as the ability to work effectively with clients who are culturally different. The service provider is the focus in this definition. There is an emphasis on behavior or interactions that can be assessed as competent. But who decides whether a service provider's care or service has been 'competent'? What would this look like in practice?

Many of the social sciences have adopted the concept and terminology of cultural competence and expanded it to include elements which are, as you will see, similar to those employed in cultural safety. For example, cultural competence training in some psychology programs includes the importance of understanding the implications of a colonial history, notions of power (and disempowerment or empowerment), the consideration of how one's own culture impacts on their provision of care and how the care is received by clients. Side by side, it would be difficult to see any major difference between some ideas of cultural competence and cultural safety.

Readings

The following readings provide more details about cultural competence.

Ihara, E. (n.d.). Cultural Competence in Health Care: Is it important for people with chronic conditions? Georgetown University, Health Policy Institute, Issue Briefs on Challenges for the twenty-first century: Chronic and Disabling Conditions, https://hpi.georgetown.edu/cultural/.

Kohli, H. K., Huber, R., & Faul, A. C. (2010). Historical and theoretical development of culturally competent social work practice. *Journal of Teaching in Social Work, 30*(3), 252–271. https://doi.org/10.1080/08841233.2010.499091

Brach and Fraser (2000) provide some key strategies for improving the patient–provider interaction and institutionalizing changes in the healthcare system. These include:

1. Provide interpreter services
2. Recruit and retain minority staff
3. Provide training to increase cultural awareness, knowledge, and skills
4. Coordinate with traditional healers
5. Use community health workers
6. Incorporate culture-specific attitudes and values into health promotion tools
7. Include family and community members in health care decision-making
8. Locate clinics in geographic areas that are easily accessible for certain populations
9. Expand hours of operation
10. Provide linguistic competency that extends beyond the clinical encounter to the appointment desk, advice lines, medical billing, and other written materials.

Approaches that focus on increasing knowledge about various groups, typically through a list of common health beliefs, behaviors, and key 'dos' and 'don'ts', provide a starting point for health professionals to learn

more about the health practices of a particular group. This approach may lead to stereotyping and may ignore variation within a group, however. For example, the assumption that all Latino patients share similar health beliefs and behaviors ignores important differences between and within groups. Latinos could include first-generation immigrants from Guatemala and sixth-generation Mexican Americans in Texas. Even among Mexican Americans, differences such as generation, level of acculturation, citizenship or refugee status, circumstances of immigration, and the proportion of his or her life spent in the U.S. are important to recognize.

It is almost impossible to know everything about every culture. Therefore, training approaches that focus only on facts are limited, and are best combined with approaches that provide skills that are more universal. For example, skills such as communication and medical history-taking techniques can be applied to a wide diversity of clientele. Curiosity, empathy, respect, and humility are some basic attitudes that have the potential to help the clinical relationship and to yield useful information about the patient's individual beliefs and preferences. An approach that focuses on inquiry, reflection, and analysis throughout the care process is most useful for acknowledging that culture is just one of many factors that influence an individual's health beliefs and practices. (Ihara, n.d.)

Activity

Ihara (n.d.) provides a number of strategies for improving the cultural competence of practitioners and organizations. Which strategies can you identify that are either already in place or would be beneficial in your local services? Choose one of the priority strategies for your location. If you had to write a proposal to your supervisor, how would you justify your request to implement your chosen strategy?

Cultural Humility

Cultural humility has arisen from the medical professions in the U.S. in response to what was seen as a limitation of cultural competence. *Culturally Connected* is a Canadian website that provides information and resources about cultural humility for health professionals. They define cultural humility using Tervalon and Murray-Garcia's (1998) definition:

- Cultural humility is a stance toward understanding culture. It requires a commitment to lifelong learning, continuous self-reflection on one's own assumptions and practices, comfort with 'not knowing', and recognition of the power/privilege imbalance that exists between clients and health professionals.
- A cultural humility approach is interactive: we approach another person with openness to learn; we ask questions rather than make assumptions; and we strive to understand rather than to inform.
- Embracing and learning about the similarities and differences between health professionals and clients, such as language, religious beliefs or values, age, gender, understandings of health and illness, or sexual orientation, can help providers to understand a client's health concerns, experiences, and preferences for care.

Reading
Gallardo, M. E. (Ed.). (2014). *Developing cultural humility: Embracing race, privilege and power*. Sage.

This book is a series of personal life experiences of psychologists from underrepresented communities and the challenges and rewards they experience in their own lives. The book is an excellent demonstration of how to examine and reflect on one's own cultural identity in very intentional ways.

Cultural Responsiveness

Cultural responsiveness is a concept that has been used in education and therapy. The concept has been applied to the work of school psychologists, teachers, therapists, social workers, occupational therapists, and even architects. The concept is not clearly defined and is lacking a strong literature base. The term seems to have been used interchangeably in the literature with other terms. Even so, we have included cultural responsiveness here should readers come across it in their own exploration of the literature or in their workplaces.

Reading
Below are a few readings relating to cultural responsiveness for those interested in exploring this area.

Hays, P. A., & Iwamasa, G. Y. (Eds.). (2006). *Culturally responsive cognitive-behavioral therapy: Assessment, practice, and supervision*. American Psychological Association. https://doi.org/10.1037/11433-000.

Misurell, J. R., & Springer, C. (2013). Developing culturally responsive evidence-based practice: A game-based group therapy program for child sexual abuse (CSA). *Journal of Child and Family Studies, 22*, 137–149. https://doi.org/10.1007/s10826-011-9560-2.

Sisko, S. (2021). Cultural responsiveness in counselling and psychology: An introduction. In V. Hutton, S. Sisko (Eds.), *Multicultural responsiveness in counselling and psychology*. Palgrave Macmillan, Cham. https://doi.org/10.1007/978-3-030-55427-9_1.

Summary of Concepts

Overall, these various concepts or frameworks have provided us with evolving ways of thinking about and exploring culture, identities and diversity. The limitation of these frameworks or models is that we don't know very much about how they actually play out in practice. We don't have much research to show what works best or what actually makes

a difference. The terms get thrown about as if they mean something in particular, but there are assumptions underlying what these concepts mean and major differences in how the concepts are defined, both within and between different groups.

If staff or students undergo some 'cultural' or 'diversity' training or workshops, what does that mean? What are they taught? How do we know it will make a positive difference? How do we know that what is taught is not harmful—perhaps creating more stereotypes or discrimination against certain groups?

While certain concepts, in an academic understanding, might be seen as more or less effective, when delivered in a workshop or similar it might depend on who was delivering the workshop, or how the issues are managed or presented. This makes it difficult to assess and understand exactly what is being taught and the impacts. We have therefore looked at each of the different concepts or frameworks and some of the weaknesses and strengths. Through this discussion and analysis, you should have a better understanding of how knowledge, values, and understanding influence practice.

Table 2.1 is a synthesis of some of the strengths and limitations of cultural safety and other frameworks. You might identify other strengths and limitations in your own analysis to add to this table:

Critical Thinking

- Reflect on the wide range of terminology and concepts relating to working in cultural contexts. Getting caught up in the current terminology can present a barrier for health professionals to working well in cultural contexts.
- How do professionals ensure that policies and frameworks for practice do not just linger in folders and on web pages of health services? What can you do as an individual to see policies put into practice?
- With many cultural frameworks, there is a strong desire to have a tool to measure outcomes. What is the risk of applying a tool that is developed by the service providers? How will you know if you have achieved competence, humility, or safety?

Table 2.1 Cultural frameworks, some strengths, and limitations

Framework	*Key idea or elements*	*Strengths*	*Limitations*
Cultural safety	– Be *regardful* of difference—treating people the same does not recognize or honor diversity – Decolonize practice: recognize the impact of colonizing history on current health, services, and systems – Recognize power relationships in practice – Reflective practice is a key tool to safety – Understanding own culture is key to recognizing its impact on others – Safety is determined by recipient of care	– Conceptually addresses elements that theoretically should improve health outcomes – Shifts power from providers to recipients – Shifts focus from the 'exotic other' to self – Is potentially applicable to any situation of cultural difference	– Requires more research – Has generally focused on application in interpersonal contexts and not as much in organizational or structural contexts – Resistance from some to concept of decolonization
Cultural awareness	– Focus on awareness of overt differences between groups – Stems from anthropology	– Provides a starting point to understand difference – Helps to establish basis for development of cultural safety	– Unachievable to be aware of or knowledgeable about all cultures – Based on anthropological overt differences – Views cultures as static – Can lead to stereotyping

(continued)

Table 2.1 (continued)

Framework	*Key idea or elements*	*Strengths*	*Limitations*
Cultural sensitivity	– Sensitive to elements of difference between self and clients – Recognizes rights to difference	– Extends awareness to an acceptance of the right to difference	– Improvement of practice requires more than sensitivity to issues – Stays at the individual level rather than organizational
Cultural competence	– Awareness, knowledge, and skills relating to culture Understand self as culture bearer – Recognition of historical, social, and political influences	– Relatively extensive literature base	– Potentially perpetuates colonizing practices and power imbalances – Can be deemed competent by other than recipients of care – not always consistently defined
Cultural humility	A commitment to lifelong learning, continuous self-reflection on one's own assumptions and practices, comfort with 'not knowing', and recognition of the power/privilege imbalance that exists between clients and professionals	Addresses the individual practitioner's potential power and privilege	Lack of literature

Making It Local

Find your current service's cultural framework. If you are a student, visit a health service in your local area. Critique the framework for how useful it would be in practice. Are there any particular frameworks that seem

to be gaining prominence? If so, how are staff enabled or supported to implement these in practice?

Scenario

A local health service wanted to assess how well it was doing providing care to clients of a specific minority group: young, gay males 18–25. The practice manager developed a written client satisfaction survey that was left in the reception for clients to take and return to the receptionist.

- What do you think of this approach to assessing care for this population group?

As you answer, reflect on what assumptions you might have made about the practice manager, the receptionist, and the clients. It is natural to have some preconceived notions about who these people are, but it's also important to ask yourself, why? There is no right or wrong here—just encouragement to challenge our own, often unconscious biases. For example, who assumed the receptionist to be female? What might their religious background be if working in a clinic for gay men—can we really make any assumptions?

For all the information provided, it is really not possible to tell if this strategy would work or not. Cultural safety is about *how* you do something, not *what* you do. If the practice has established rapport with their clients, has identified that written surveys would be acceptable, possibly through asking their clients, and there is trust, then this could be a safe approach.

- How might you go about seeking feedback from clients? Would you use the same approach for all?
- How appropriate would this be in your specific location? Explain your response—why or why not?
- How would you personally know if you were providing culturally safe care to such a group?
- What potential biases might you have that could impact on your care of this demographic?

Further Reading

Walters, K. L., Johnson-Jennings, M., Stroud, S. et al. (2020). Growing from our roots: Strategies for developing culturally grounded health promotion interventions in American Indian, Alaska Native, and Native Hawaiian Communities. *Prevention Science 21*, 54–64. https://doi.org/10.1007/s11121-018-0952-z.

Viruell-Fuentes, E. A., Miranda, P. Y., & Abdulrahim, S. (2012). More than culture: Structure racism, intersectionality theory and immigrant health. *Social Science & Medicine*.

Wong, Y, J., McCullough, K., & Deng, K. (2019). Asian American Men's Health Applications of the Racial-Cultural Framework. In D. M. Griffith, M. A. Bruce, R. J. Thorpe, *Men's health equity. A handbook*. Routledge: New York.

Peterson, L. S., Villarreal, V., & Castro, M. J. (2017). Models and frameworks for culturally responsive adaptations of interventions. *Contemporary School Psychology, 21*, 181–119. https://doi.org/10.1007/s40688-016-0115-9.

Conclusion

We have covered a variety of approaches to learning about and understanding cultures, identities and diversity in professional practice. We have not covered all the models and approaches to learning about these concepts. For example, diversity, equity, and inclusion training (DEI) is another approach that we have not covered but which you may want to investigate. Keep in mind that no single approach is likely to have all the answers. If there were such an approach, the health and social challenges facing us all in the U.S. would have been met and dealt with long ago. Cultural safety has arrived at a set of principles for ensuring that dominance, assumptions, and stereotyping do not result in a lack of safety and accessibility for those who have a different cultural background to the providers. In this way, it is not a discrete set of skills that we can perform to demonstrate safety, but rather a set of principles for

practice that are relevant to any setting—including the need to ask or talk to those you provide care or service to, reflect on what you bring to the encounter, examine your own potential biases and assumptions, and decolonize practice.

This chapter has briefly explored frameworks that have been developed and used in health and other disciplines. While it may be an individual choice as to which framework resonates with readers, cultural safety is offered as the preferred approach because of its transferability across disciplines, contexts, and cultures and the essential element of recognizing the role of colonization in health outcomes today. This will be discussed in more detail in later chapters.

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