Australian Government
National Health and Medical Research Council

CULTURAL COMPETENCY IN HEALTH:
A guide for policy, partnerships and participation

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A guide for policy, partnerships and participation

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PREFACE

All Australians have the right to access health care that meets their needs. In our culturally and linguistically diverse society, this right can only be upheld if cultural issues are core business at every level of the health system—systemic, organisational, professional and individual.

This guide is one step towards this goal, giving a model for cultural competency that can be applied by health systems and organisations to improve health for all.

Recognising that the inclusion of cultural issues in health care is crucial, the NHMRC has identified the need to increase cultural competency in health as a priority. To ensure that the resource developed was as comprehensive as possible, the NHMRC Health Advisory Committee drew together a Working Committee with personal and professional experience of cultural diversity issues as well as clinical and population health expertise. The guide's development involved a wide-ranging process of consultation and a review of the available research and practice evidence. The principles and guidance in this document are based on its findings.

This guide contributes to a growing body of work in the area of cultural competency – a concept which embeds the notion of reciprocity. The particular strength of this resource is its national application, and its focus across the four domains — systemic, organisational, professional and individual — where action is critical to increase cultural competency.

The guide aims to increase cultural competency for the benefit of people from culturally and linguistically diverse backgrounds, taking a cue from growing international emphasis on improving health outcomes by promoting healthier living and environments. It uses the issue of overweight and obesity to illustrate the model. The guide acknowledges diverse views in the landscape of cultural competency, using feedback from the consultation process to highlight current debates in Australia and internationally.

Australia has long been culturally diverse and our population continues to grow in diversity. While the model given in the guide applies generally, the Working Committee sought the advice of the Aboriginal and Torres Strait Islander members of NHMRC on whether the scope should include Aboriginal and Torres Strait Islander issues in relation to cultural competency. Given the need to focus on these issues in depth and the risks associated with not being able to do so in the time available, it was decided to ensure the exemplary work undertaken to date is included and to recommend the development of a specific resource.

We believe the guide will stimulate broader discussion and ownership of the issues it raises and its recommendations. But our hope is that it begins nationally supported and sustained change. The health of our culturally diverse population depends on it.

Professor Elizabeth Waters
Chair, Increasing Cultural Competency Working Committee

SUMMARY

The National Health and Medical Research Council (NHMRC) has developed this guide to help policy makers and managers with culturally competent policy and planning at all levels of the health system. The guide draws together evidence on programs for increasing cultural competence and research on influences and determinants of healthy living and environments, within culturally and linguistically diverse communities. It gives practical strategies for increasing cultural competency (see Chapter 3 in particular) and where available, gives examples of evaluated programs at local level that aim to make a difference.

Why is cultural competency important?

Australia has long been culturally diverse, with more than 500 language groups in existence prior to European settlement in the late 1700s. Our population continues to grow in diversity of language, culture, religion and country of background. Our multicultural heritage has enriched our society immeasurably, but a diverse population also challenges the health system to meet the needs of a wide range of culturally and linguistically diverse groups. People who live in Australia come from diverse social, political and economic backgrounds, and we all have a wide range of experiences, behaviours, and beliefs in relation to health and illness. We are also exposed to and contribute a variety of protective and risk factors for healthy living.

*Achieving culturally competent health care is **everybody's responsibility.** It is not just the province of governments and policy makers, health care providers dealing with ethnicity, or culturally and linguistically diverse communities. It benefits everyone in Australia and can only be achieved through collaboration across the community.*

For people who come from other lands to live in Australia, the impact of settlement and acculturation varies widely depending on their experience and situation. In addition, there are many determinants of health and wellbeing from outside the health system, such as housing, employment, education, spirituality and social connections to the life of the community. As a result, the health and wellbeing of culturally and linguistically diverse communities depend on a complex balance of social, economic, environmental and individual risk and protective factors.

Australia is becoming more responsive to the needs of people from diverse backgrounds, and policies exist at national and State and Territory level that enshrine the right of all Australians to equal access to health services that meet their needs. Despite these policies, the health system is challenged to meet the needs of a population with a broad range of cultural and linguistic backgrounds. As a result, health inequalities exist for many culturally and linguistically diverse (CALD) background communities. Implementing policies effectively to ensure equity and access to health promotion, health care and social services for a diverse population will require action at every level of the health system.

Examination of the issues raised in this document is both timely and in tune with the intent of the forthcoming WHO World Health Report 2006 which will celebrate health worker contribution to health care across a range of practice settings.

A health system that is culturally competent:

- acknowledges the benefits that diversity brings to Australian society;
- helps health providers and consumers to achieve the best, most appropriate care and services;
- enables self-determination and ensures a commitment to reciprocity for culturally and linguistically diverse consumers and their communities; and
- holds governments, health organisations and managers accountable for meeting the needs of all members of the communities they serve.

A model for change

This guide acknowledges four dimensions of cultural competency — systemic, organisational, professional and individual — which interrelate so that cultural competence at an individual or professional level is underpinned by systemic and organisational commitment and capacity.

Application of the model to health promotion and public health programs is supported by practical guidance provided in this guide, with a focus on:

- placing CALD background communities at the centre of organisational approaches to promoting healthier living and environments;
- ensuring that the health system can capture, enumerate and measure diversity, and consider diversity in programming, planning and resource allocations;
- acknowledging that cultural competency at management level affects the service culture of every organisation;
- recognising the need for a culturally competent evidence base in health promotion and health service delivery, supported by research into cultural competence issues and leading to culturally competent monitoring and evaluation;
- developing and implementing training and practice standards to ensure that information on people from CALD backgrounds is used as a context for interaction not as a tool to assume behaviours or attitudes; and
- recognising the policy imperative to increase both the quality and resourcing of professional development as a key strategy in achieving culturally competent practice.

Health improvements for a diverse nation

To effectively promote healthier living and environments to a diverse nation, a national approach is required. This should target all levels of government and promote better services through the creation of networks, planning and strategic direction.

The health sector must form partnerships with ethnic communities and together develop culturally appropriate health promotion and health service delivery that is consistent and sustainable. The aim should be to transform health policy, planning and delivery, so it is suitable for a culturally diverse Australia, increasing cultural competency at all levels of the system, partnering with the multicultural sector in planning, implementing and evaluating health care, health promotion and public health strategies, and reducing health inequalities in the short and long term.

DEFINITIONS OF KEY CONCEPTS

Acculturation describes phenomena that result when groups of individuals having different cultures come into continuous first-hand contact, with subsequent changes in the original cultural patterns of either or both group. Under this definition, acculturation is distinguished from culture change, of which it is an aspect, and assimilation, which is at times a phase of acculturation (Redfield et al 1936).

Community development involves helping communities to identify issues of concern and facilitating their efforts to bring about change in these areas, ultimately helping to empower communities with the skills needed to take control over and improve their situation (Hawe et al 1990).

Community involvement describes the full range of research, consultation and participation in a decision-making process of a group of people sharing a common interest (eg cultural, social, political, health, economic geographic).

Consumer involvement describes the engagement of individuals in a decision-making process as partners, advisers and informants.

Cultural capital includes forms of knowledge, skill, education — any advantages a person has that give them a higher status in society, including high expectations (Richardson 1985).

Cultural competence is a set of congruent behaviours, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations (Cross et al 1989 cited in Eisenbruch 2004a). Cultural competence is much more than awareness of cultural differences, as it focuses on the capacity of the health system to improve health and wellbeing by integrating culture into the delivery of health services.

To become more culturally competent, a system needs to:

- value diversity;
- have the capacity for cultural self-assessment;
- be conscious of the dynamics that occur when cultures interact;
- institutionalise cultural knowledge; and
- adapt service delivery so that it reflects an understanding of the diversity between and within cultures (RACP 2004).

Cultural and linguistic diversity refers to the wide range of cultural groups that make up the Australian population and Australian communities (Multicultural Mental Health Australia 2005). The term acknowledges that groups and individuals differ according to religion and spirituality, racial backgrounds and ethnicity as well as language. In this report the term 'culturally and linguistically diverse background' (CALD background) is used to reflect intergenerational and contextual issues, not just migrant experience.

Cultural self-assessment involves a system, organisation, profession or individual undertaking an audit of awareness, knowledge and skills in cultural competence (National Center for Cultural Competence 2004).

Diversity dividend refers to the benefits of using the diversity in the workforce to optimise performance, promote innovation and to connect with diverse customers and partners, and as a key enabler of business success (DIMIA 2001).

Diversity management is a tool for capturing the diversity dividend. It focuses on managing the difference within a workforce, capitalising on the benefits of diversity and minimising workplace challenges (DIMIA 2001).

Equality and equity — equity in health means that all people have an equal opportunity to develop and maintain their health, through fair and just access to resources for health. Equity in health is not the same as equality in health status. *Inequalities* in health status between individuals and populations are inevitable consequences of genetic differences, of different social and economic conditions, or a result of personal lifestyle choices. *Inequities* occur as a consequence of differences in opportunity (eg unequal access to health services) (WHO 1998).

Health promotion is a process of enabling people to increase control over and to improve their health. Health promotion, through investments and actions, acts on the determinants of health to create the greatest health gain for people, to contribute significantly to the reduction of inequities in health, to ensure human rights, and to build social capital (WHO 1997).

Institutional racism is that which, covertly or overtly, resides in the policies, procedures, operations and culture of public or private institutions - reinforcing individual prejudices and being reinforced by them in turn (Institute of Race Relations 2005).

Knowledge transfer is the development, exchange and use of information within and between groups and organisations within a network or community (Centre for Primary Health Care 2002), including the transfer of learned experience of working across cultures.

New and emerging communities are those which generally have small numbers in any one population centre, lack organised advocacy or social networks, have difficulty accessing government services and may require substantial assistance and time to settle effectively in Australia (Multicultural Affairs Queensland nd).

Protective factors reduce the likelihood of a person suffering a disease, or enhance their response to the disease should it occur (AIHW 2002).

Reciprocity refers to mutual respect and valuing the benefits of diversity, dialogue and shared learning (Procter 2003a).

Risk factors are characteristics, variables, or hazards that, if present for a given individual, make it more likely that this individual, rather than someone selected at random from the general population, will develop a disorder (Multicultural Mental Health Australia 2005).

Social inclusion refers to a situation where all people feel valued and can participate in decision making that affects their lives, allowing them to improve their overall wellbeing (VicHealth 2005).

Social exclusion is the process of being shut out from the social, economic, political and cultural systems that contribute to the integration of a person into the community (VicHealth 2005).

INTRODUCTION

The National Health and Medical Research Council (NHMRC) developed this guide with the aim of:

- bringing together available evidence about the benefits and challenges that cultural and linguistic diversity brings to the health system in Australia; and
- giving guidance primarily to policy makers, managers, health professionals and health and social researchers on culturally competent policy, planning and practice at every level of the health sector to promote healthier living and environments.

The principles for cultural competence outlined in this guide apply to health care for all Australians. In order to give practical guidance in cultural competence, the focus of the guide has been confined to increasing cultural competence to benefit people from culturally and linguistically diverse backgrounds, with an emphasis on healthier living and environments.

The guide uses overweight and obesity to illustrate a model for increasing cultural competency. Overweight and obesity is a major health problem across the population and encompasses many complex social and cultural issues. Preventing overweight and obesity is an important aspect of promoting healthier living and environments and one that has varying effects across and within diverse communities.

Overweight and obesity occur when dietary intake exceeds energy expenditure over a period of time.

Many factors contribute to overweight and obesity, reflecting inherited, metabolic, behavioural, environmental cultural, psychosocial and socioeconomic conditions. Environments, lifestyle, diet and levels of physical activity are major contributors to the obesity epidemic in Australia.

Development of the guide

In 2004, the NHMRC Health Advisory Committee (HAC) identified as a priority the development of a resource for increasing the cultural competence of the health sector and partners working with culturally and linguistically diverse communities to improve health.

A Working Committee was formed to oversee the management of the project. The Committee includes public health researchers and practitioners as well as representation from: the Federation of Ethnic Communities' Councils of Australia; the Centre for Culture and Health; Multicultural Mental Health Australia; the Victorian Centre for Culture, Ethnicity and Health; NSW Multicultural Health Communication; university departments of public health and health sciences; and State departments of health. The membership brings a wide range of personal and professional experience of diversity issues. Membership details and terms of reference are at Appendix A.

The model in this guide is based on the results of qualitative research products commissioned for the project,[1] which included the analysis of written submissions on the issue and impact of cultural competency, a literature review and national consultations involving the health, community and ethnic communities sectors. Information collected through the submissions and literature review was used to develop questions for focus groups, which were explored in depth as part of the national consultations.

[1] The research and consultation report is available on the NHMRC website.

A first draft of the guide was distributed widely for comment. Fifty-three submissions were returned, which contained positive responses about the direction and content of the guide and many useful suggestions for its improvement. Details of the guide's development are given in the process report (Appendix B).

Scope of the guide

Cultural competence in health promotion continues to evolve,with a number of debates stretching the concepts and shaping our understanding of the issues. This affected the guide's development and as a result some comment on the scope of the guide is necessary.

The original intention, as stated in the terms of reference, was to develop a framework and toolkit for increasing cultural competence. However, the outcomes of the national consultations made it clear that intervention was needed at the policy level, to raise awareness at all levels of the health system and promote the integration of cultural competence into policy, planning and practice. Feedback on the initial draft of the guide helped to clarify the guide's focus on health policy and program planners.

The outcome is a guide that outlines high level principles and strategies but also gives practical steps that can be taken at systemic, organisational, professional and individual levels. While not aimed directly at health providers it is hoped that the guide will help with program planning, implementation and care at all levels within the health system.

Some specific issues require more detailed discussion.

Cultural competency for Aboriginal and Torres Strait Islander Peoples

For most of the services that comprise the health sector in Australia, meeting the needs of Aboriginal and Torres Strait Islander Peoples in a culturally respectful way is a significant challenge. The Working Committee recognised the unique position of Australia's first peoples in all their cultural and linguistic diversity. Many issues and definitions included here are relevant to culturally competent health practice for Aboriginal and Torres Strait Islander communities, including the critical role of partnership structures and processes and the need for:

- a multi-dimensional approach to cultural competency (with action at systemic, organisational, professional and individual levels); and
- effective and culturally inclusive research and evaluation.

Advised by Aboriginal and Torres Strait Islander members of the NHMRC and Health Advisory Committee, the Working Committee formed the view that the scope of the project limited the opportunity to cover issues in sufficient depth and ran the risk of diluting the complexities of culturally respectful health service delivery for Aboriginal and Torres Strait Islander Peoples.

The Working Committee urges the NHMRC to follow this guide with a specific resource addressing cultural competency for Aboriginal and Torres Strait Islander Peoples. Ideally this approach would build on existing resources such as the Cultural Respect Framework and the distinct policy and service delivery structures available (see Appendix C).

Taking a broad approach

The guide addresses cultural competence in general terms, however the concepts are relevant to promoting better health outcomes and healthier environments for many specific groups within the community — for example infants and children, adolescents, women, the aged, people with mental illness or disability, and their carers. A growing body of work in Australia and internationally is examining the needs of specific groups and how to address them. The guide seeks to build on this work rather than replicate it, drawing on expert material such as the Commonwealth's National Mental Health Plan, and seeking to encourage broader discussion and dissemination of the issues (see Appendix C for details of resources and organisations for further information).

Evolving debates on cultural competence

Many different perspectives within the landscape of cultural competence emerged during the guide's development. These are acknowledged rather than resolved here and include debates about terminology, the nature of diversity within and between communities, the variety of circumstances that contribute to experiences of health and health inequalities, and the best means of achieving cultural competence.

The feedback suggested alternative and emerging terms for cultural competence including 'cultural responsiveness', 'cultural awareness' and 'cultural sensitivity'. Similarly, an array of terms were proposed to describe people from diverse communities (eg culturally and linguistically diverse [CALD], culturally and/or ethnically diverse [CAOED], non-English speaking background [NESB]).

The guide's use of 'cultural competence' and 'culturally and linguistically diverse background' (CALD background) aims for terminology that is widely recognised and builds on momentum engendered by the international focus on cultural competence and health promotion (eg through the Ottawa Charter 1986 and more recently the Bangkok Charter 2005). Terminology is intended in its broadest, most inclusive sense, reflecting a dynamic view of diversity in Australian society and the role that background, experience, length of stay, inter and transgenerational issues and diversity within and between communities play, along with language and culture, in forming diversity.

Debate about different approaches to achieving cultural competence is also evident in the literature and through the consultations. Some advocate mandated approaches: legislative frameworks, prescribed performance measures, mandatory training and monitoring. Others prefer promotional and educative approaches emphasising building awareness and incremental

change at all levels. Examples of a range of strategies are included in the cultural competency tables in Chapter 2.

Need for evidence

Another finding was the many gaps in the evidence base, both in terms of research on interventions, as well as the more serious issue, that individuals and groups from CALD backgrounds are being systematically excluded in research due to the challenges and additional investments required to ensure their participation. Research frequently excludes consideration of people from CALD backgrounds and their health issues. The national consultations found that much work is underway across Australia in culturally appropriate health promotion and health interventions, but research issues, methodologies and rigour vary widely. At a local level, it is also common for projects to be constrained by design and funding, so that they exclude harder to reach population groups, are either not appropriately evaluated or the results not published or disseminated. Despite the limits this imposes on effective knowledge generation, synthesis and transfer, the national consultations found that notional best practice in areas such as community participation, communication and training is increasingly being adopted at the local level.

Next steps

The consultation and feedback identified suggestions for future work, including:

- development of accountability mechanisms and performance indicators;
- identification of core competencies;
- improved data collection, reporting and sharing;
- mandatory implementation and/or measures and mandated training; and
- development of a range of 'hands-on' resources.

These ideas cannot be taken up within the scope of this project but provide the basis for further consideration and next steps (Chapter 4).

Structure of the guide

- **Chapter 1** gives the context for the guide, discussing diversity, the causes and costs of health inequalities, and why increasing cultural competency in health promotion is important.
- Using the key learnings from the consultation report as the basis, **Chapter 2** outlines principles for increasing cultural competency and promoting healthier living and environments. A model for increasing cultural competency is outlined, including tabulated competencies needed to underpin effective health promotion — both generic and applied — illustrated by examples focussing on healthier living and environments.

- **Chapter 3** shows how the principles and the model can be brought together to make a difference in communities. It gives strategies for developing culturally competent health promotion programs and projects, illustrated by examples of evaluated projects. It also uses scenarios to demonstrate practical application of the model.
- **Chapter 4** identifies areas for future work and outlines opportunities for next steps in the Australian context.

The appendices include a list of resources and websites that can be used to obtain further information and to disseminate useful information that emerged during the consultation.

1 OVERVIEW

This chapter presents background material supporting a model for cultural competency in health care. It looks at health profiles within a diverse Australia, and identifies from the literature barriers to culturally competent health promotion and factors that may influence moves towards healthier living and environments.

1.1 Australia — a culturally diverse nation

With hundreds of languages spoken, most of the world's religions practised and 23 per cent of Australians born overseas (ABS 2001), Australia is one of the most culturally diverse countries in the world.

Australia's diversity brings significant cultural, social and economic benefits to the Australian community in general. Specific benefits to population health arising from cultural diversity include:

- the progressive diversification of the food supply (eg changes to Australian eating habits as shown by the introduction of new foods and the use of healthy cooking methods such as stir-frying [Wahlqvist 2002]) and associated health protection;
- introduction of diverse sports and games (eg wide availability of martial arts lessons) which may broaden opportunities for physical activity;
- diversity in the health workforce (eg the bilingual skills, cultural knowledge and experience and ideas that health professionals from diverse cultural backgrounds bring).

Australia has long been a diverse place, with over 500 language groups in existence in 1788 and evidence of interaction between Indigenous people and other groups prior to European settlement in the late 1700s.

This diversity has evolved throughout Australia's history, with peak events and successive waves of migration continuing to reshape Australian society. Phenomena such as convict transportation, gold rushes, the Irish Famine, industry demand (eg pearling, wool, sugar cane) and even gender imbalances contributed to fluctuations in migration patterns and the composition of Australian society. Combined with wars, upheavals and humanitarian crises on various continents, Australia has a continuous history of absorbing new people, with each group contributing and undergoing complex adjustments over successive generations.

The profile of people settling here since World War II reflects continuing changes in political and social stability around the world. Two streams of migration have emerged — migration for skilled and family immigrants and resettlement of people in humanitarian need.

Migration is a complex phenomenon and the individual immigrant goes through a series of stages of adjustment and response to a number of

Australia's diverse population — a snapshot at 30 June 2004

- *Almost 1 in 4 people living in Australia were born overseas, the highest proportion in more than 100 years.*
- *Almost half of the overseas-born population in Australia were from Europe. Migration from Europe has fallen over the past 8 years, while migration from other regions increased.*
- *Sudanese-born people are the fastest growing group of Australians born overseas, increasing by an average 26 per cent each year over the past 8 years, followed by Afghanistan (12 per cent) and Iraq (11 per cent).*
- *The largest net addition to Australia's population over the past 8 years was from people born in New Zealand, up by 127,000, while China contributed 60,800, South Africa 47,400 and India 43,800.*
- *Western Australia had the highest proportion of overseas-born residents (29 per cent) while Tasmania had the lowest (11 per cent).*

ABS (2005)

stressors related to the preparation, process and postmigration adjustment (Bhugra 2004). There are three theories that attempt to explain the impact of migration on health and wellbeing (Alati et al 2003).

- The 'migration-morbidity' hypothesis suggests that migrants would be expected to have worse mental health than their host society due to pre and post migration stressors. This is not necessarily a common outcome in migrant populations today, although several studies on the health of refugees have demonstrated this effect.
- The 'healthy migrant' effect — whereby people in good health are more likely to meet eligibility criteria, and to be willing and economically able to migrate (NSW Health 2004) — has many supporters, and is backed up by many studies (Donovan et al 1992; NSW Health 2004). This effect could be due to the self-selection process, which encourages individuals with positive health and resilience to migrate. Immigrant children and young people may also have a cache of 'cultural capital', even the ability to switch between identities, languages and cultural norms, giving them greater flexibility.
- Finally, the 'transitional effect' suggests that the health advantage that some migrant groups show disappears over time. This effect has been documented for physical health outcomes such as cardiovascular disease and cancer, and emerging studies in the mental health literature also suggest this occurring for psychological outcomes. This effect may become more evident in the next decade as the young immigrants of the 1950s and 1960s reach ages at which they are at greater risk of chronic conditions (AIHW 2004a).

Implications for the health sector

The health sector response to the challenge of meeting the needs of people from a broad range of cultural and linguistic backgrounds will include:

- addressing similarities and differences within communities based on gender, age, length of stay, literacy and beliefs;
- effectively implementing policies to ensure equity and access to health services and promotion for a diverse population;
- planning and delivering culturally competent and appropriate health promotion and health services;
- addressing systemic attitudes to cultural diversity that can influence how communities survive and succeed;
- addressing research gaps about the contribution of systemic risk factors (such as access to health services) to inequalities in health for CALD background communities; and
- developing and maintaining a culturally competent health workforce.

1.2 Health profiles within a diverse Australia

The diversity in health, wellbeing and behaviours within Australia, outlined below, highlights the need to recognise a broad range of factors contributing to healthier living and environments.

The health status of migrants can vary according to a range of factors, which include not only birthplace and fluency in English, but also the process of migration, stage in the life course, whether the person is part of an established, emerging or refugee community, and each person's balance of protective and risk factors.

There are a number of factors that make it difficult to monitor and draw conclusions on the health of immigrants in Australia:

- the heterogeneity of the process of migration and the processes of socio-cultural adjustment (Bhugra 2004);
- the diversity between individuals and generations and within and between communities;
- the continual changes in patterns of migration; and
- the potential for changes in health status with acculturation.

This section draws upon available data and commentary, which includes summary data on mortality and hospitalisation collated nationally[2] and in some jurisdictions. There is also a wealth of community-based research that provides detailed information on specific groups. Some examples of local studies are summarised in boxes in the margins of this section and in Section 3.1.

National mortality and hospitalisation

For specific causes of death, there is significant variation between population groups, for example in 2001–2002 (AIHW 2004a, AIHW 2005a):

- Asian-born immigrants had especially low death rates for colorectal and prostate cancer, respiratory diseases and suicide; and
- immigrants born in the United Kingdom and Ireland experienced higher rates of breast and lung cancer (which may reflect a higher level of smoking); and
- some immigrant groups from Southern Europe, South Pacific Islands, North Africa, the Middle East and Asia had higher diabetes mortality rates.

For hospitalisation, there were also variations between groups (AIHW 2004a), with rates from 2001–2002 showing that:

- Asian-born immigrants were hospitalised more often for tuberculosis, although the annual number of cases was small;

[2] For purposes of health comparison, migrants may be grouped into four regional groups — it is recognised that these groups are broad and ethnically diverse, and that comparisons at this level provide only general trends (AIHW 2004a).

- females born in Asia had higher rates of hospitalisation for cervical cancer —women born in these regions also report lower rates of regular Pap smear testing (ABS 2002);
- hospitalisation for gastritis and duodenitis among persons born in Continental Europe and Asia was higher than for Australian-born persons; and
- the overseas-born hospitalisation rate for skin cancer was less than half that for Australian-born people.

State-based data

Analysis of data in New South Wales suggests that among people born overseas (NSW Health 2004):

- certain groups rate their health poorer on average than Australian-born groups (eg Italian, Chinese and women born in India and the Philippines) — these differences may also reflect cultural differences in perception of health and in interpreting and answering survey questions;
- people born in Lebanon, Fiji, Italy, India, and Greece, females born in the Philippines and males born in South Africa have high rates of hospitalisation for diabetes or its complications;
- people from Lebanon, Fiji and India have high rates of hospitalisation for coronary heart disease and people from Lebanon, Fiji, India and Greece have high rates of cardiac revascularisation procedures;
- people born in the United Kingdom and women born in New Zealand have high rates of lung cancer; and
- people born in Vietnam, the Philippines, India, Indonesia, China, Hong Kong, Korea, Fiji, Malaysia, and the Former Yugoslavia have high rates of tuberculosis.

Data on new and emerging communities

New and emerging communities may be particularly disadvantaged. Echevarria (2002) identified communities from Iran and Afghanistan who contend with problems of poverty, unemployment, lack of affordable housing, lack of English language skills, social isolation and exclusion, discrimination and racism. Newly arrived refugees are also almost twice as likely to report their health as either ‘fair’ or ‘poor’, compared with the general population (NSW Health 2004).

The settlement outcomes of migrants and humanitarian entrants to Australia have been monitored by the Longitudinal Survey of Immigrants to Australia (LSIA) (DIMIA 2003). Data thus far reveals that outcomes for humanitarian entrants are generally poorer than for other groups of immigrants. The LSIA data also indicate that outcomes for humanitarian entrants have deteriorated in recent years. These appear to be largely as a consequence of changes of source countries for the Humanitarian Program (especially the shift towards refugees from Africa and the Middle East/Central Asia).

Protective and risk factors

There are numerous social and environmental determinants of human behaviour that may affect health (Singh & De Looper 2002) — these include both risk and protective factors. Factors vary for particular population groups, at different times across the lifespan and within communities.

Protective factors

Protective factors are health-promoting characteristics that improve resilience and increase resistance to risk of ill health. In CALD background communities, protective factors may be related to:

- healthy diet — for example, the cardioprotective effects of the traditional Mediterranean diet (Bautista & Engler 2005);
- access to foods — established communities are more likely to have access to foods from their traditional diet;
- social inclusion and community attachment— for people from countries that have established communities in Australia, migration may mean reconnection with family members and continued involvement in community life.

Risk factors

Different kinds of risk factors affect the health of CALD background communities, including psychosocial determinants of health associated with migration and settlement, and health risk factors that occur across the population. There is much diversity in risk factors both between and within CALD background populations.

Psychosocial risk factors

Psychosocial risk factors resulting from the stresses associated with settlement in a new country may have an impact on the health and wellbeing of individuals. These stresses may include:

- past experiences of flight and trauma;
- racism and discrimination;
- alienation, isolation, cultural bereavement and lack of community attachment (Eisenbruch 1990);
- lack of cultural capital (eg established networks) within the community;
- encountering lack of cultural competence and perhaps institutionalised racism within the health system;
- lack of social and family support networks and change of traditional roles within the family;
- loss of status, particularly in terms of employment; and
- loss of self-esteem, feelings of powerlessness and communication difficulties.

Need for appropriate primary care

In a study aiming to explore the relationship between level of acculturation and health indicators among Arabic-speaking people in Sydney (n=851), almost three-quarters of males and around one-third of females had a body mass index greater than 25. Smoking levels were 37 per cent for males and 28 per cent for females (compared to a national rate of around 19 per cent). Females were less likely than other females in NSW to have been tested for diabetes or raised blood pressure.

Rissel et al (1998)

Some communities may be socio-economically disadvantaged while some new and emerging communities may lack established infrastructures to provide community members with social support, as well as physical access to services and related factors such as public transport (eg in rural areas, outer urban developments). Individuals within each community may have their own genetic, social and environmental and gender-based risks, as well as individual coping skills.

Health risk factors

Health risk factors are associated with increased levels of cardiovascular disease, cancer, injury and other diseases and poorer mental health (AIHW 2005b). These factors — and some examples of their levels among specific groups — include:

- *smoking* — in the 1997 and 1998 NSW Health Surveys, men born in New Zealand, Vietnam and Lebanon reported higher rates of current smoking than Australian-born men, while Italian-born men were less likely to report current smoking. Women born in Italy, China, Vietnam, the Philippines and India were much less likely to report current smoking than the Australian-born women and women born in New Zealand were more likely to report current smoking than Australian-born women (NSW Health 2004).
- *physical inactivity* — in 2000, people who usually spoke a language other than English at home were more likely to be insufficiently physically active or sedentary than people who spoke English at home (Holdenson et al 2003);
- *overweight and obesity* — in 2001, without accounting for age differences among these populations, a higher proportion of Southern and Eastern-European-born people were overweight or obese compared to people born in Australia (Holdenson et al 2003). As well as dietary acculturation, factors that influence nutrition post-migration include cultural beliefs and knowledge of food, exposure to advertising and the media, confusion over dietary guidelines, the cost of food, convenience, preferences and lifestyle (Renzaho 2004); and
- *genetic susceptibility* — some conditions are more likely to occur in certain groups (eg one study found familial hypercholesterolaemia is common among Christian Lebanese [Burnett et al 2005]).

Other factors include risky alcohol consumption, high blood cholesterol, high blood pressure and poor nutrition. When several risk factors coexist, the risk of certain chronic diseases — cardiovascular disease, diabetes, kidney disease — is multiplied (AIHW 2005b). As well, having one of these chronic diseases can predispose to another, for example cardiovascular disease is a common complication of diabetes.

Protective factors in CALD background populations mean that adverse levels of health risk factors in first generation migrants tend to be lower than those of the general population. The process of acculturation can result in uptake of alternative behaviours and the progressive loss of the healthy migrant effect over time since settlement (Donovan et al 1992).

Acculturation and diet change

Studies into the diet of immigrants in Australia have found that:

- *Chinese people born in Australia and those with a longer length of stay tend to replace some traditional Chinese foods with wheat products, red meats and coffee (Hsu-Hage et al 1995);*
- *older Greeks living in Australia eat more meat, legumes, protein, margarine, poly-unsaturated fats and beer and less cereals, carbohydrates, wine and olive oil than people living in Greece (Kouris-Bazos et al 1996);*
- *the longer Vietnamese people live in Australia, the more likely they are to eat take-away foods (Brock et al 2001); and*
- *the diets of refugees and migrants from sub-Saharan Africa are likely to change to include more 'foods for white people', given their comparative socioeconomic advantage after migration, and the effects of cultural influences (eg television advertising) (Renzaho 2004).*

Health risks among migrants entering under a humanitarian program

The evidence base on health problems of refugees and asylum seekers in Australia is small, due to lack of research in this area of population health. Traditionally many refugees are in good health and seek to positively engage with the new society in which they find themselves; changing international, transnational and global circumstances may have an impact on the health status of new and future arrivals. However, these immigrants have experienced greater instability and disruption to their lives pre-migration, and may have more health problems and psychological distress, lower levels of income, and lower employment levels (DIMIA 2003).

In addition to the range of complaints similar to those of the rest of the Australian population, the following health problems are likely to be common among refugees (RACGP 2002):

- psychological disorders such as post-traumatic stress disorder, anxiety, depression and psychosomatic disorders;
- direct physical consequences of torture such as musculoskeletal pain or deafness;
- under-recognised and under-managed hypertension, diabetes and chronic pain;
- poor oral health, as a result of poor nutrition and diet, lack of fluoridated water, poor dental hygiene practices and limited dental care in the past;
- infectious diseases including tuberculosis and intestinal parasites; and
- delayed growth or development in children.

Key points

- While rates of death and hospitalisation are lower among Australians born overseas than among Australian-born people for many causes, these general trends do not necessarily reflect the inequalities in health that exist for many CALD background communities.
- Small and emerging communities (eg refugees and humanitarian entrants) may be particularly disadvantaged, contending with poverty, unemployment and under-employment, lack of affordable housing, lack of English language skills, social isolation and exclusion, discrimination and racism.
- Although many first generation migrants bring with them lifestyle behaviours that are protective of health, psychosocial risk factors associated with migration and settlement may damage health. Inappropriate acculturation and cultural bereavement can result in uptake of alternative lifestyle behaviours.

1.3 Culturally competent health promotion

Health promotion is integral to a population-based approach to healthier living and environments. Effective health promotion is based on relevant research findings, planned with the involvement of communities, provides appropriate preventive messages and is supported across all levels of the sector through policy and resource development. It is likely to improve health and wellbeing among people from diverse cultural and linguistic backgrounds and reduce short and long-term costs to the health system.

The following barriers to culturally competent health promotion and health services found in the literature highlight the need to take action across the health sector (Dept Human Services [Vic] 1996; Gow 1999; Ming & Ward 2000; Rowley et al 2000; von Hofe et al 2002; Dept Human Services [Vic] 2003; Migrant Health Service 2003; VicHealth 2003; Arrendondo 2004; Dept Health and Ageing 2004; Dept Human Services [Vic] 2004; Eisenbruch 2004a).

- **Lack of uptake of policy frameworks** — while policy frameworks for increasing cultural competency exist, they need to be integrated into all levels of the health system to dictate and support promotion of healthier living and environments in a cross-cultural context. Unless diversity issues are reflected in priorities, resourcing and reporting at every level, they will not be integral to health services.
- **Lack of evidence base** — although some studies have been done in this area (Singh & De Looper 2002; O'Brien & Webbie 2003), there remain many gaps in the evidence base. Mainstream research frequently excludes consideration of people from CALD backgrounds due to perceived methodological difficulties and costs. There has been much less Australian research on overweight and obesity relevant to CALD background population groups and communities compared to population groups who are predominantly English-speaking and of high literacy, and those who are able to easily access health services.
- **Inconsistent practice** — there is currently a lack of consistent practice in health promotion for healthier living and environments for CALD background communities.
- **Insufficient resources** — there is a lack of an appropriate level of resources to overcome constraints affecting policy development, program planning, professional development, language services and community development. Short-term project funding, as a whole, generally does not allow time for change or sustainability of positive outcomes. In the context of more diverse populations and the need to specifically address intergenerational issues, and the longer time required to undertake respectful and adequate consultation and preparation, short-term funding becomes prohibitive beyond establishing processes.

- **Lack of community participation** — system barriers to community participation include lack of work at grass roots level and lack of investment in community capacity building. A predominantly 'top-down' approach within health systems generally, excludes people from CALD backgrounds from identifying and developing health promotion strategies for healthier living and environments. As a result, health promotion programs and health programs may be implemented without appropriate consultation and community involvement from the outset.

Implications for health promotion

Factors identified through the literature review that improve effectiveness of health promotion include:

- integrated, multifaceted and properly planned communication strategies;
- formal and informal community information networks;
- community control or significant influence over design and implementation;
- established consultative processes;
- strategies that respect differences in interaction styles and approaches within individual communities;
- evaluation and feedback to the community;
- adequately funded language services, including access to interpreters and appropriate materials;
- cross-cultural training of health professionals and administrative staff;
- bilingual staff in health services; and
- working in partnership with multicultural service providers and non-government organisations.

Reciprocity at work

Programs are unlikely to succeed unless they are based on mutual respect and understanding and are adopted as a shared responsibility by the community. The limits of an exclusively top-down approach can also apply to CALD background community structures, so that use of informal networks as well as working through community leaders may be needed to encourage the participation of all community members.

1.4 Factors affecting healthier living and environments

Many factors reduce the participation of CALD background communities in health-promoting activities. These largely reflect the inability of the health system to engage people from all backgrounds.

Problems with resettlement (as outlined in Section 1.2), lack of familiarity with the complex Australian health system, and lack of consideration of the health and spiritual beliefs of different cultures, may make it difficult for CALD background communities to access health services.

A range of factors have been identified as affecting participation of CALD background communities in health-promoting activities. It should be noted that a very small proportion of the published peer-reviewed evidence base relates to influences and determinants of views, perceptions, attitudes and practice in relation to healthy living and environments for Australian-based CALD background people.

- **English language proficiency** — most health information about health services is in English, or is translated directly from English into community languages and so is not culturally relevant. Such 'literal' translations may lack cultural awareness and sensitivity. At other times communication difficulties can make it hard for people from CALD backgrounds to understand formal text chosen by service providers. This makes the expression of ideas and wishes difficult and may disempower CALD background individuals and communities (Karantzas 2003; Bayly 2001; Vic Dept Premier & Cabinet 2001; Eyler 2002; Procter 2003a; Reijneveld et al 2003).
- **Insensitivity to the needs of CALD background communities** — this can inhibit access to appropriate health services through, for example, a reluctance to use bilingual practitioners and/or interpreters to overcome communication difficulties. It requires service providers to understand the concept of culture and its impact on human behaviour, and recognise how specific problems are experienced, expressed and defined by consumers and carers of diverse cultural backgrounds (Procter 2003a).
- **Family responsibilities** — for many women, family obligations have to be met before undertaking other activities such as health-promoting activities (eg recreation and physically active initiatives). Their role as primary carer of children may also limit their involvement in recreation or sporting activities (Taylor & Toohey 1997; Lee & Brown 1998; Migrant Information Centre Eastern Region 2001; Eyler 2002). For some women, conventional methods or activities, such as the use of music in aerobics, is not permitted.
- **Social isolation** — having no one to go with to the health activity can be an impediment to beginning and maintaining a health activity or program, particularly for women from CALD background backgrounds

(Kondos 1994; Moseley 1997; Taylor & Toohey 1997; VicHealth 1997; Lee & Brown 1998; Eastern Perth Public and Community Health Unit 1999; Bayly 2001).

- **Access to transport** — people from diverse cultural and linguistic backgrounds may be more likely to attend services close to home or transport (Taylor & Toohey 1997; Migrant Information Centre Eastern Region 2001; Eyler 2002).
- **Cost** — the costs of health-related activities may limit access for individuals or families (VicHealth 1997; Migrant Information Centre Eastern Region 2001; Bayly 2001).

For women in particular there may be difficulties in accessing health care, including:

- cultural restrictions regarding movement in public spaces (eg needing a chaperone, not being allowed to drive, being financially dependent on the family);
- cultural restrictions on education and employment for women, which puts them in a highly dependent position when living in a culture where they do not know the language, the legal system or their rights, may have limited family and social networks and do not know how to access appropriate health services; and
- cultural imperatives for women to see female health workers (where necessary with the involvement of a female interpreter).

Implications for uptake of health-related activities

Factors identified through the literature review that may improve uptake of health-related activities include:

- appropriate publicity of activities;
- use of peer educators, role models and champions to engage CALD background communities;
- activities to raise awareness of and encourage access to the variety of culturally appropriate services available (eg GPs, dietitians, physiotherapists);
- delivering health services in consumers' preferred settings;
- family involvement in decision-making;
- opportunities to increase confidence and general skills and to see practical benefits (eg cooking classes, store tours); and
- having a range of activities in one venue catering for different ages, genders and skill levels; and
- working in partnership with key CALD background communities to increase community capacity building and encourage participation in different activities.

2 A MODEL FOR INCREASING CULTURAL COMPETENCY FOR HEALTHIER LIVING AND ENVIRONMENTS

This chapter outlines a model and four dimensions for action — systemic, organisational, professional and individual — to increase cultural competency for healthier living and environments.

Principles underpinning the model encapsulate a vision for a culturally competent Australian health sector and set the groundwork for the types of strategies and actions that lead to this vision. The principles highlight a number of areas to address cultural competence in the health sector, including legislative imperatives for action.

2.1 Principles underpinning the model

The following principles for a culturally diverse and competent health sector are founded on the universal human right of everyone to have access to health care that meets their needs and the reciprocal responsibilities that ensure these rights are upheld:

- engaging consumers and communities and sustaining reciprocal relationships;
- using leadership and accountability for sustained change;
- building on strengths — know the community, know what works; and
- a shared responsibility — creating partnerships and sustainability.

Engaging consumers and communities — reciprocal relationships

"Why should it always be the way that extra money is needed to provide these services? The thinking process is wrong — it should not be an afterthought" (Melbourne consultation)

All health consumers have a right to clear, relevant, accurate messages about their health and healthier living and environments. This is integral to a culturally competent health care sector and can only be achieved with the close involvement of CALD background communities.

CALD background communities share responsibility with the health care sector for accessing consumer views and ensuring messages are culturally relevant and responsive. The aim of establishing reciprocal relationships is that differing contributions and expertise of CALD background community members and health professionals is valued, learning is exchanged and partnerships formed.

"Given the educational needs and receptive attitudes expressed by parents and grandparents, we need to think beyond a home-based approach and consider a whole-of-community approach to public health interventions, mindful of the venues where children, parents and grandparents congregate and exchanges occur."

Green et al (2003)

Approaches that combine community development, capacity building and peer education help establish reciprocal relationships and strengthen a community's capacity to support its members and liaise with the health sector. In particular new and emerging CALD background groups and sub-groups of well-established CALD background communities (eg older people, women and adolescents) require sensitive health sector approaches that support participation.

However, sustained reciprocal relationships require support and resources. Adequate funding structures with realistic timeframes that allow

development of skills and resources, planning and prioritising, are essential for CALD background communities to participate fully in the development of services for themselves and their members. Lasting and effective partnerships result where representation reflects a community's diversity rather than being confined to hierarchical channels.

Using leadership and accountability for sustained change

The principles acknowledge that existing government frameworks mandate action on cultural competence (see Appendix C). These include charters and frameworks on a multicultural Australia, health and consumer rights that establish responsibility for cultural competency and set out legislative and ethical obligations for individuals and organisations across the four dimensions of the model.

"Cultural competency needs to filter through an organisation. Someone needs to be responsible for it and management needs to be supportive if it is to work." (Brisbane consultation)

Creating cultural competence requires a shift in thinking as well as practice. Mandatory measures are supported by initiatives that promote good governance and reward change. An approach that combines mandatory measures with incentives for improvement includes:

- strong accountability mechanisms;
- ensuring performance against these mechanisms;
- persuasive leadership for change at senior levels across the sector;
- applying existing tools and initiatives to create cultural competence eg risk assessment/management, continuous improvement cycles, triple bottom line reporting, safety and quality initiatives;
- systematic change management strategies;
- an evidence base built on culturally competent research that can inform policy, planning, education and capacity building, and evaluation; and
- measures to build a culturally competent workforce.

"The leaders of communities and mainstream providers have never had consultations with each other. They have lived together for 60 years and never spoken." (Sydney consultation)

Health organisations, policy makers and planners need to seek data, develop infrastructure, set achievable short, medium and long-term goals and use business best-practice tools to achieve sustained cultural responsiveness.

Building on strengths — know the community, know what works

An understanding of the diverse groups served by the health sector and the implications for health care are crucial for cultural competence. A population health approach builds this understanding through exchanges of information, sharing of data and interventions based on analysis of diverse community needs.

A wide variety of high quality research from a variety of methodological backgrounds needs to be nurtured and developed. Current and emerging practice in CALD background communities needs to be considered. This work acknowledges protective behaviours that are already at work within communities and enables identification of 'risk' behaviours. In this way the

effects of acculturation and changed context on risk and protection factors can be continually mapped, monitored and fed back to culturally diverse communities as well as decision-makers in the health sector.

A shared responsibility — creating partnerships and sustainability

Securing partnerships across the health sector in a systematic and sustained way is an important principle for increasing cultural competence. Issues can be identified and acted on in a long-term systematic way rather than through episodic ad hoc programs. Shared learning amplifies the benefits of other health strategies, helps to avoid mistakes and allows successes to be expanded and taken up across services more efficiently.

Community development strategies are more effective where they are funded for sustained outcomes, where partnerships are formed with larger, well-resourced regional, State or national bodies and other intermediaries (eg ethno-specific agencies, cultural groups, the media); and — where possible — links are made with well-resourced initiatives in broader health services.

Key points

- Consumers have a right to health initiatives that respond to their social, cultural, linguistic, gender and spiritual and/or religious diversity and promote their health and wellbeing in this context. This right is supported at all levels of government and across health and professional organisations and systems.
- Promotion of healthier living and environments is a reciprocal relationship — CALD background communities and the health sector seek to engage, learn and exchange at all stages of health care research, development and delivery.
- Leadership and accountability for cultural competence and responsiveness to diversity begins at the highest levels of systems, organisations and professions and continues to individual development and practice.
- A population health approach to developing a culturally responsive health sector emphasises data and information on the diversity of communities and acknowledges CALD background experience and successful practice, particularly in the areas of risk and protective behaviours.
- Increasing cultural competency is a shared responsibility requiring partnerships across the health and human services, education and research sectors, using systematic and sustainable approaches.

2.2 The model

This section presents the four-dimensional model for increasing cultural competency in the health sector, identified through the research conducted for this project. The model identifies the factors that create and support competency along each dimension. Tables on the following pages outline generic competencies in areas such as policy/evaluation, budgeting, management and consumer participation, together with corresponding strategies. Specific competencies are also given that might be used to promote healthier living and environments — illustrated by the area of prevention and management of overweight and obesity.

Integral to the model is the need for:

- capacity and conviction at systemic and organisational levels to direct, support and acknowledge culturally competent practice at an individual or professional level; and
- clear delineation of levels of responsibility and the interrelationship between these levels.

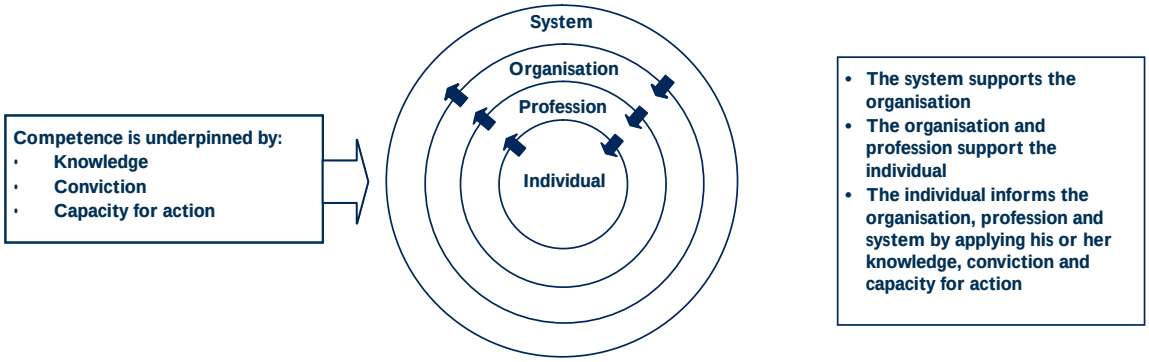
The model acknowledges four dimensions of cultural competency (Eisenbruch et al 2001):

- **Systemic** — effective policies and procedures, mechanisms for monitoring and sufficient resources are fundamental to fostering culturally competent behaviour and practice at other levels. Policies support the active involvement of culturally diverse communities in matters concerning their health and environment.
- **Organisational** — the skills and resources required by client diversity are in place. A culture is created where cultural competency is valued as integral to core business and consequently supported and evaluated. Management is committed to a process of diversity management including cultural and linguistic diversity at all staffing levels.
- **Professional** — over-arching the other dimensions, at this level cultural competence is identified as an important component in education and professional development. It also results in specific professions developing cultural competence standards to guide the working lives of individuals.
- **Individual** — knowledge, attitudes and behaviours defining culturally competent behaviour are maximised and made more effective by existing within a supportive health organisation and wider health system. Individual health professionals feel supported to work with diverse communities to develop relevant, appropriate and sustainable health promotion programs.

*The Commonwealth Government's **Productive Diversity Program** is articulating and promoting the business case for language and cultural diversity for the contribution it makes to gaining and sustaining a competitive edge in a globalised and diverse marketplace.*

The primary objective of the program is to encourage and assist Australian businesses to use the diversity available in their workforce to optimise performance, promote innovation and to connect with their diverse customers and business partners, and as a key enabler of business success. In partnership with corporates and specialists, the program develops management tools and business case studies based on best-practice examples of how utilising diversity can contribute to an organisation's bottom line.

Interplay between the dimensions of cultural competency



Source: Research and consultation report commissioned for this project (see Appendix B)

Systemic specifications

A culturally competent health system:

- acknowledges cultural competency as integral to core business;
- recognises that consumers move around the health system and that the whole system should support cultural competency and aspire to a seamless approach;
- resources the capacity and policy infrastructure to foster culturally competent practice;
- defines and disseminates information on core cultural competencies across the system;
- facilitates consistent and culturally competent research and data collection across jurisdictions to improve knowledge and monitoring;
- provides for increased utilisation of language services to support culturally competent practice;
- identifies a skill set for culturally competent practice and supports health organisations and individuals to value and achieve culturally competent practice;
- encourages a broader view of culturally competent practice through the promotion and marketing of health departments and health services, the built environment, and institutional respect for cultural traditions (eg diet, social customs); and
- supports community development as a key strategy to increase cultural competency for healthier living and environments.

Competency table for systemic specifications

Systemic specifications Generic	Application	Examples
Policy/evaluation		
• A prerequisite policy infrastructure exists to direct and support culturally competent practice in the health system. • The policy infrastructure embeds the notion of reciprocity to ensure the active participation of CALD background communities. • The policy is integrated into management planning and evaluation mechanisms in the health system. • A practical commitment to cross-cultural practice is demonstrated through evaluation and monitoring mechanisms for the policy.	• CALD background communities are engaged to examine the system level barriers to addressing the influences, causes and prevention of health risk factors. • Reciprocity is recognised in the content of strategies designed to prevent and reduce health risk factors. • Specific acknowledgement of the influence of various cultural beliefs and practices, as well as the social context for people from CALD background, are factored into policies, systems and projects.	• A local health network ensures sustained engagement of a reference group reflecting cultures within the local government area during the development and implementation of major policy and strategies that affect recreation and physical activity of residents. • Government departments and policy-making bodies work closely with multicultural peak bodies that can provide best advice for policy or curriculum development for environments to promote and support determinants of wellbeing and weight. • A discussion paper on 'Whole Environment Diversity' identifies factors that can support culturally sensitive health services including marketing, the built environment, signage and contractual arrangements (eg catering).
Budgeting		
• Budget and resource provisions are in place to support adequate cross-cultural training of main-stream workers. • High priority areas such as improved data collection and language services are supported by specific budget strategies. • An active compliance process ensures accountability for expenditure.	• Funds are allocated for processes that adequately consult and engage CALD background communities to make lifestyle changes. • Funds are allocated for additional structural and communication needs for appropriate surveillance, evaluation and monitoring. • Resources to target CALD back-ground communities in prevention projects are identified as part of core funding.	• Local agencies agree to identify opportunities for alternative ways to allocate their resources for a targeted program that promotes and evaluates local walking groups.
Consumer participation		
• The importance of harnessing community capacity is understood. • The role of participation by vulnerable populations is championed and ensured. • There is structural involvement of CALD background representatives in planning and service development processes and research and evaluation followed by health organisations.	• CALD background communities are actively and appropriately engaged to participate in designing and implementing interventions (eg through involvement of generations and acculturation influenced perspectives). • CALD background communities are encouraged to articulate issues relevant to healthier living and environments and their views on the most effective community approaches.	• A new government program provides financial incentives for community organisations and parent groups to organise community events that promote physical activity and access to affordable fresh fruit and vegetables. • CALD background community representatives work with a State health organisation, a teaching hospital and university on a 'diversity in health' curriculum, which incorporates consumer feedback and supervised placements for medical and nursing students.

Systemic specifications Generic	Application	Examples
Information		
• Population data and relevant health data exist that capture culturally and linguistically diverse information and are made accessible to health organisations.	• Appropriate categorisation of data is undertaken to ensure analysis of common cultural pathways and influences is considered. • Ethnicity and incidence data relevant to healthier living and environments are analysed to establish priority cultural and linguistic community targets.	• Data on births by mothers' age, cultural background, preferred language spoken at home or ethnicity and local area/health region are analysed and made available to health agencies involved in ante and postnatal care.
Education		
• Education establishes and communicates a vision for culturally competent practice and strategies that achieve it across organisations. • Education on roles, responsibility and accountability mechanisms for cultural competence is promoted.	• Appropriate information on vision and practice of a culturally responsive health service is made available to support system-wide training. • Mandates accountability training for managers. • Mandates induction/ orientation training on roles/responsibility for culturally competent practice.	• An information kit is distributed to all health organisations providing general information on aims for culturally responsive health care, roles/responsibilities and 'how to' information for managers. • A generic induction 'shell' kit is prepared for health organisations to use in conjunction with their own induction material. • Annual statistics on training held for new health workers and managers are collated and disseminated.

Organisational specifications

A culturally competent health organisation:

- recognises that its client base is diverse and includes people from a range of cultural and linguistic backgrounds based not simply on language or country of birth but on a rich diversity of heritage and culture and differing degrees of acculturation;
- acknowledges from the highest levels all the way through the organisation that cultural competency and diversity management are integral to core business;
- recognises that cultural competence is as much about changing itself as about changing the culturally diverse clients;
- forms partnerships with community groups, other health organisations, ethno-specific agencies and other sectors to make its policies and processes more culturally competent;
- moves away from a 'quick fix' approach and allows time and resources for sustained change;
- facilitates close community involvement, through the development of partnerships with adults, young people and families, in designing and implementing health promotion programs;
- recognises the benefits of diversity and dialogue across cultures and aims for a workforce that reflects the cultural makeup of the population it serves;
- employs bilingual staff and peer educators to work with CALD background communities;
- encourages exchange between CALD background communities and health professionals to ensure communities receive what they need and want;
- includes other health services and professionals in program development and encourages them to use interpreter and other language services;
- puts in place ongoing professional development for interpreters; and
- draws upon and where necessary creates an evidence base drawn from culturally competent research.

Leading change

Service leaders across all settings and at all levels can lead change by:

- *questioning ineffective monocultural governance structures and systems;*
- *understanding the dynamics of leadership and the role it plays in a multicultural context;*
- *identifying mutual benefits for the organisation and clients/staff;*
- *initiating dialogue with clients/staff about the service:*
  - *what is it that our service does/provides?*
  - *to what extent is it in the best interests of clients and staff ?*
  - *how culturally appropriate and sensitive are services?*
  - *to what extent are they in tune with the changing needs of consumers and carers?*

Procter (2003b)

Competency table for organisational specifications

Organisational specifications Generic	Application	Examples
Policy/evaluation • Commitment to cross-cultural policy exists and is captured in a relevant client/consumer charter. • Program planning is inclusive of cross-cultural considerations and requires community input. • Culturally sensitive evidence base considerations and outcomes are central to program evaluation and review. • Partnerships with community health services and key professionals are integral to program planning and delivery. • A process of diversity management is implemented where cultural diversity is acknowledged as enriching services for clients and employees.	• Culturally competent research on healthier living and environments is prioritised and generated. • Organisations concerned with healthier living and environments engage with CALD background communities to consider the relevance of prevention strategies. • Partnerships with community services experienced in aspects of prevention, or those experienced in social and mental health and wellbeing, healthy eating and appropriate physical activity are formed and maintained.	• Organisations work closely with ethno-specific and multicultural agencies during the design and planning of research and programs with a focus on healthy living and community wellbeing. • In response to consumer feedback and population data, a State/Territory health body funds 'well being partnerships' where ethno-specific community groups and local sporting clubs partner to increase healthy lifestyle practices and physical activity for identified age and gender groups.
Budgeting/resources • Health organisations have the capacity in the area of human resources, material resources and financial resources to provide and sustain culturally competent practice in the long term. • Health organisations reinforce their expectations in culturally competent practice through tiered and mandatory professional development addressing knowledge, capacity and conviction issues.	• Resource levels relevant to CALD background priority groups are identified. • Health and community service structures are able to support and resource responses to the health strategies. • Funding is allocated for culturally competent research and development of an evidence base on healthier living and environments.	• Organisations provide opportunities for gentle physical activity, identifying sports facilities that accommodate religious and cultural needs of clients and their families. • A project explores incentives for school-based lunchbox guidelines that account for cultural diversity within school communities. • A health organisation ensures language services are integrated across the continuum of services, as well as emergency and high-risk areas.

Organisational specifications Generic	Application	Examples
Consumer participation • Population data and relevant health data that capture diversity of cultural information exist and are used to identify CALD background communities. • Health organisations have the skills, knowledge, resources and existing networks to mobilise community resources and form partnerships with community groups. • Health organisations understand the importance of harnessing community capacity and involve CALD background communities in initiation of programs and resources. • The health organisation works with other community health services, traditional healers and professionals to research consumer need and disseminate information.	• The level and type of CALD background community participation required is identified with reference to jurisdictional coverage and sensitivity to the issue. • Community resources are sought to address healthier living and environment issues.	• Using population data that suggests lifestyle factors account for poorer outcomes following heart surgery for a specific group, a hospital liaison officer and community dietician work with an ethno-specific community group to develop strategies for improving dietary practices in the post-operative period. • A seniors' cultural community group in conjunction with a community health centre runs a series of 'Healthy Living' seminars on combining western medicine with traditional healing practices.
Management • Management competencies are articulated in performance agreements in relation to achieving an organisation with the capacity and commitment to work effectively in cross-cultural environments. • Performance within their competency is assessed. • There is organisational endorsement and support for diversity management initiatives (eg bilingual staff recruitment, cultural competency development, partnership processes).	• Program managers make the appropriate allocation of resources to foster sustained involvement of people from CALD backgrounds in development of programs addressing issues important to them. • The appropriate organisational resources required to engage communities and empower them to address healthy living and environments issues are identified.	• The annual budget for a health organisation allocates funds for the participation of CALD background community leaders in regular discussions with the board of management and to earmark funds for CALD background-specific development and outreach activities. • A Human Resource Unit works with managers, local CALD background groups and recruitment agencies to ensure best-practice recruitment outcomes that reflect the organisation's target population.
Education • Information and training in culturally responsive practice is provided to all mainstream workers appropriate to their role in the organisation.	• Information on cultural competence — including roles and responsibilities, the culturally diverse context of the organisation's client base etc — is provided to all mainstream workers. • There is ongoing professional development for interpreters and bilingual health workers. • Accountability training for managers is conducted.	• Cross-cultural training is offered to every new employee as part of the induction program. • Regular skills development and accreditation is provided or facilitated by the organisation.

Professional specifications

A culturally competent profession:

- builds cultural competency into both generic and specialist training and in professional development;
- develops cultural competency standards to guide the work of health professionals;
- disseminates information about specific CALD background groups to help health professionals become more confident in working with CALD background communities;
- ensures that generic skills rather than stereotypes are promoted, so that professionals understand that people are influenced by their cultural context and circumstances but are not defined by them;
- promotes generic and specialist skills in cross-cultural training; and
- encourages and supports integration of cultural competencies into health professional practice.

Competency table for professional specifications

Professional specifications Generic	Application	Examples
Professional development and training • Professional bodies and training institutions include cultural competency in entry level education of health professionals. • Professional bodies provide their members with ongoing opportunities for generic and specific professional development in cultural competency.	• Professional development and training include diversity considerations and sensitivity training in relation to developing strategies and communication aspects of policy, plans and interventions.	• Communication with families to explore opportunities for activity within family life is covered in professional newsletters and updates. • Professional bodies provide or promote member attendance at seminars on cultural competency and related skills.
Self-reflection • Health professionals are respectful and empathetic when dealing with CALD background patients. • Health professionals have the capacity to understand the potential impact of the cultural and linguistic background of clients (health behaviours, communication styles, treatment options, decision-making). • Health professionals have the conviction, skills and understanding to adapt practice to cross-cultural requirements (context considerations, time, resource requirements, alternative approaches).	• Health professionals engage members of diverse CALD background communities to understand the differences in values placed on determinants of health risk factors. • Professionals consistently seek to understand the perspectives of CALD background in any health program, strategy or engagement.	• Health professionals understand cultural expectations, values and experiences as the context for providing advice and interventions eg in relation to chubby babies, weight, contraception and physical activity. • A group of general practitioners and CALD background community leaders and health workers meet regularly to exchange information on issues such as communication protocols, immunisation and flu vaccine programs, medication management and treatment options.

Professional specifications Generic	Application	Examples
Information • Health professionals have acquired knowledge and can access information about CALD background communities, their histories and specific health issues as the context for understanding culture and health interactions. • Health professionals know about the range of resources to support cross-cultural practice (interpreters, translated resources, community partners). • Health professionals undertake a mapping exercise to understand the multicultural referral system so they are able to contact these services if they need to.	• Health professionals access information sources and experts on CALD background communities. • Where information is unavailable, health professionals commit to consulting widely and engaging relevant communities early in the process in order to minimise harm and maximise shared outcomes. • Health professionals and organisations sustain contemporary awareness of influences and relevant services available to differing communities.	• Health professionals contact community health services and multicultural resource centres for respected community workers/ peer educators who have knowledge and expertise in the values and norms of their respective communities in relation to dietary habits, norms, practices, and concepts of activity and leisure. • Health promotion activities (eg messages on physical activity) take account of different contexts and cultural perceptions of leisure, status, social and gender roles.
Education/skills • Health professionals include cultural and linguistic considerations in their decision-making. • Health professionals have the capacity to use resources to allow cross-cultural communication (interpreters, translated resources, community partners). • Health professionals separate their own values and beliefs from their clients' in their judging and decision-making.	• Cultural considerations are taken into account in proposing interventions. • Appropriate information tools are utilised to deliver a culturally appropriate set of messages about health promotion and health supporting environments.	• A health professional seeks advice and support from relevant community and multicultural groups and arranges support and interpreter services for a CALD background patient in preparation for discussion of treatment options with patients and families.

Individual specifications

A culturally competent individual:

- acknowledges the importance of cultural understanding to achieve effective communication;
- feels confident in his or her abilities to communicate effectively with CALD background groups;
- can advocate with and/or on behalf of clients and their communities;
- recognises and respects that communities are their own cultural experts and is able to facilitate a community development approach;
- appreciates that many people from CALD backgrounds need to involve family and community in discussions about health related issues;
- feels comfortable about involving an interpreter when there is a language barrier;
- understands how differences in culture, language and migration experience may have an impact on the way health promotion programs are developed;
- shares their experiences with other health professionals while respecting confidentiality;
- has undergone a process of self-reflection to understand the impact of personal cultural identity on his or her practice; and
- undertakes continuing professional development to develop the necessary skill set to foster culturally competent practice.

Self-reflection leads to: "the effective care of a person/ family from another culture by a person who has undertaken a process of reflection on own cultural identity and recognises the impact of their culture on own practice."

Eisenbruch et al (2001)

A health professional with cultural capabilities identifies how his or her cultural values, assumptions and beliefs affect practice and decision-making, and respects, informs, consults and negotiates with people in a way that accounts for their cultural choices about healthier living and environments.

Eisenbruch (2004b)

Competency table for individual specifications

Individual specifications Generic	Application	Examples
Self-reflection		
• Individuals have the capacity to consider cultural and language specific issues in health promotion. • Individuals have the conviction to adapt practice to be inclusive of cultural and linguistic diversity (context considerations, participation and partnership requirements, time and resource requirements).	• Consider cultural, linguistic and migration issues around food and activity, knowledge and choices. • Consider differing perceptions about body image and the role of specific activities as recreation. • Understand the significant place that diet, and activity behaviours play in processes of cultural maintenance. • Understand intergenerational differences with respect to attitudes to food and activity.	• Health professionals focus on positive messages eg appropriate foods and food preparation techniques both from the culture of origin and the host country. • A practitioner reconsiders her approach and seeks expert CALD background input and specialist medical and health professional advice when she finds that patients from a particular CALD background group do not respond to her presentation of dietary information and instructions for management of diabetes.

Individual specifications Generic	Application	Examples
Information		
• Individuals have acquired knowledge and can access information about communities, their histories and specific health issues as required. • Individuals know about the range of resources to allow culturally competent practice (interpreters, translated resources, community partners, face-to-face sessions). • Individuals can access health promotion messages in different languages in a culturally sensitive context.	• Identify priority CALD background groups through data acquisition and analysis relevant to service jurisdiction. • Understand diet and physical activity issues relevant to these groups; and the differences within groups — gender, age, education, generational.	• Health professionals share web-based resources that encourage good practice and provide basic community-specific information relevant to cross-cultural health promotion (eg the Centre for Ethnicity and Health website www.ceh.org.au). • A rural general practice contacts the local division of general practice for assistance to establish links with new immigrant families to understand diet and physical activity issues.
Education/skills		
• Individuals can position health promotion within a linguistic, cultural and migration context. • Individuals have skills to mobilise community resources to inform the communication process. • Individuals understand and are able to determine a sensitivity of the specific health issue and its implications for both approach and timeframe relevant to achieving behavioural change. • Individuals consider each client's pre-migration experience, health beliefs and the impact of these on their health and behaviour. • Individuals can identify the most effective strategies including audience segmentation, message design, media use, partnership arrangements, and response and activity design. • Individuals have the capacity to use resources to allow cross-cultural practice (interpreters, resources, community partners). • Individuals can critically appraise the scientific evidence base for cultural bias and recognise culturally appropriate evidence. • Individuals can evaluate interventions and programs in a culturally appropriate fashion.	• Work with communities to identify protective and risk environments and behaviours to improve healthy eating and increase physical activity. • Design an approach and messages that are informed and developed from within the specific cultural context. • Develop health promotion messages that resonate with communities and build on protective environments and behaviours. • Identify formal and informal media and types of informant who will carry the message, with a particular consideration of authority voices in CALD background communities. • Allow for message reinforcement by equipping health professionals responding to food, activity, psychosocial and wellbeing issues with the necessary resources. • Participate in and facilitate partnerships between individuals or communities and health care providers in individual care and in policy setting.	• A community health service works with an ethno-specific community group to develop a physical and mental fitness program for young people and funds representatives to attend youth health/ lifestyle conferences eg on drug use, crime, alcohol and smoking. • A general practice develops a simple protocol for use by its health professionals to help consider all relevant issues when interviewing and treating clients and their families. • A community worker translates results from local parent education programs on healthy eating into press releases and builds relationships with ethnic radio stations and ethnic newspapers to disseminate that information, working with interpreters where health professionals don't speak community languages other than English. • A general practitioner informs herself about positive culturally appropriate health for a CALD background client group that is highly represented in her practice.

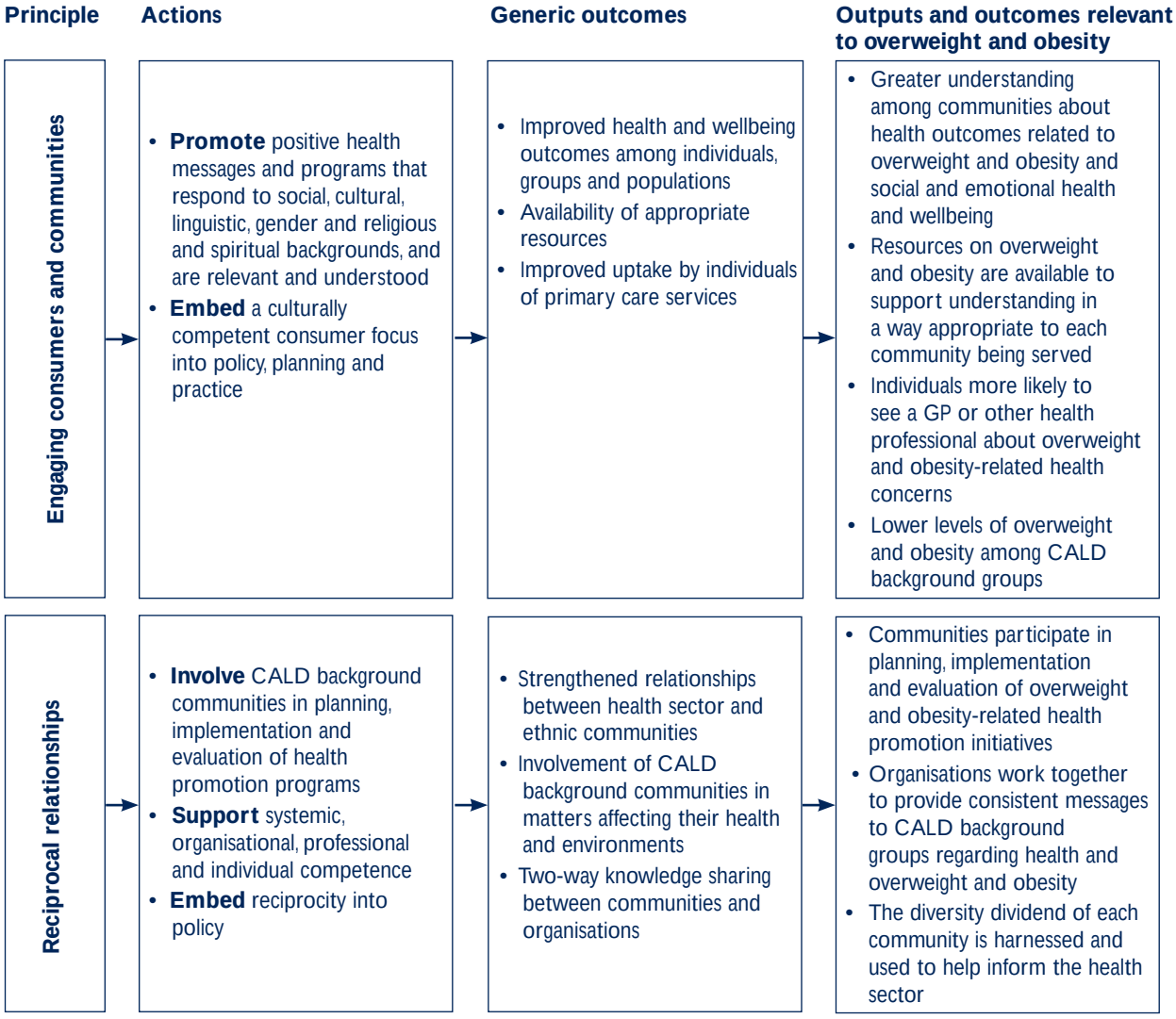
3 PUTTING THE MODEL INTO PRACTICE

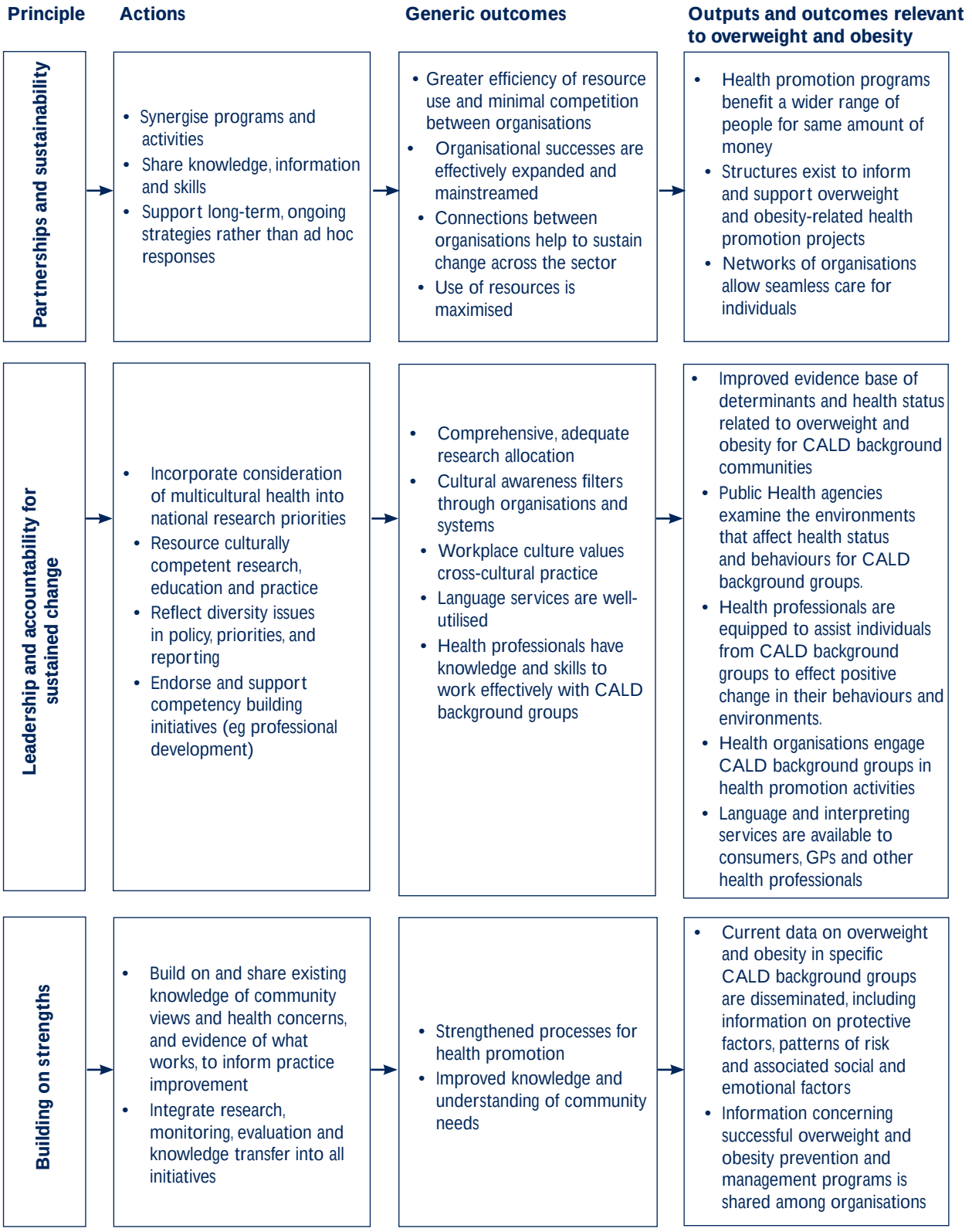
This chapter gives guidance on how the model of cultural competency can be put into practice and how the competencies at the four levels of the model can work together.

The chapter includes:

- a flowchart showing how actions guided by the principles presented in Chapter 2 can enhance cultural competency and improve health and wellbeing for CALD background communities;
- considerations for developing culturally competent health promotion programs and projects, illustrated by examples of evaluated projects at local level; and
- scenarios that highlight strengths and weaknesses in approaches to developing culturally competent health promotion programs, with a focus on overweight and obesity.

3.1 Turning principles into actions




Principle
Actions
Generic outcomes
Outputs and outcomes relevant to overweight and obesity
Partnerships and sustainability
• Synergise programs and activities
• Share knowledge, information and skills
• Support long-term, ongoing strategies rather than ad hoc responses
• Greater efficiency of resource use and minimal competition between organisations
• Organisational successes are effectively expanded and mainstreamed
• Connections between organisations help to sustain change across the sector
• Use of resources is maximised
• Health promotion programs benefit a wider range of people for same amount of money
• Structures exist to inform and support overweight and obesity-related health promotion projects
• Networks of organisations allow seamless care for individuals
Leadership and accountability for sustained change
• Incorporate consideration of multicultural health into national research priorities
• Resource culturally competent research, education and practice
• Reflect diversity issues in policy, priorities, and reporting
• Endorse and support competency building initiatives (eg professional development)
• Comprehensive, adequate research allocation
• Cultural awareness filters through organisations and systems
• Workplace culture values cross-cultural practice
• Language services are well-utilised
• Health professionals have knowledge and skills to work effectively with CALD background groups
• Improved evidence base of determinants and health status related to overweight and obesity for CALD background communities
• Public Health agencies examine the environments that affect health status and behaviours for CALD background groups.
• Health professionals are equipped to assist individuals from CALD background groups to effect positive change in their behaviours and environments.
• Health organisations engage CALD background groups in health promotion activities
• Language and interpreting services are available to consumers, GPs and other health professionals
Building on strengths
• Build on and share existing knowledge of community views and health concerns, and evidence of what works, to inform practice improvement
• Integrate research, monitoring, evaluation and knowledge transfer into all initiatives
• Strengthened processes for health promotion
• Improved knowledge and understanding of community needs
• Current data on overweight and obesity in specific CALD background groups are disseminated, including information on protective factors, patterns of risk and associated social and emotional factors
• Information concerning successful overweight and obesity prevention and management programs is shared among organisations

3.2 Strategies for culturally competent promotion of healthier living and environments

Working with communities is fundamental to culturally competent health promotion programs and projects. This entails exchanging information with communities so that they have input to and feedback on all stages of the initiative from needs definition and planning through to evaluation and dissemination of the findings.

Partnering with ethnic communities

A common finding of existing interventions is the need to partner with ethnic communities to ensure cultural competence in health promotion.

There is a vast array of different strategies for CALD background consumer participation that can be used to engage CALD background consumers in planning, implementing and evaluating health programs, projects and services. All of these strategies are important and as many as possible should be used to adequately represent consumer views. The more that CALD consumers are able to participate in different ways, the more likely an organisation is to be responsive to their needs. Below are examples of different strategies, adapted from a resource developed by the Centre for Culture, Ethnicity and Health (CEH 2004):

- **CALD background consumers on Boards of Management—** organisations are provided with representation on Boards of Management that reflects CALD background communities within the area;
- **consumer planning days —** an issue relevant to a particular CALD background community is identified and presented to that community to make decisions which are incorporated into planning processes;
- **consumers on project/reference groups —** organisations seek participation by CALD background community members in planning processes and contribution to implementation and evaluation;
- **consumer advisory groups —** CALD background consumers are engaged to provide input to groups that are separate from Boards of Management to elicit responses to particular questions;
- **focus groups —** CALD background consumers are invited to participate in organised discussions and to share their views and experiences on a particular topic; and
- **informal sessions and printed materials —** sessions are held to provide information to CALD background communities about relevant health issues and services and associated printed materials are also distributed.

People working with CALD background communities need to be mindful of cultural differences in communication styles (DAA & ADEA 2005). Suggestions for encouraging participation include paying a sitting fee,

The Reciprocity in Education project

Based on a model of interactive learning between mainstream mental health services and three CALD background communities, the brief for this SA project was developed by consumers, carers and a local advisory group.

Evaluation of the project highlights a number of its successes, including:

- *establishing reciprocal learning between health care workers and the CALD background communities;*
- *developing the key role of CALD background community educators who acted as a communication bridge;*
- *innovative use of a culturally appropriate definition of 'depression' and the use of composite stories as a vehicle for sharing learning;*
- *providing a reflective vehicle for mental health workers to engage with the community about their cultural perspectives;*
- *influencing professional behaviour and attitudes towards mental health methodologies and interventions for people from CALD background communities; and*
- *creating ongoing networks and a useful model for further application.*

Procter (2003a)

and modifying the formal structure of committees to include structured interviews, home visiting, peer visiting and attendance at CALD background community gatherings.

Consumer participants need to be supported not just by providing information but through continuing processes such as mentoring (CEH 2004).

Gathering information

The information needed to support cultural competency in promoting healthier living and environments will vary depending on the type of program planned. In all instances it is necessary to research target groups based on community demographics and to keep regular CALD background population statistics as part of the demographic profile. The influence of various cultural beliefs and practices, as well as the social context for people from CALD background, is an important part of any profile. Some States and Territories have reporting frameworks that may assist. Other sources of information may include State/Territory population health units for risk factor and chronic disease prevalence surveys, ABS demographic and National Health Survey data, longitudinal surveys (eg Women's Health Australia survey), Divisions of General Practice local community surveys, public health units, and university departments working on community health projects.

Variation exists within cultural groups. To ensure that health messages are conveyed appropriately to the target community, it is important to obtain demographics within as well as between CALD background community groups to inform resources and specific approaches that will be necessary.

For effective evaluation of a program or project, it is necessary to gather baseline data. Quantitative data can be used to assess changes in outcomes while qualitative data can be used to determine changes in perceptions or knowledge. Innovative ways of gathering data may be required — for example, standard pre and post questionnaires may be inappropriate.

It is useful to gather information on similar initiatives, particularly if they have been evaluated and any tools validated.

While written consent may not always be appropriate it is essential that all participants are aware of the information they are being asked for and how this information will be used, and consent is provided verbally.

Working with others

As well as working with communities themselves, it is important to develop ongoing networks and relationships with CALD background community groups and agencies that provide services to CALD background communities. This provides the opportunity to engage in reciprocal learning, valuing the lived experiences of others, supports ongoing dialogue and helps to avoid duplication of effort (Procter 2005). Building relationships with other organisations and individuals can also broaden the capacity of an organisation and increase access to resources.

Qualitative study finds exercise programs need to be targeted

This study of Polish, Dutch, Greek and Macedonian women found large demographic differences between the ethnic groups, particularly in education and English competence. This indicates the inappropriateness of community programs that assume that all CALD background Australians will respond equally to the same interventions.

Lee & Brown (1998)

Learn to swim program for Muslim women in Eastern Perth

This project achieved good attendance and results through:

- *community consultation;*
- *recruiting through various local community organisations;*
- *implementation at a very local level (including consideration of child care, transport needs and family commitments);*
- *investing time and resources into developing trust between program enablers and the women;*
- *ensuring women were given specific times to swim when men were not present at the pool; and*
- *focus on collaboration and partnerships between local government and the Arabic speaking community.*

Eastern Perth Public and Community Health Unit (1999)

With high staff turnover and changes in governance, it can be hard to maintain partnerships between organisations. While it may require the drive of an individual to build goodwill between organisations, continuing the partnership should not rest with individuals. Linkages may be formalised as partnerships (eg through an agreement signed by the CEOs of the organisations). As well, systems need to be developed so that linkages become a standard part of organisational processes, for example through protocols, regular meetings or phone calls, and processes for sharing information.

Getting the methodology right

While all methodologies will be based on the basic structure of planning, implementing and evaluating, details of the method will vary with each project. Involving communities in needs definition and planning from the outset will help to ensure that:

- the different needs of different groups within the community are recognised;
- the linguistic needs of CALD background groups are met (eg via use of interpreters and in language or translated resources where appropriate); and
- culturally appropriate promotional strategies and media are used for program recruitment and social marketing campaigns.

Investigate the types of media that different CALD background communities use. The use of traditional ethnic channels — print and radio — is a basic component of any information or education activity targeting CALD background communities. The ideal campaign is an integrated mix of traditional and ethno-specific media (Vic Dept Premier & Cabinet 2001).

Using a variety of approaches is likely to give greater coverage. For example, a combination of the following will help to reach a wider audience than a single approach:

- appoint participants as peer educators to spread the word;
- use local newspapers and community health centre newsletters and local media (eg radio);
- undertake broad public education campaigns; and
- use ethnic and community radio.

It is also important to take a flexible approach to implementing the program. Monitoring outcomes and/or performance during implementation and comparing these to baseline data collected at the start of the program will help to determine the type and extent of any problems with the methodology and opportunities for improvement.

Providing awards (tangible or intangible) may help to encourage and maintain sustainable linkages between the health organisation and the community.

Listening to ethnic communities about diabetes

The Migrant Resource Centre North West (Victoria) ran a program to develop, pilot and evaluate culturally appropriate strategies for supporting self-management of Type 2 diabetes. Maltese, Vietnamese and Filipino communities were involved from the planning stage, on the Steering Committee, on focus groups and in development and implementation.

A consumer participation approach focused on developing specific strategies for the different communities, and was flexible enough to adapt to community feedback throughout the project.

Project evaluation found that it offered high quality, appropriate and accessible models of self-management of diabetes to the target communities.

Centre for Culture, Ethnicity and Health (2004)

Engaging people from CALD backgrounds

A research project that consulted Greek, Samoan and Arabic speaking communities in NSW, Qld and Vic found that participants wanted health messages delivered via a range of media. Each community is different and consideration needs to be given to differences in preferred language, literacy levels, living environment and level of understanding of the health condition of interest. Therefore a suite of educational materials would be more appropriate to effectively engage these communities.

DAA & ADEA (2005)

Evaluating projects and sharing the findings

Regardless of the scope of a health promotion program, evaluation provides the only effective way to learn about the impact you are having on intended and unintended outcomes (as well as potential benefits and harms) and allows this information to be fed back into the organisation and community. It is important to:

- establish performance measures based on community expectations and goals, appropriate to the program;
- ensure evaluation methodologies are able to provide the information sought, and are developed and deemed appropriate in consultation with representative CALD background community members;
- implement evaluation procedures in partnership with CALD background community representatives and leaders; and
- aim to demonstrate that initiatives, work practices or achievements meet the needs expressed by CALD background communities.

Models of culturally specific interventions and education programs that have been shown to improve outcomes include:

- *clinics in a general practice setting;*
- *community education programs combined with family support;*
- *one-on-one teaching interventions;*
- *focus groups; and*
- *use of a bilingual community health worker.*

von Hofe et al (2002)

Knowledge transfer is a recognised responsibility. Transferring the findings from successful and effective programs into both professional and community development is important in ensuring that the findings filter back up to the organisation to influence resourcing, and findings are also transferred the other way back to the community.

Publishing an evaluation report is a first step towards disseminating the findings of the program but it is not enough on its own. Other strategies for sharing the learnings from a program include:

- training through workshops, train-the-trainer and continuing professional education;
- communication through print, video and computer technologies (such as databases of good practice stories);
- library databases, search systems and websites;
- policies, administrative arrangements and funding incentives;
- committees and other decision-making structures; and
- collaborative applied research programs that can also lead to the publication of reports in peer reviewed scientific and professional literature.

It is essential that budget allocations recognise the additional structural and communication needs required for appropriate surveillance, evaluation and monitoring.

Key points

- Engaging consumers from CALD backgrounds can occur on a number of different levels, all of which have benefits and issues. Different levels of participation may be relevant to different stages of a project and may also depend on background, situation and age.
- Planning involves demonstrating ongoing networks and relationships with CALD background communities, maintaining community demographic profiles and ensuring that problem definition and choice of strategies incorporate community consultation findings.
- Program design should include mechanisms to support reciprocity for partnerships, ongoing dialogue and continuing information exchange and capacity building.
- Methodologies should include a variety of approaches and be flexible enough to adapt to community input at all stages of the project.
- Evaluation is essential to improve the evidence base for health promotion practice in CALD background communities. It can be used to establish whether a program has achieved its goals and objectives, to secure additional funding, to identify opportunities for improvement, and to enable continuous quality improvement.

3.3 The model in action — scenarios

This section provides examples of how the strategic changes and competencies described in Chapter 2 and the strategies outlined above can be brought together to support culturally competent best practice across all levels of the health sector. This is illustrated through scenarios based on real life examples that describe initiatives at national, State/Territory, regional and community levels. Each scenario is followed by an analysis of the initiative, which highlights the benefits and limitations of the approach described.

Scenario 1 — National media campaign promotes healthy eating

Under the direction of a steering committee set up for the purpose, a national organisation developed a campaign to raise awareness among CALD background groups of the importance of maintaining a healthy weight. The campaign's aim was to focus on groups identified through research as undergoing changes in dietary patterns and increasing overweight and obesity.

Representatives from these communities were engaged in a number of ways:

- *draft brochures were reviewed by ethnic advisory groups and revised accordingly;*
- *revised brochures were re-focus tested by ethnic community members and again revised; and*

- *brochures were translated into 10 languages and distributed at commercial venues (shops, banks, etc) for relevant communities.*

Evaluation of the campaign was through interviews with adults from the cultural groups before, during and after the campaign. The published evaluation report showed that the messages had been taken up better by some cultural groups than others. The findings suggested that the development process itself may not have been appropriate for all groups.

Discussion points for scenario 1

What worked well?

- **Research** — Existing data were analysed to identify groups that would benefit most from the campaign.
- **Leadership** — The nature of the campaign shows leadership for cultural competence and responsiveness to diversity at a national level.
- **Community engagement** — The consumer advisory and focus groups encouraged dialogue with consumers from a range of ethnic backgrounds.
- **Evaluation** — Baseline data were collected before the campaign was implemented to allow comparison with qualitative data collected both during and after the campaign.
- **Knowledge transfer** — Publication of the evaluation report allowed for transfer of the findings of the campaign, including findings on the methodology employed.

What could have been done better?

- **Partnerships** — Working with relevant community organisations may have streamlined the process, facilitated community engagement and provided a foundation for ongoing dialogue.
- **Community involvement in planning** — Findings from the final evaluation suggest that it would have been of benefit to involve cultural groups in planning the project as opposed to focus testing the developed product, preferably through representation on the steering committee.
- **Methodology** —An integrated mix of traditional and ethnic specific media (eg augmenting the campaign through local print and radio) may have reached more people. Translating one resource into multiple languages decreases cultural specific relevance. It is preferable to create ethno-specific resources catering to the needs and wants of each target group. Employing culturally appropriate evaluation methods would enhance the quality of data collected.
- **Sustainability** — Community partnerships should be cultivated to enhance ownership over resources and to assist in dissemination and promotion of the materials in small group settings.

Scenario 2 — State Department supports cultural competency in language service provision

A State health authority was undergoing a process of culture change under the leadership of a newly appointed director. Previous research had identified priorities for action across the sector, including improving access to primary care for people from CALD backgrounds. The challenge was to make cultural competency integral to core business and ensure that it was supported across the department.

Critical intervention points (ie areas with the greatest potential to improve health and wellbeing) were identified as: improved use of language services by health professionals; employment of bilingual staff; and cross-cultural training for health professionals, including managers of health services.

A program to support the improved use of interpreters was rolled out first. A multi-faceted approach was taken to implementing the program:

- *guidance on developing local policies and procedures to support the improved use of interpreters and translators was provided through an information kit distributed to community health services;*
- *information sheets on how to work effectively with interpreters were disseminated to primary health care professionals throughout the State; and*
- *a brochure outlining primary care services available was disseminated to the public through migrant resource centres and ethno-specific organisations.*

The published evaluation of the program — including analysis of qualitative data on community health service use of interpreters relative to cultural breakdown of patients, surveys of GPs, and interviews with consumers — found that while health organisations and professionals had increased their use of interpreters, consumers were still unlikely to seek their assistance. Further work in this area was planned.

Discussion points for scenario 2

What worked well?

- **Policy and resourcing** — The program showed a commitment at the systemic (State) level to increasing access and providing equitable service to people in need of language support to communicate with the health system.
- **Leadership** — The program required the leadership of a committed high level manager and organisation.

What could have been done better?

- **Reciprocity** — There was little involvement of consumers in identifying consumer needs and no community engagement in development of the project. This may explain why the program had least success in improving consumer use of interpreters.

- **Evaluation** — Although information was gathered from organisations, health professionals and consumers on the uptake of interpreters, no data was collected that could be used to inform service development, support sustainability or improve uptake of interpreters by consumers.
- **Methodology** — The brochure in English is limited to English literate audiences only. The program's resource development strategy could have been further supported by State policy mandating the implementation of adequate policies and procedures relating to language service usage by primary care organisations.
- **Partnership** — Although professional bodies were engaged in disseminating program materials, there was no partnership approach taken to program planning and development and little support for sustained improvements in practice.
- **Sustainability** — To ensure sustained change, the Director and other senior management should ensure regular reporting on progress and analysis of data at local area or regional level. They might also allocate an ongoing percentage of budget resources, subject to evaluation of outcomes, and extend human resource strategies eg training health professionals and managers of health organisations.

Scenario 3 — Focus on overweight and obesity in a rural region

Published research had identified that although people from Somalian, Sudanese and Eritrean communities had few problems with overweight and obesity on settlement, low levels of physical activity and changes in diet in Australia were leading to increasing overweight and obesity in these groups. Past projects in the region had shown some success but limited evaluation and high staff turnover meant that knowledge gained had been lost and changes in service delivery had not been sustained.

In collaboration with the local community, the area health service designated resources for a new project. Two steering committees were convened — a project management committee and one with representatives from each of the three communities.

Interviews were conducted with community members to identify culturally significant barriers affecting access to primary care and health beliefs on overweight and obesity:

- *limited understanding of the Australian health system;*
- *lack of knowledge about the causes of chronic diseases; and*
- *limited understanding of the impact of overweight and obesity on health.*

A forum was held to provide feedback to the communities on the above findings and to seek further comment and direction. Bilingual educators were used to explain the relationship between overweight and obesity and health.

Existing resources on overweight and obesity were evaluated for their appropriateness for the communities and a resource kit developed for each

community, drawing on information collected through the interviews and forums. Health professionals ultimately determined the information to be included in the resource kit. While similar, the kits reflected the differing needs identified in each community. The kits were then distributed to health professionals including GPs via relevant networks. It was hoped that the kits would be used to improve health education offered to members of these communities.

Discussion points for scenario 3

What worked well?

- **Community involvement** — Community needs were identified by the consumers themselves through consumer interviews at the outset of the project. Feeding the information back to the community ensured that needs had been properly understood by project management.
- **Reciprocity** — Beginning with community interviews, validating these with health professionals and then returning to the community forum to gain further direction and provide feedback proved to be a successful strategy. A community feedback loop is an important part of maintaining a respectful relationship with community members.
- **Existing networks** — The project benefited from being able to tap into emerging networks of ethno-specific community resources and services. The initial phases of the project were effective in furthering links with key groups in the local community and increasing the understanding of overweight and obesity and its impact on health.

What could have been done better?

- **Evaluation** — Little time and resources were available for evaluation. In future, a percentage of the budget should be allocated during the planning stage for evaluation.
- **Leadership** —Ongoing strategies are required, aimed at health professionals, which would support increased cultural competence at professional/individual levels. Providing kits without ongoing professional development and support would limit their use.
- **Sustainability** — Steering committees and partnerships created for the project could be used to embed change and evaluate sustained outcomes.

Scenario 4 — Dealing with diabetes in a small community

A registered nurse working in the health service in a small community was impressed by results of a program to improve diet and physical activity — a community theatre project — among South Pacific Islanders with diabetes. She decided to trial the program among the Greek population in her area. However, there was only a minimal response and the project could not proceed.

Uncertain how to approach the community, the nurse sought advice from the priest at the Greek Orthodox Church. She was then able to meet with a small group of community members and begin discussions about the type of project that might be appropriate.

A steering group including community representatives was convened and worked with community members to identify a program of appropriate activities —food shopping tours and increasing culturally relevant food availability. The support of the health service's Board of Management meant that this food security project could be conducted by staff members during work hours. The shopping tours proved so popular that evening sessions were also started, with funding from the Greek Orthodox Church.

The availability of healthy food that was part of the Greek cuisine improved as local food operators and shop owners were encouraged and supported to supply healthier varieties of various Greek foods. The project became established at this point and so participants were encouraged to attend the health service for preparation of a management plan (using Medicare Chronic Disease Management items).

Analysis of data gathered through the project — biometric data, participation levels and participants' perceptions of the project — suggested that the project was successful in improving access to healthy foods as well as health behaviours. However, no staff involved in the project had the time or expertise to develop an evaluation report that could be published so the findings from the project have not been more widely disseminated.

Discussion points for scenario 4

What worked well?

- **Consumer involvement** — The subsequent project took a high level approach to consumer participation, supporting ongoing participation by community members and business owners in planning processes and contribution to implementation and evaluation.
- **Partnerships** — The involvement of the local Greek Orthodox Church provided mechanisms for both accessing community members and sustaining change.
- **Relevance** — Food shopping classes were relevant to Greek cuisine, so that participants were able to use what they had learnt in their everyday lives.
- **Methodology and sustainability** — The project used a multi-strategy approach to the issue, not just health education. Creating a supportive environment for change, by looking at food availability that is culturally appropriate increases sustainability. Funding gained through use of the Medicare Chronic Disease Management items can be used to help sustain the project.
- **Evaluation** — The collection of both quantitative and qualitative data enabled evaluation of both the changes in health outcomes resulting from the project and the success of the project as a community building initiative.

What could have been done better?

- **Reciprocity** — The initial approach (the theatre project) did not engage the community in any way, rather applying principles that had been effective in another setting and with another target group without consulting the community for cultural appropriateness.
- **Partnerships** —while the support of the Church may have improved acceptance of the project among some community members, it could also reduce participation among others. Use of informal connections as well as formal community channels might better reflect the heterogeneity of the community and help to maximise participation.
- **Leadership** — Although the project was initiated by an employee, and there was a prompt, supportive response from the organisation and commitment to the project, leadership is needed to move from one-off individual cultural competence to sustained organisational competence.
- **Knowledge transfer** — The lack of secured funding to support publication of the evaluation report (eg to allow the nurse time to write the report) meant that the program's findings were not disseminated.

Scenario 5 — Focus on physical activity and Muslim women in a local government area

The president of the local Muslim Women's Association became concerned that Muslim women were not participating in regular physical activity or exercise programs provided by the local community health centre. Nor were they members of local sporting clubs and gymnasiums. She decided to approach the Arabic-speaking access worker of the local migrant resource centre. Through her encouragement and guidance the president approached the local council with this issue. In response to the issue the Recreation Department appointed staff to find out more in order to develop an initiative to encourage more Muslim women to participate in regular physical activity.

The staff visited small groups of Muslim women in their homes and over coffee asked them informally about the barriers to participation in physical activity.

Some of the reasons identified were:

- *lack of women-only venues, childcare, transport;*
- *absence of Arabic-speaking and culturally appropriate physical activity classes; and*
- *prioritisation of family duties.*

The council staff encouraged the women to plan appropriate activities to meet their needs. The women were then assisted by the migrant resource centre and council staff to apply to the council for the following:

- *periods of time at the local swimming pool when only women can use the facilities;*
- *belly dancing classes as a form of exercise using the local community facilities;*
- *use of their community bus to provide transport for the women as needed;*
- *discrete outdoor venues and activities to be organised where women can maximise exposure to the sun (hence increasing Vitamin D levels).*

Approval from the council was obtained. A screen was installed in the local swimming pool to section off a part of the pool to be used at certain times for the Muslim women's swimming lessons. Arabic-speaking instructors provided indoor and outdoor belly dancing classes. An appropriate outdoor venue was provided and the women organised their own roster for volunteers for childcare and transport. The success of this initiative allowed the council to implement these activities on an ongoing basis.

Evaluation points for scenario 5

What worked well?

- **Community involvement** — The Muslim women instigated the initiative and were empowered to gain control over their own health and assisted to take community action to plan appropriate activities to meet their needs.
- **Reciprocity** — Beginning with culturally appropriate community consultation and informal interviews, barriers were identified and council cooperated to meet the women's needs.
- **Sustainability** —Community action approach allowed for environmental change. The availability of culturally appropriate venues and physical activity classes allows ongoing support to Muslim women. Women organise their own childcare and transport, therefore reliance on additional funding is not needed. Because the program was initiated by the women themselves, sustainability is increased.

What could have been done better?

- **Evaluation** — Little time and resources were available for evaluation. No monitoring of improved health outcomes of the women, attendance rates over time and participant satisfaction, took place.
- **Sharing the successes** —Although this initiative is highly successful and sustainable, there are no mechanisms for sharing the findings with other cultural groups. No project report was written and there was little publicity.

- **Methodology** — It is not always possible to make changes to venues to make them suitable to the requirements of all users. It is recommended that the needs of a diverse range of local people are incorporated in designing and building community venues and structures (eg bocce facilities, yoga rooms and discrete outdoor areas).

Scenario 6 — Improving uptake of outpatient cardiac rehabilitation among Lebanese patients

A large teaching hospital had been running outpatient cardiac rehabilitation programs for some time. Aware of the number of Lebanese patients attending for cardiac procedures, the hospital management offered an outpatient cardiac rehabilitation program that aimed to target this group. The cardiac rehabilitation coordinator who ran the program had limited experience with this cultural group but made a point of visiting each Lebanese patient while they were still in hospital and explaining to them the importance of cardiac rehabilitation. Numbers of Lebanese patients attending the program remained low and few completed the full program.

A member of hospital management with a commitment to equitable health service provision realised that the experience of patients with limited English at the hospital could be improved and that this might also improve attendance at the cardiac rehabilitation program. She lobbied for employment of more interpreters, particularly those fluent in languages spoken in communities in the hospital's catchment area. Management response was positive— additional interpreters were employed and provisions made for their continuing professional development.

In parallel to these changes, the cardiac rehabilitation coordinator liaised with the Australian Lebanese Welfare Committee to obtain advice on how best to raise awareness of the importance of cardiac rehabilitation within the Lebanese community and attract participants to the program. This led to a meeting with a group comprising the few patients who had attended the outpatient program and others who were approached in hospital but did not attend. Through this group, the cardiac rehabilitation coordinator learnt that in many cases, her initial approach to the patient had not been clearly understood. These language difficulties had also contributed to patients' decisions not to attend the program. There were also some difficulties for men in attending a program run by a woman.

To address these issues, the cardiac rehabilitation coordinator started involving an interpreter both in visits to inpatients and in the delivery of the program. Program content was also adapted in consultation with the consumer group.

Evaluation points for scenario 6

What worked well?

- **Partnerships** — The involvement of the Australian Lebanese Welfare Committee is likely to lead to ongoing relationships between the hospital and the local Lebanese community.

- **Consumer involvement** — The redesign of the program benefited from the feedback from both consumers who had attended and those who had not, gaining insight into the shortcomings of the program itself and the reasons for non-attendance.
- **Provision of language services** — Engaging interpreters will improve services for members of these language groups, thereby effecting change across the hospital as well as within the cardiac rehabilitation program.

What could have been done better?

- **Cross-cultural training** — Provision of cross-cultural training to staff members may have assisted in more culturally competent approaches being taken to program development in the first instance.
- **Evaluation** — While the program will be evaluated in terms of attendance and outcomes, there are no mechanisms built into the program to evaluate the experiences of participants. Establishing an ongoing consumer advisory group may assist with this.
- **Leadership** — Although a member of the hospital's management and individuals such as the cardiac rehabilitation coordinator are committed to culturally competent practice, a lack of high level policy to support ongoing improvement may affect the sustainability of the program.
- **Knowledge transfer** — No attempts were made to report and disseminate the findings of the project.

Implications for the health sector

- To promote healthier living to a diverse nation, the health sector must form partnerships with ethnic communities and together develop culturally appropriate health promotion initiatives.
- The initiatives should take into account differences between communities and within each community.
- State health departments need to show leadership in policy development in ensuring the provision of culturally appropriate services.
- All organisations need to prioritise this issue in their planning to ensure a culturally competent organisation and workforce.

4 NEXT STEPS

The momentum for increasing cultural competency in health, in Australia and overseas, is creating a growing body of work. This chapter seeks to build on this, outlining opportunities for next steps in the Australian context.

Increasing cultural competency is a process of incremental change. It requires sustained commitment at the highest levels of government and across the health sector and a structured approach with short, medium and long-term timeframes.

4.1 Next steps across the dimensions of competency

In developing this guide, some clear recommendations emerged, key among them being the need for a specific resource for increasing cultural competency in programs and services for Aboriginal and Torres Strait Islander Peoples.

This section identifies this and other next steps for each of the four dimensions of competency — systemic, organisational, professional and individual. The boxes in the margins suggest discrete projects that agencies or organisations could use to progress cultural competency in a specific area.

At all levels, an important next step is to use, test, review, evaluate and debate the model for increasing cultural competency presented in this guide.

Promoting cultural competency through forums

- *A national forum on the defining issues for culturally competent health care in Australia, including ways to progress practical aspects and establish a 'core business' approach to cultural competence*
- *Partnerships between non-government organisations and various tiers of government on forums for promoting cultural competency.*
- *Regional-based forums and collaboration between State/Territory units and health organisations on implementing cultural competence at the local level.*

Systemic

Many actions could promote commitment at the highest levels and across all tiers of government and non-government organisations. These include action to:

- Develop a specific resource for Aboriginal and Torres Strait Islander Peoples that would:
  - — provide a comprehensive exploration of the multifaceted issues surrounding culturally competent practice for Aboriginal and Torres Strait Islander communities; and
  - — build on existing resources such as the AHMAC Cultural Respect Framework and the distinct policy and service delivery structures available.
- Collaborate on a national framework for culturally competent health practice. This could include work on strategies:
  - — that promote better understanding and development of population data, including strategies that promote access to and dissemination of key government and other data sets;
  - — that build a system-wide approach to results-based accountability frameworks that include performance measures and articulate obligations under existing national and State/Territory jurisdictions; and

  - — that draw on existing initiatives and partnership approaches with specialist agencies eg multicultural units.
- Develop a comprehensive long-term change management strategy, drawing on successful parallel approaches (eg in patient safety and infection control). A change management strategy could examine:
  - — prioritising health system leaders and managers to garner high level support; and
  - — strategies for influencing and achieving change in research approaches and increasing the evidence-base.
- Progress key areas of research and information including:
  - — a comprehensive systematic approach to research study designs and samples that addresses the substantial weaknesses in specific areas (eg inclusion of population representative samples, design of intervention programs appropriate to the needs for diverse communities, or divergent communities; adequately costing research to ensure population diversity and appropriate methods for engagement and interpretation is a consistent feature; consent procedures respectful of literacy capability in clinical care and research);
  - — evaluating the evidence of interventions which seek to improve cultural competency using this model or components of the model; and
  - — mapping the economic impact of increasing cultural competency in the Australian context.
- Promote best-practice diversity organisations, for example through:
  - — a system-wide approach to fostering diversity management that addresses human resources, accountability and education strategies;
  - — a framework for information management systems in health services that promotes appropriate data indices and acquisition relating to diversity (eg language spoken at home, country of birth, ethnic affiliation) and works towards high level commitment not to compromise on data; and
  - — exploring the ethical requirements for culturally competent health communication, including obtaining informed consent, prescribing and health professional/patient interaction.

Organisational

A number of steps could be taken to enhance and codify cultural competence within organisations:

- participate in partnership forums between government and health organisations about how to implement the model locally;
- implement budget strategies that mobilise resources and prioritise cultural competence across the organisation (eg in language services, data collection, education and training and human resource management);

Gaps in research — project suggestions:

- *Studies with specific communities in order to build a comprehensive understanding of the health status and other issues facing new and emerging CALD background communities.*
- *Methodological approaches that overcome resistance to including people from CALD backgrounds in research due to perceived difficulties such as cost and methodological issues.*
- *Studies that increase understanding of overweight and obesity issues in specific CALD background communities in order to more effectively promote healthier living and environments.*

Data and information project suggestions:

- *Develop protocols that address cultural competency in data collection including sampling, appropriate indices of diversity and ethics issues eg ethical consent and framing of data collection.*

Diversity management project suggestions:

- *Develop a practical toolkit to assist organisations' health workers to become more culturally competent, incorporating existing best-practice examples.*
- *Identify strategies for a more diverse health workforce such as recruitment and succession planning for diversity.*
- *Implement induction training in cultural competence.*

- develop and implement management competencies and performance measures including recruitment and succession planning for diversity, education of existing health workers and protocols for ethical communication in health care (eg exploring different ways of obtaining informed consent);
- identify and develop context-specific competencies relevant to the organisation, its health workers and that reflect the community it serves; and
- develop context-specific competencies (a 'one size fits all' approach involving a core set of competencies is not appropriate as different contexts require different competencies).

Professional

Professional bodies can initiate or contribute to a number of next steps. These can:

- demonstrate leadership by raising the profile of the value of increasing cultural competency and recommending strategies for professional practice;
- commission policies that embody a culturally competent approach to specific health or organisational issues;
- participate in partnership forums with government and other agencies about how to implement the model;
- ensure that ethical and other professional conduct codes incorporate principles of cultural competency;
- use newsletters, websites and professional body libraries to promote information to members on building cultural competency;
- develop context-specific competencies for the relevant health professional group; and
- hold regular information forums and workshops at professional development events.

Professional bodies and diversity — project suggestions:

➤ *Develop a context-specific and practical toolkit to assist health professionals to become more culturally competent, incorporating existing best-practice examples.*

Individual

Individuals can find ways to increase their cultural competency such as:

- accessing a toolkit or other existing material to develop self-awareness and competencies in diversity issues;
- participating in cross-disciplinary forums that encourage information- and skill-sharing, support and awareness of the value of increasing cultural competency; and
- recognising and discussing with colleagues opportunities to improve or introduce cultural competency into existing practices.

Individuals and diversity —project suggestions:

➤ *Commit to undertaking at least one activity, course or development opportunity each year that enhances awareness or competencies in working with diverse communities.*

4.2 Culturally competent health care for a diverse society

Through the multilevel approach supported by this guide, we aim for a situation where:

- the general community and the health sector have a greater awareness of the impact of culture on health;
- quality of life and health and wellbeing of people from culturally and linguistically diverse backgrounds are improved and the social exclusion of individuals, families and communities is reduced;
- reciprocal relationships are the starting point of health care interventions, based on mutual learning and respect;
- service provision responds to the needs of people from diverse communities and their carers, and recognises the role of traditional health beliefs and practices and informal support networks;
- health care interventions are evidence-based or informed; and reflect Australia's cultural diversity in their design and implementation;
- research into promoting healthier living and environments informs health sector practice and exchanges between the health sector and communities; and
- research projects and programs are inclusive of culturally diverse population groups and communities.

Increasing cultural competency is a long-term goal, achieved through incremental change. Australia is not unique in recognising the value of a culturally competent health system and its potential to improve health outcomes for all. Current chronic disease epidemics highlight the areas and opportunities for specific work — in this guide we have examined how the system could be improved to tackle overweight and obesity concerns.

Further work on the issues raised by the guide and the ideas suggested in this chapter is essential for effective and efficient health systems and improved access to health care and healthy environments for our diverse population. This will require sustained commitment at all levels of community and government.

The impact of this guide and increases in cultural competency may be best measured over time, where all within the health system — clinicians, managers, policy makers, researchers, educators and trainers, frontline health and specialist multicultural workers — incorporate culturally competent principles across their work programs.

APPENDICES

A Membership and terms of reference of the Working Committee

Committee membership

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Vice-Chancellor's Adviser on Diversity
Professor of Culture and Health
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Literature review and national consultation
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Judith Miralles & Associates, Melbourne

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Ms Elizabeth Hall
Ms Jenny Zangger
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Ampersand Editorial & Design, Canberra

Terms of reference

In order to increase the cultural competency of the health sector and partners working with communities in a culturally and linguistically diverse Australia to improve health, the Working Committee on behalf of the NHMRC Health Advisory Committee will:

1 Engage in a process of consultation with multiple stakeholders to (a) establish the most important components of a toolkit to improve cultural competence; (b) develop the criteria for a review of the evidence base in this field; (c) ensure credibility; and (d) establish priority users, and beneficiaries.

2 Conduct a systematic review of the evidence, to identify factors relevant to improving cultural competence:
   - advancing healthier living and environments;
   - the design and uptake of health messages and related information;
   - barriers to the uptake of this information and related behaviours;
   - evidence of innovative, and evaluated exemplar approaches for improving healthier living and environments, which emphasise the assets and cultural practices brought by families from culturally diverse backgrounds; and
   - illustrations and examples of literature should specifically focus on issues associated with the promotion of healthy weight, eating choices and physical activity, and prevention of overweight and obesity across the lifecourse.

3 Develop a framework for cultural competence in promoting healthier living and a toolkit for implementation. In the first instance, these resources should be directly applicable to the current policy needs in relation to population overweight and obesity prevention strategies.

4 Undertake consultation to test the appropriateness and credibility of the toolkit.

5 Develop an implementation and dissemination strategy.

6 Document the gaps in knowledge and identify national research needs and priorities.

7 Present the framework and toolkit to HAC.

B Process report

The NHMRC has developed this resource to guide policy makers and managers on culturally competent policy and planning at all levels of the health system.

The original intention (as specified in the terms of reference) was to develop a framework and toolkit for increasing cultural competency for healthier living and environments. However, after the national consultation phase was completed, the Working Committee agreed that it was important to target the policy and planning level. It was decided to develop a guide to raise awareness of cultural issues among policy makers and managers, aiming to promote the integration of cultural competence within different levels of the health system.

At its first meeting the Working Committee discussed ways to ensure consumer representation of CALD background communities throughout the project. Rather than having one consumer on the Working Committee attempting to represent all CALD background communities, members agreed to a broad public consultation strategy that would provide an opportunity at a national level for CALD background consumers as individuals and organisations, to provide input. The following public consultation strategy was undertaken:

- an initial call for submissions in 2004 about how to address factors to:
  - advance healthier living and environments;
  - improve the design and uptake of health messages; and
  - identify barriers to changing behaviours;
- eight national workshops to discuss these and other factors, to assess their importance and impact on cultural competency across differing geographic areas and organisations; and
- a call for submissions in 2005 on the NHMRC draft *Increasing Cultural Competency for Healthier Living — a Handbook for Policy, Planning and Practice.*

The development of the guide was informed by a review of literature and programs, analysis of written submissions received from the call for submissions in 2004, and input from the eight national workshops. The consultation draft was further refined in the light of comments from the call for submissions in 2005.

The Working Committee acknowledges the importance of developing strategies for disseminating and implementing the guide, as detailed in this process report.

Research phase

The objective was to identify key health sector competencies underpinning effective communication of healthy living outcomes in relation to population obesity strategies to Australians from a language and cultural background other than English. There were three parts to this phase.

Review and analysis of written submissions

Organisations and interested individuals were invited to make submissions about how to address factors to:

- advance healthier living and environments;
- improve the design and uptake of health messages; and
- identify barriers to changing behaviours.

Twenty-four submissions were received, as listed below. Despite considerable variability in the submissions, there were some common themes, including the need to acknowledge the diversity within and between CALD background communities when considering the advancement of healthier living.

Abbas Adam Director	Productive Diversity Section Multicultural Affairs Branch Australian Government Department of Immigration and Multicultural and Indigenous Affairs
Rochelle Arellano	Anglicare
Ilse Blignault Senior Research Fellow	School of Public Health & Community Medicine and Centre for Culture and Health The University of NSW
Tom Calma A/g Race Discrimination Commissioner	Human Rights and Equal Opportunity Commission
Pernilla Ellies Population Health Nutritionist	North Metropolitan Area Health Service, WA
Simon Forrest A/g Director	Multicultural SA
Sophie Francis	
Dr Diana Horvath AO Administrator	South Western Sydney Area Health Service
Sandra Lambert Chief Executive Officer	Department of Disability, Housing & Community Services ACT Government
Abd Malak AM Director	Diversity Health Institute
Dr Gavin Melles Lecturer	International Unit Medicine, Dentistry & Health Sciences Faculty University of Melbourne
Cam Nguyen Chief Executive Officer	Australian Vietnamese Women's Welfare Association

Peter O'Hara Senior Consultant	Office of Mental Health West Australian Transcultural Mental Health Centre
Lorella Piazzetta Advocacy Worker	Multicultural Development Association Inc.
Phillip Prideaux Executive Officer	Ethnic Communities' Council of NSW Inc.
Elvia Ramirez Mental Health Promotion Coordinator	Queensland Transcultural Mental Health Centre
Joseph De Riva O'Phelan Principal	Decies Management Consulting
Dr Judith Rochecouste Associate Director	Centre for Applied Language and Literacy Research Edith Cowan University, WA
Dr Peter Sainsbury Director	Division of Population Health Central Sydney Area Health Service
Peter Todaro Director	NSW Multicultural Health Communication Service
Angela Van Dyke	Administration Centre Fairfield City Council, NSW
Dr Glenn Ward Chair	Cross Cultural Communication Committee Diabetes Australia – National Office
David Weston Chief Executive Officer	Adult Multicultural Education Services
Leonie Young Chief Executive Officer	Beyond blue

Literature review

The literature review involved the development of a search strategy to answer the question, 'what is the evidence for the effectiveness of interventions designed to improve healthy living and environments for communities of culturally and linguistically diverse backgrounds?'. The nature of this research question precluded a broader systematic review of the area.

The initial review focused on literature covering the promotion of healthy weight, eating choices and physical activity and the prevention of obesity across the life course to Australians from culturally and linguistically diverse backgrounds. The primary focus was evaluated examples of good practice in Australia, with some international articles included for comparative purposes. Some policy documents and conceptual studies were also read.

The analysis of the literature sought to identify current best-practice models and conceptual frameworks to:

- advance healthier living among culturally diverse populations;

- improve the design and uptake of health messages among culturally diverse populations; and
- overcome barriers to uptake of health information and behaviour modification among culturally diverse populations.

The time period was from 1994 to 2004, with the aim of including the most contemporary and relevant major research efforts.

The search targeted journals with a specific focus on health promotion/ prevention, mental health, nursing, cultural diversity and cultural competence, and included electronic journals.

Documents were excluded where they had a focus on cultural groups with little or no relevance to Australia, did not address the issues outlined in the research questions, were outside the specified timeframe or were not written in English.

Internet websites and catalogues targeted included:

- PubMed;
- Library University catalogue and databases including CINAHL, MAIS, ERIC and Cochrane;
- Multicultural databases eg Multicultural Mental Health at Queensland Health (www.health.qld.gov.au/hssb/hou/resources.htm), and Multicultural Mental Health Australia (www.mmha.org.au);
- cultural and diversity databases (eg Cultural Diversity and Transcultural nursing www.culturediversity.org);
- Centre for Culture Ethnicity and Health catalogue and website (www.ceh.org.au);
- Cultural Competency in Medicine (www.amsa.org/programs/gpit/cultural.cfm);
- HIC and National Resource Centre for Consumer Participation in Health library catalogues;
- State/Territory and Australian Government department websites eg DHS Cultural Diversity Guide www.dhs.vic.gov.au/cultdivguide.htm and Queensland Government;
- health promotion agencies such as VicHealth;
- Health Research Council of New Zealand (www.hrc.govt.nz and www.moh.govt.nz);
- Australian Multicultural Foundation (www.amf.net.au);
- American Counselling Association (www.amcd-aca.org); and
- Council of Europe (www.coe.org).

Internet searches using subject guides of popular search engines — Google, Netscape and Yahoo — proved worthwhile as they identified the more ‘grey’ and esoteric literature. Search terms used included: culturally competent practice; cultural sensitivity training; cross-cultural training; nurse training; general practice; general practice and CALD training; nursing; management and CALD; curriculum and health.

As noted in this guide, a very small proportion of the published peer-reviewed evidence base relates to influences and determinants of views, perceptions, attitudes and practice in relation to healthy living and environments for Australian-based CALD background people.

During the literature review, no relevant economic evidence was identified.

No original generalisable research was conducted as part of this project.

National consultations

The written submissions and literature findings pointed to a number of important factors and interventions that were further explored during the national consultation phase. The consultations attempted to determine how important these were and whether there were any other factors (not covered in the submissions or literature) that had an impact on cultural competency. The consultations also provided an opportunity to assess the importance of these factors and interventions across differing geographic areas and organisations. In total, eight consultations were held during late January and early February 2005 as outlined below.

Sydney

National Ethnic Disability Alliance
Multicultural Mental Health Australia
NSW Service for the Treatment and Rehabilitation Of Torture and Trauma Survivors (STARTTS)
Transcultural Mental Health Centre
Diversity Health Institute, Multicultural Health Unit
Dieticians' Association
NSW Multicultural Health Communications
Diabetes Australia
NSW Division of General Practice

Melbourne

Victorian Health Promotion Foundation
Centre for Multicultural Youth Issues
Australian Multicultural Foundation
Darebin Community Health Service
Centre for Culture, Ethnicity and Health
National Heart Foundation, Victoria
Ethnic Communities' Council, Victoria

Adelaide

Transitional and Community Services
Cancer Council of South Australia
Ethnic Link Services
Migrant Health Service
Diversity Directions
Multicultural Communities' Council of South Australia
Metropolitan Domiciliary Care
Alzheimer's' Association
Department of Health, Minister's Office
Women's Health Statewide

Brisbane

Cancer Screening Services Unit
QLD Program of Assistance to Survivors of Torture and Trauma
Harmony Place — Multicultural Centre for Mental Health and Wellbeing
Brisbane Multicultural Development Association
Transcultural Mental Health
Family Planning QLD
Dieticians' Association of Australia

Gold Coast

Breast Screen Queensland, Gold Coast Service
Multicultural Communities' Council of Gold Coast
South Coast (Gold Coast) Health Promotion Unit

Darwin

Melaleuca Refugee Centre
Healthy Living Northern Territory
Diabetes Australia
Darwin Hospital
NT Division of General Practitioners'

Perth

Diabetes Australia WA
Child Community Health, Department of Health
North Metro Population and Community Health
Multicultural Aged Care Service WA
WA Transcultural Mental Health Centre
Community Services, Health and Education Board

Hobart

Greek Welfare Centre Hobart
Department of Education — ESL Program
Department of Health and Human Services
National Heart Foundation Tasmania

Public consultation

Public consultation targeting the intended users of the guide took place during June and July 2005 and involved a call for submissions publicised in the *Commonwealth of Australia Government Notices Gazette* and *The Weekend Australian*. In addition, invitations were forwarded to all professional colleges and known interested parties. Fifty-three submissions were received, from the following individuals and organisations.

Lyn Andersch Manager	Multicultural Tasmania
Professor Christopher Baggoley Executive Director	Public Health and Clinical Co-odination Division Department of Health Government of South Australia
Robert Bean	Robert Bean Consulting
Nerida Bellis-Smith Professional Services Director	Dietitians Association of Australia
Jan Bennett Assistant Secretary	Health Services Improvement Division Australian Government Department of Health and Ageing
Rosemary Bryant Executive Director	Royal College of Nursing
Dermot Casey Executive Director	Office of the Safety and Quality Council
Dr Ching Choi	Australian Government Australian Institute of Health and Welfare
Professor Andrew J S Coats Dean	Faculty of Medicine The University of Sydney
Helen Connor Chair	Australian Mental Health Consumer Network
Ruth Das Policy and Projects Officer	NSW Refugee Health Service
Anne Eayrs	Alzheimer's Australia
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Finalising the guide

The Working Committee met on 25 July 2005 to consider the public consultation submissions and their inclusion in the guide.

The guide was then revised accordingly.

Prior to endorsement by the NHMRC, the guide underwent an independent review process and was assessed against the NHMRC key criteria for assessing information reports. The guide was further refined in response to the reviewer's report.

Dissemination and implementation

Dissemination involves making guides accessible, advertising their availability and distributing them widely. Multiple dissemination strategies ensure greater coverage than a single strategy.

The dissemination strategy for this guide includes distribution of the document to:

- State and Territory health departments;
- individuals and organisations who participated in the research phase and consultation process; and
- other relevant organisations and bodies.

The guide is also available in PDF and Word formats from the NHMRC website, with hyperlink options to facilitate navigation.

Dissemination alone is not enough to change the behaviour of health professionals.

Members of the Working Committee are committed to supporting the uptake of the guide and will continue to promote it through their own organisations and other relevant bodies. Members will also present the guide at relevant conferences, workshops, seminars and workforce development forums, endeavouring to make the guidance as practical as possible by illustrating its guidance with real life case studies.

A Powerpoint presentation, based on the guide, is available on the NHMRC website. This aims to assist anyone communicating about cultural competency at workshops, seminars or forums.

C Useful resources and websites

This appendix provides some tools and resources that may be of use in applying the model put forward in this guide, many of which were provided through the consultation process. These have not been evaluated by the Working Committee.

Resources

- Australian Government Department of Immigration and Multicultural and Indigenous Affairs (1989) *The National Agenda for Multicultural Australia*. www.immi.gov.au/multicultural/australian/index.htm
- Australian Health Ministers' Advisory Council (2004) *Cultural Respect Framework for Aboriginal and Torres Strait Islander Health 2004–2009*. www.health.gov.au/internet/wcms/publishing.nsf/Content/health-oatsih-pubs-crf.htm
- DAA & ADEA (2005) *Identification of Priority Needs for Nutrition Information Materials to Cater for Australia's Culturally and Linguistically Diverse (CALD) Communities*. Prepared by the Dietitians Association of Australia and the Australian Diabetes Educators Association for Diabetes Australia. www.diabetesaustralia.com.au
- Federation of Ethnic Communities' Councils of Australia *A Cultural Dictionary*. www.fecca.org.au/world%20views/countries/countries.html
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- National Chronic Disease Strategy (under development)
- National Health and Medical Research Council (2005) *Strengthening Cardiac Rehabilitation and Secondary Prevention for Aboriginal and Torres Strait Islander Peoples: a Guide for Health Professionals (includes a toolkit on cultural competency)*. www.nhmrc.gov.au
- National Public Health Partnership (2001) *Highlights of Public Health Activity in Australia: a Report to the Australian Health Ministers' Advisory Council*. www.nphp.gov.au/publications
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- Queensland Health (2003) *Cultural Diversity — A Guide for Health Professionals*. www.health.qld.gov.au/multicultural/cultdiv/default.asp
- Rundle A, Carvalho M, Robinson M (eds) (1999) *Cultural Competence in Health Care: a Practice Guide*. Jossey Bass, SF
- Victorian Department of Human Services (2004) *Cultural Diversity Guide: Planning and Delivering Culturally Appropriate Human Services*. www.dhs.vic.gov.au/multicultural/downloads/cultural_diversity_guide.pdf

- Victorian Department of Premier and Cabinet (2001) *Access to Information about Government Services among Culturally and Linguistically Diverse Audiences.* www.information.vic.gov.au/faqs/

Further resources are included in the bibliography.

Organisations

- Australian Government gateway
  www.australia.gov.au
- Australian Bureau of Statistics
  www.abs.gov.au
- Australian Multicultural Foundation
  www.amf.net.au
- Australian Institute of Health and Welfare
  www.aihw.gov.au
- Centre for Culture Ethnicity and Health (Victoria)
  www.ceh.org.au
- Community Relations Commission
  www.crc.nsw.gov.au
- Cultural Competency in Medicine
  www.amsa.org/prgrams/gpit/cultural.cfm
- Department of Immigration, Multicultural and Indigenous Affairs
  www.immi.gov.au
- Diversity Health Institute Clearing House
  www.dhi.gov.au/clearinghouse
- Diversity Australia
  www.diversityaustralia.gov.au
- Federation of Ethnic Communities Councils of Australia
  www.fecca.org.au
- Health Insurance Commission
  www.hic.gov.au/yourhealth/our_services/ahsfna.htm
- Mauri Ora Association (New Zealand)
  www.mauriora.co.nz
- Multicultural Mental Health Australia
  www.mmha.org.au
- NSW Multicultural Health Communication
  www.health.nsw.gov.au/health-public-affairs/mhcs/
- Queensland Health Multicultural Health
  www.health.qld.gov.au/multicultural/default.asp
- Royal Australian College of General Practitioners
  www.racgp.org.au
- Royal Australasian College of Physicians
  www.racp.org.au

- University of New South Wales Centre for Culture and Health www.cch.med.unsw.edu.au
- Victorian Department of Human Services www.dhs.vic.gov.au/cultdivguide.htm

State and Territory based organisations include:

- organisations to assist survivors of torture and trauma (eg ASETTS in WA and STARTTS in NSW);
- migrant resource centres — accessed through www.australia.gov.au

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The National Health and Medical Research Council

The National Health and Medical Research Council (NHMRC) was established in 1936 and is now a statutory body within the portfolio of the Australian Government Minister for Health and Ageing, operating under the National Health and Medical Research Council Act 1992 (NHMRC Act). The NHMRC advises the Australian community and the Australian Government, and State and Territory governments on standards of individual and public health, and supports research to improve those standards.

The NHMRC Act provides four statutory obligations:

- to raise the standard of individual and public health throughout Australia;
- to foster development of consistent health standards between the states and territories;
- to foster medical research and training and public health research and training throughout Australia; and
- to foster consideration of ethical issues relating to health.

The NHMRC also has statutory obligations under the Prohibition of Human Cloning Act 2002 (PHC Act) and the Research Involving Human Embryos Act 2002 (RIHE Act).

The activities of the NHMRC translate into four major outputs: health and medical research; health policy and advice; health ethics; and the regulation of research involving donated IVF embryos, including monitoring compliance with the ban on human cloning and certain other activities. A regular publishing program ensures that Council's recommendations are widely available to governments, the community, scientific, industrial and education groups.
The Council publishes in the following areas:

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- Blood and Blood Products
- Cancer
- Cardiovascular Health
- Child Health
- Clinical Practice Guidelines – Standards for Developers – Topics
- Communicable Diseases, Vaccinations and Infection Control
- Diabetes
- Drug and Substance Abuse
- Environmental Health
- Ethics in Research–Animal
- Ethics in Research–Human
- Genetics and Gene Technology
- Health Procedures
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