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**NATIONAL HEALTH AND MEDICAL RESEARCH  
COUNCIL (NHMRC)**

**INCREASING CULTURAL COMPETENCY FOR  
HEALTHIER LIVING & ENVIRONMENTS**

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**Discussion Paper**

24 March 2005

**Cultural Perspectives and Judith Miralles & Associates**



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## 1. KEY LEARNINGS

- Increasing the cultural competency of the health sector and its partners is compelling and of national importance.
- The success of any attempt to increase the cultural competency of the health sector and its partners depends on a multifaceted approach that addresses systemic, organisational, professional and individual competence.
- Culturally diverse groups manifest a range of behaviours and the promotion of healthier living and environments needs to identify both 'risk' and 'protective' behaviours, with a view to affecting the former by the latter.
- Successful health communications engage communities in a reciprocal approach so that communities become authors in the development of the health communication.

The responsibility for identifying and promoting healthier living and environments is most productive when it is a shared responsibility between culturally and linguistically diverse communities and the health sector. This approach recognises that as a result of a number of factors, including resourcing, the advocacy role of multicultural organisations is sometimes limited to responding rather than identifying issues.

- Conviction to implement culturally sensitive and appropriate communications is a higher order issue than knowledge or skills and should be considered across systemic, organisational, professional and individual competencies.

This reflects the sector's impression of a growing intolerance for culturally sensitive services.

- There is a notional cultural or religious sensitivity index surrounding a health communications impacting on the
  - ▶ approach (strategy),
  - ▶ timeframe and
  - ▶ resources.

Not all health communications issues carry the same cultural sensitivity. Therefore it is important to consider a notional sensitivity index for each particular message. The main impact of the sensitivity ranking will be on the approach or strategy adopted and the time frame required for behavioural change. In general, the more sensitive an issue, the more culturally specific the strategy and the longer the time considerations.

In terms of resources, the impact of high sensitivity does not necessarily mean more resources, but does mean culturally relevant ones.

- There are many different types of evidence. A broader definition of 'evidence base' that includes evidence tested by practice is important when evaluating examples of health communications to people from culturally diverse backgrounds.

## 2. EXECUTIVE SUMMARY

### 2.1 OVERVIEW

Cultural Perspectives and Judith Miralles & Associates were commissioned to undertake a research and development process to inform the considerations of the National Health and Medical Research Council (NHMRC) Working Committee in the area of *Increasing cultural competency for healthier living and environments*.

The project objective was the identification of the key professional 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.

The working definition of 'competence' used by the consultants incorporated the notion of individual as well as organisational, professional and system level capacity to act in order to support culturally and linguistically appropriate services. Embedded in the concept of cultural competence are knowledge, conviction and capacity for action at an individual and organisational level (Audigier 2000). Eisenbruch (2004) similarly emphasises the skill-based notion of competence 'that includes the system no less than the patients / subjects / informants' (p18). Eisenbruch cites Cross et al's, definition of cultural competence:

*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 professionals to work effectively in cross-cultural situations (p18).*

The project sought to identify factors relevant to improving cultural competence so as to:

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

The project findings will be used to inform the development of a framework and toolkit for increasing the cultural competence of the health sector and partners working with culturally and linguistically diverse communities in multicultural Australia.

### 2.2 THE RESEARCH METHOD

The research had three distinct phases.

- Review and analysis of public submissions
- Literature review

- National consultations

The first phase involved an **analysis of submissions** received by the NHMRC in response to a public request as well as targeted invitations to key stakeholder organisations and interested individuals during October and November 2004. In all, 24 submissions were received.

The analysis of the submissions provided an important set of initial considerations that were further explored during the literature search and the national consultation forums.

The **literature review** formed the second methodology and 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 initial literature 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. As agreed in the first meeting with the Working Committee, the review included a limited number of exemplars from the allied fields of nursing and counselling as well as the management and education sectors. The primary focus was evaluated examples of good practice in Australia, with some readings of international articles for comparative purposes. Some policy documents and conceptual studies were also read.

The written submissions and literature findings pointed to a number of important factors and interventions that were further explored during the **national consultation** phase of the project. The consultations attempted to determine how important these were and whether there were any other factors (not covered in the submissions or literature) that impacted on cultural competency. The consultation 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 in the following locations; Sydney, Melbourne, Adelaide, Brisbane, Gold Coast, Darwin, Perth and Hobart.

## 2.3 A STRUCTURE FOR CONSIDERATION

The report is framed against:

- A lack of consistent practice in health communications for healthier living and environments.
- A predominant top-down approach excluding people from diverse language and cultural backgrounds from the identification, prioritisation and development of health communications for healthier living and environments.
- A lack of agreement about a common use policy framework guiding and supporting health communication practice in a cross-cultural context.

- Lack of an appropriate level of resources.

With this context in mind, the consultants developed an initial cultural competency model (see 4.1) to structure the report's findings and to provide for initial consideration, some strategic examples of cultural competencies.

The model incorporates the key learnings, suggested approaches and priorities identified through the three distinct information collection phases. It also gives voice to the belief expressed in the consultative phase of the project that the application or exercise of cultural competence at an individual or professional level requires a systemic and specific organisational capacity and conviction to direct, support and acknowledge culturally competent practice. Inherent in the model is the view that cultural competency needs to clearly delineate the levels of responsibility and the interrelationship between these.

The model identifies four dimensions of cultural competency:

- Systemic
- Organisational
- Professional
- Individual

At the **systemic level**, the model posits that in order to foster culturally competent behaviour and practice, policy objectives, procedural requirements, monitoring mechanisms and resource capacity are fundamental.

At the **organisational level**, individual health organisations need to be supported by the health system to both value and achieve culturally competent practice. At the operational level, the focus should not be solely on resource capacity and outcome measurement, but also on fostering organisational change for workplace cultural and linguistic diversity.

Organisational cultural competency guarantees that the skills and resources required by client diversity are in place and also creates a culture where cultural competency is valued as integral to core business activity and consequently supported and evaluated.

This systemic and organisational competency is a necessary precursor for individual culturally competent practice. The **individual dimension** has long been the focus for the discussion on competency and the knowledge, attitudes and behaviours defining competent practice. Yet individual practice does not exist in a vacuum. Culturally competent behaviour is maximised and made more effective when it exists within a supportive health organisation and wider health system.

The fourth dimension, **professional practice**, is conceptualised in the model as a competency over-arching the three previous – systemic, organisational and individual. Within the health sector, specific professions develop the standards and codes of practice framing the working lives of individuals. Professional cultural

competence would ensure the cultural competence is identified as a key component in under and post-graduate education and professional development (and consequently lead to curriculum development). It would also result in the development of cultural competence standards to guide the profession

## 2.4 THE OUTPUT

The report structure was developed in consultation with the Working Committee and includes individual sections summarising the research findings and detailing the relevant competencies for each dimension. The competencies are presented in a generic form as well as being considered in the applied area of obesity prevention. This approach increases the value of the cultural competency, allowing application to the broadest range of health communications.

The application of the generic competencies to the specific area of obesity prevention gives voice to the views of the participants at the national consultations and the authors of various submissions who saw the topic of obesity prevention as the vehicle to discuss cultural competence in the broader health sector.

## 2.5 THE FINDINGS

### Systemic Competency

- Cultural competency in health communication requires a systemic capacity to capture, enumerate and measure diversity. It requires diversity considerations in programming, planning and resource allocations.

Organisational Competency

- Culturally and linguistically diverse communities need to be at the centre of organisational approaches to communicating healthier living and environments.

This will result in health communications that are efficient in terms of appropriate media use, effective in terms of the message being communicated and culturally relevant in terms of understanding the sensitivity factor of healthier living issues in individual communities.

- Health communications is far broader an area than information delivery and needs to fully appreciate the capacity of the audience to receive information, existing information consumption behaviour and preferred sources of information for specific health messages.
- The role of the GP in the provision of health communications to culturally and linguistically diverse communities cannot be overstated. They are a critical nexus in the delivery of better health outcomes. As a consequence, they need to be centrally positioned in communications design.
- Cultural competency at management level has particular relevance as it affects planning, performance expectations, resources and service values within organisations; in a word, the service culture of the organisation.

Professional Competency

- There is a need for training and practice standards to deliver the competency necessary to use information on people from diverse language and cultural backgrounds as a context for interaction not as a tool to predict or assume behaviours or attitudes.

Individual Competency

- There is a policy imperative to increase both the quality and resourcing of professional development as a key strategy in achieving culturally competent practice.
- Cultural competency will be enhanced by a more consistent level of information exchange on the outcomes of health communications for healthier living and environments targeting culturally and linguistically diverse communities.

Competency Toolkit

- The tool kit should be able to be used as both a planning and evaluation tool. This would maximise the integration of culturally competent practice as an organisational core activity.

## **3. CONTEXT**

### **3.1 BACKGROUND**

A number of key themes emerged during the analysis of the data from the three research phases. These are:

- A lack of consistent practice in health communications for healthier living and environments.
- A predominant top-down approach excluding people from diverse language and cultural backgrounds from the identification, prioritisation and development of health communications for healthier living and environments.
- A lack of agreement about a common use policy framework guiding and supporting health communications practice in a cross cultural context.
- Lack of an appropriate level of resources.

### **3.2 PROJECT OBJECTIVES**

The overarching project objective was the identification of the key professional 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.

The project sought to identify factors relevant to improving cultural competence so as to:

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

The project findings are to be used to inform the development of a framework and toolkit for increasing the cultural competence of the health sector and partners working with culturally and linguistically diverse communities in multicultural Australia.

### **3.3 METHODOLOGY**

#### **3.3.1 *Frame of reference for analysis of data***

The analysis of the written submissions, the literature review and the national consultations has been informed by a working definition of 'competence' incorporating the notion of individual as well as organisational, professional and system level capacity to act in order to support culturally and linguistically

appropriate services. Embedded in the concept are knowledge, conviction and capacity for action at an individual and organisational level (Audigier 2000). Eisenbruch (2004) similarly emphasises the skill-based notion of competence 'that includes the system no less than the patients / subjects / informants' (p18). Eisenbruch cites Cross et al's, definition of cultural competence:

*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 professionals to work effectively in cross-cultural situations (p18).*

These frames of reference provided a useful starting point for the analysis of the existing evidence base and the public submissions and consultations.

The analysis of the written submissions and the literature review was organised under a number of headings in keeping with factors relevant to improving cultural competence. The headings were:

- What interventions / skills / knowledge are deemed to be important? (e.g. establishing networks with ethnic community organisations, use of community champions, understanding role of family....)
- What structures / policies are deemed to be important? (e.g. bilingual staff, cross-cultural training for staff, allocated budgets for language services...)
  - ▶ How are these manifested at individual, organisational, professional and system level?
  - ▶ What factors impact on take up of culturally competent practice? (individual and organisational drivers; individual and organisational impediments)
- What factors impact on take up of health activity / message? (e.g. proximity to home, cost, role models...)
  - ▶ role of cultural practices and beliefs in determining lifestyle choices and behaviours;
  - ▶ role of English language competence in being able to make informed decisions;
  - ▶ impact of settlement issues; and
  - ▶ impact of key demographic variables.

The project findings are informed by an analysis of three distinct data sources, namely,

- Public submissions
- Literature review
- National consultations

### 3.3.2 Public submissions

As part of this project the consultants undertook an analysis of the submissions received by the NHMRC on the issue of communicating health messages to culturally and linguistically diverse communities.

This process invited organisations and interested individuals to make submissions on the topic by addressing the three key factors critical to the development of a competency framework and tools to facilitate its adoption. The three factors were:

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

#### Profile of the submissions -

Twenty four submissions were received by the NHMRC. The profile of the submissions is provided below.

Table 1.

Characteristic	Categories	Numbers
Organisation Type	Individual	2
	Ethnic Specific Organisation	1
	Multicultural Community Organisation	2
	Mainstream Community Organisation	3
	Academic Institution	2
	Health Department – Hospital etc	3
	Health Department – Policy/Area Management	5
	Government Department (other than Health)	5
	Local Council	1
	Submission for funding	1
State/Territory of Origin	ACT	4
	NSW	9
	QLD	2
	SA	1
	VIC	4
	WA	4

There was a degree of variability amongst the submissions. While just over half of the submissions addressed their comments to the factors identified in the request, a large number took different approaches and included previously prepared reports on associated research, as well as a submission for funding.

Variability was also evident in the length of submission, with 13 submissions being between two to five pages. As a consequence, some submissions tended to be fairly narrow in the range and number of issues addressed.

Given the variability of submissions, the consultative phase of this research sought to elicit a more consistent set of inputs across the range of issues to ensure that the development of the cultural competency framework and toolkit met the needs of both practitioners and stakeholders.

### **3.3.3 Aims of Literature Review**

The primary question to be answered by the literature review was:

- What is the evidence for the effectiveness of interventions designed to improve healthy living and environments for communities of culturally or linguistically diverse backgrounds?

The initial literature 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. As agreed in the first meeting with the Working Committee, the review included a limited number of exemplars from the allied fields of nursing and counselling as well as the management and education sectors. The primary focus was evaluated examples of good practice in Australia, with some readings of international articles for comparative purposes. Some policy documents and conceptual studies were also read.

The overarching research question framing the literature review was:

- Are there evaluated models of promotion of healthy living options to people from culturally and linguistically diverse backgrounds in the health sector with proven effectiveness?

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

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

**Inclusion criteria –**

- Articles / documents written in English
- Relevant studies that have a focus on cultural competencies for all health professionals.
- Relevant studies in other professions such as management, second language acquisition, - which have developed sizeable literature in this area - were included for comparison and identification of key issues and developments.
- Specific conceptual frameworks, policy and planning documents identified as relevant including the Department of Human Services (Victoria), *Cultural Diversity Guide*, American Counselling Association, *Multicultural Counselling Competencies*, National Multicultural Mental Health Policy Steering Group, *Framework for the implementation of the National Mental Health Plan 2003-2008 in Multicultural Australia*.
- Both published and unpublished work.

**Exclusion criteria –**

Documents were excluded where they had a focus on cultural groups with little or no relevance to Australia, studies that do not address the issues outlined in the research questions, and:

- Articles / documents not written in English.
- Documents such as legal reports, provider contracts.
- Articles / documents outside the time frame.
- Articles / documents in fields not identified above.

**Time Frame –**

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

### Journal Titles Targeted –

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

- Australian and New Zealand Journal of Public Health
- European Journal of Intercultural Studies
- Synergy
- American Journal of Health Behaviour
- Child: Care, Health and Development
- American Journal of Public Health
- Journal of Transcultural Nursing
- Journal of Health Education
- Public Health Nursing

### Targeted Electronic Journals included:

- British Medical Journal ([www.bmj.com](http://www.bmj.com))
- Medical Journal of Australia ([www.mja.com.au](http://www.mja.com.au))
- Journal of the American Medical Association (<http://jama.ama-assn.org>)

Internet websites and catalogues targeted included:

- PubMed
- Library University catalogue and databases including CINAHL, MAIS, ERIC and Cochrane
- Multicultural databases e.g., Multicultural Mental Health at Queensland Health ([www.health.qld.gov.au/hssb/hou/resources.htm](http://www.health.qld.gov.au/hssb/hou/resources.htm)), and Multicultural Mental Health Australia ([www.mmha.org.au](http://www.mmha.org.au)).
- Cultural and diversity databases (e.g., Cultural Diversity and Transcultural nursing [www.culturediversity.org](http://www.culturediversity.org))
- Centre for Culture Ethnicity and Health catalogue and website ([www.ceh.org.au](http://www.ceh.org.au))
- Cultural Competency in Medicine ([www.amsa.org/programs/gpit/cultural.cfm](http://www.amsa.org/programs/gpit/cultural.cfm))
- HIC and National Resource Centre for Consumer Participation in Health library catalogues

- State and Commonwealth department websites e.g., DHS Cultural Diversity Guide [www.dhs.vic.gov.au/cultdivguide.htm](http://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](http://www.hrc.govt.nz) and [www.moh.govt.nz](http://www.moh.govt.nz))
- Australian Multicultural Foundation ([www.amf.net.au](http://www.amf.net.au))
- American Counselling Association [www.amcd-aca.org](http://www.amcd-aca.org)
- Council of Europe [www.coe.org](http://www.coe.org)

### The World Wide Web

Searches across the World Wide Web were undertaken using subject guides of popular search engines. These included Google, Netscape and Yahoo. General Internet searches proved worthwhile as they identified the more 'grey' and esoteric literature.

### Search Strategy

- A trial run to test search terms was conducted for each of the following databases – MAIS, ERIC, INFOMIT, GOOGLE and HIC library catalogues. Searching commenced with search terms **cultural competencies** and this was progressively narrowed depending on relevance and number of records secured. In searching the domain **cultural competency**, 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.
- Some of the terms elicited few relevant studies and it was thus decided to combine terms such as **general practice** and **cross cultural training**. This resulted in a larger number of records being captured. Terms related to health were dropped from the search when searching across other disciplines such as law, management but not education. In searching across other disciplines the initial search commenced with the term **cultural competencies** and once against this was progressively narrowed e.g., **management** and **cultural diversity / competence**. From the initial search a significant body of work in the mental health area was found but not in the identified health areas that are a key focus for this project such as **prevention of obesity**.
- Combinations of search terms used depended on the number of records retrieved but started broadly and became more specific when relevant. The combinations of search terms used included: healthy weight; eating choices; physical activities; prevention of obesity combined with ethnic communities; and culturally diverse communities. Following advice from the project's Working Committee, the search was narrowed to include the terms **health promotion** or **prevention**. The above strategy

was later modified to focus on Australian literature AND on unpublished as well as published literature in an endeavour to identify examples of good practice in Australia.

- The most fruitful source of documents were identified via PubMed, specialist library catalogues particularly The Centre for Culture, Ethnicity and Health, professional contacts, Working Committee members and websites. Documents and literature were considered highly relevant if they had a focus on good practice in Australia. Others included in the review were considered relevant because they had a focus on cultural competence (relating to one or more dimensions of organisational, systemic, professional and individual competence).
- The time frame and resources available for the conduct of this literature review was restricted and it was necessary to limit the search strategy to fit within these constraints.

### **Specialist Collections in Health and Ethnic Organisations**

- Specialist collections of the Health Issues Centre and the National Resource Centre for Consumer Participation in Health were searched using in-house subject catalogues. The strength of these two specialist collections is the consumer focus. The broad search term of **cultural competency** was used in the first instance. Only a small number of significant pieces of literature were identified by searching these two subject catalogues.
- The strengths of such specialist collections such as the Royal Melbourne, Hospital Library, Centre for Culture Ethnicity and Health; Migrant Information Centre Eastern Region (Victoria) and the NSW Transcultural Mental Health Centre (and the former Australian Transcultural Mental Health Network collection now housed in the Royal Melbourne hospital library) are the specific focus on culturally diverse groups. The searching of these specialist collections identified some highly relevant practice examples in cultural competence, particularly in the health promotion and mental health fields.

### **Professional Contacts**

Studies and reports were also identified by members of the Working Committee. Some unpublished projects studies relevant to this project were identified by professional contacts including Leigh Barnaby (Whitehorse Division of General Practice), Marnie Graco (Broadmeadows Health Service) and Tracey Dyt (Central Bayside Division of General Practice).

### **Search Yield**

Initially over 150 records were available. Four reviewers independently culled literature and documents according to the inclusion and exclusion criteria in order to select the most relevant articles and project reports. After collection from libraries and organisations these documents were further culled and the

remaining relevant documents and articles were reviewed for their relevance to the research questions using a template to guide the review of all documents by the four reviewers. Several unpublished documents were identified by key professional contacts and included in the review. ( The template is attached as Appendix 4)

### **Criteria for Considering Studies for this Review**

- *Types of Study* – a decision was taken not to limit the type of study design included in the review.
- *Types of Participants* – the focus of the analysis was on culturally diverse groups, new arrivals and refugees.
- *Types of Interventions* – any project or program focussed on the promotion of one of the following health weight, eating choices and physical activity and the prevention of obesity across the life-course to Australians from culturally and linguistically diverse backgrounds. However, as few studies were found it was decided to include a broader range of studies or documents focussing on advancing healthier living e.g., smoking cessation.

### **Study Strength**

It is not intended that this literature review would undertake a critical appraisal of the design of studies that were identified as relevant to the research questions and reviewed accordingly. However, it is clear that research issues, methodologies and rigour have varied between studies. As an example, only one randomised control study by Reijneveld et al. (2003) assessing the effect of a short health education and physical exercise programme on the health and the physical activity of Turkish first generation elderly immigrants was sourced. Both qualitative and quantitative research was included in the review. Selected studies are summarised in Appendix 2 providing a brief description of each study including focus on study; target group; design; description of interventions; and results.

### 3.3.4 National Consultations

An important component of the research methodology was a series of consultations in seven State/Territory capitals and one regional area (Gold Coast). Participants for the consultations were drawn from the health, community and multicultural sector. The consultations were conducted over a four-week period. The submissions and literature review provided a rich source of data from which focus group questions were developed. They provided an opportunity to emergent themes evident in the submission process and the literature review.

Date	City/Town	Participants
Jan 2005	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
Jan 2005	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
Feb 2005	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

Date	City/Town	Participants
Feb 2005	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
Feb 2005	Gold Coast	Breast Screen Queensland, Gold Coast Service Multicultural Communities’ Council of Gold Coast South Coast (Gold Coast) Health Promotion Unit
Feb 2005	Darwin	Melaleuca Refugee Centre Healthy Living Northern Territory Diabetes Australia Darwin Hospital NT Division of General Practitioners’
Feb 2005	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
Feb 2005	Hobart	Greek Welfare Centre Hobart Department of Education – ESL Program Department of Health and Human Services National Heart Foundation Tasmania

## **4. PROPOSED FRAMEWORK – COMPETENCY AREA SPECIFICATION**

### **4.1 FRAMEWORK OVERVIEW**

The model below seeks to reflect the key learnings and priorities identified through the three distinct information collection methods. It also gives voice to the belief expressed in the consultative aspects of the project that the application of cultural competence at an individual or professional level requires both a systemic, professional and organisational capacity to direct, and support culturally competent practice.

The model of cultural competency seeks to clearly delineate the levels or dimensions where responsibilities for cultural competency exist and the interrelationship between these.

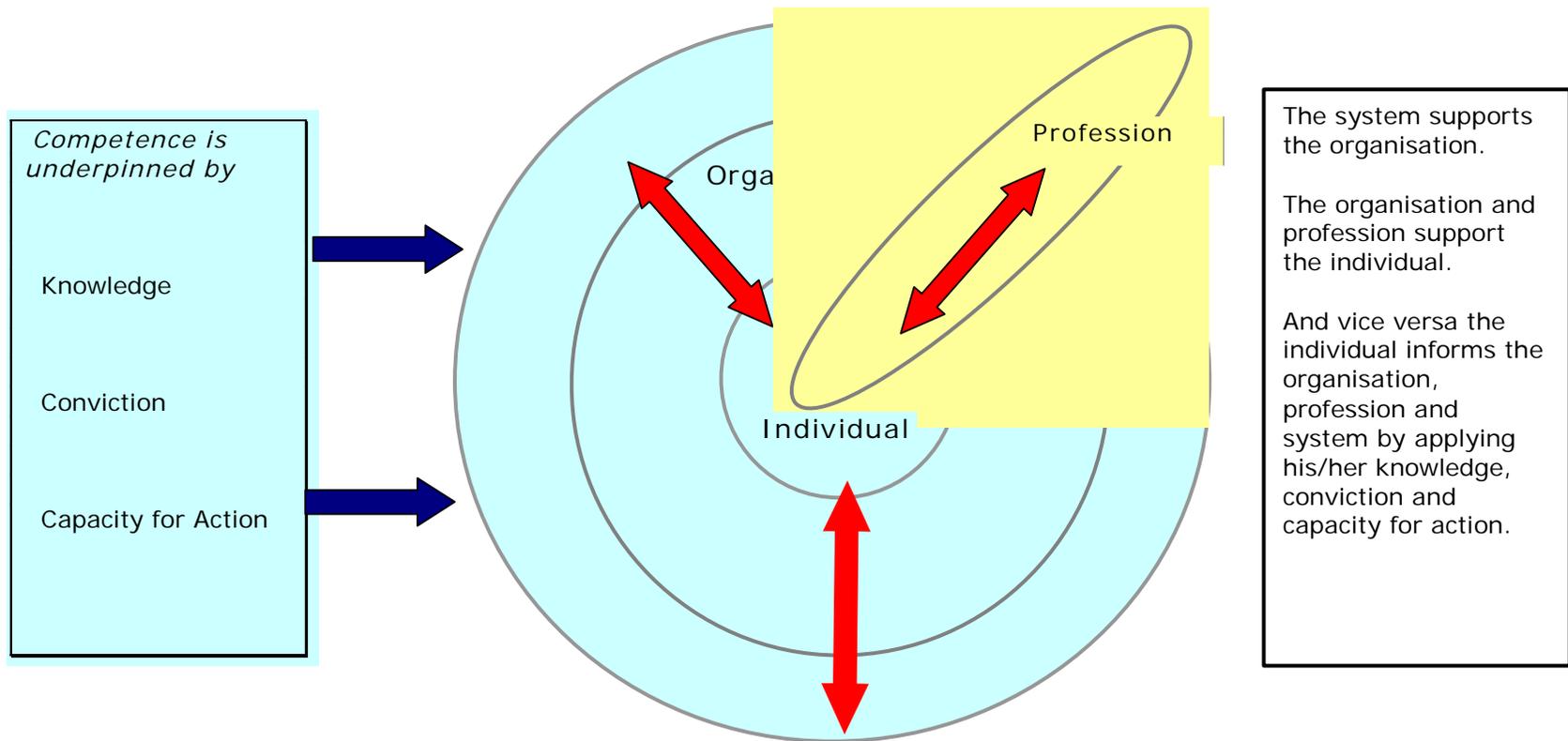
The model represented below in diagrammatic form comprises four cultural competency dimensions:

- Systemic
- Organisational
- Professional
- Individual

Intervention: Use of interpreters

Question: How does the client experience this intervention?

How does the system / organisation / individual respond?



At the **systemic level**, the model recognises that in order to foster culturally competent behaviour and practice, the system needs to have the policy objectives, procedural requirements, monitoring mechanisms and resource capacity to achieve this outcome.

At the **organisational level**, individual health organisations need to be supported by the health system to both value and achieve culturally appropriate and sensitive outcomes when dealing with individuals and communities from culturally and linguistically diverse backgrounds. At this operational level, the focus should be on resource capacity and outcome measurement as well as on fostering the commitment of management for cultural and linguistic diversity at all staffing levels of the organisation.

Systemic and organisational competency is a necessary precursor for individual culturally competent practice. The individual dimension has long been the focus for the discussion about competency for which there are specific knowledge, attitudes and behaviours. Yet culturally competent practice at an individual level does not exist in a vacuum. Culturally competent behaviour is maximised and made more effective when it exists within a supportive health organisation and wider health system.

The health **profession** represents the fourth dimension of cultural competency. Health professionals work within organisational structures and are an intrinsic part of the health system. Their practice, professional standards and on-going development need to be underpinned by standards, curriculum and guidelines with 'built in' cultural competencies.

As a means of illustrating the interrelated nature of these levels and their cumulative impact on culturally competent practice, an intervention has been identified and considered across the four dimensions. The area of intervention is the use of interpreters and the key question posed is, 'How does the client experience this intervention?'

The way to assess whether the client experiences culturally competent outcome lies in the response across all four levels of the model.

An effective use of interpreters to meet client needs would require:

- An commitment through policy and resourcing at the systemic level that service delivery includes measures to increase access and provide equitable service to people who may need language support to communicate with the health system.
- An organisational response in which
  - ▶ resources are made available for the use of professional interpreters;
  - ▶ policies and procedures are in place to require the use of interpreters in certain situations;
  - ▶ public contact staff have the necessary skills to use interpreters effectively to communicate with culturally and linguistically diverse clients; and

- ▶ a management that values the use of interpreters and understands the impact of interpreter use on resources, productivity and the time required for the intervention.
- As a professional, health practitioners need to have the expertise to work with interpreters for diagnosis and treatment discussions, the experience to assess when interpreters are essential and know how to access interpreters, so that they can effectively communicate with clients from diverse cultural and linguistic backgrounds.
- At an individual level workers in the health system need to know how to use interpreters effectively, are aware of how to procure interpreters, and be committed to use them.

The following sections summarise the research findings and detail the relevant competency considerations across the four dimensions of the model. The competencies are presented in a generic form as well as being considered in the applied area of obesity prevention. This approach increases the value of the cultural competencies by allowing application to the broadest range of health communications.

The application of the generic competencies to the specific area of obesity prevention also gives voice to the views and perspectives expressed by the consultation participants and by the authors of a number of submissions that used the topic of obesity prevention as the conduit to discuss broader cultural competencies.

## 4.2 SYSTEMIC CULTURAL COMPETENCY

### 4.2.1 *Findings from public submissions, literature review and public consultations*

When looking at the issue of cultural competency on a systemic level, the issue most commonly raised and one that was prevalent throughout all three areas of the research (the public submissions, literature review and national consultations), was that of adequate resourcing and funding. This, along with the existence of government practices and programs put in place to support the application of competency, were seen to be the starting point of such action and therefore an integral part of the process.

It was noted that, without this commitment, recognised through appropriate policy infrastructure, there is no foundation for culturally competent standards to 'filter through' at an organisational level. The consultations also highlighted the need for a comprehensive diversity approach; a system wide approach in which diversity issues are reflected in policy, priorities, resourcing and reporting. An essential aspect of this commitment would be an active compliance process that would not only stimulate behaviour but also legitimise it.

A number of documents analysed during the literature review provided examples of national and international efforts to codify culturally competent practice (Office of Minority Health (USA) 2000, Department of Human Services (Victoria) 2004, 2003, 1996, Department of Health and Ageing 2004, American Counselling Association 2004).

Of particular interest in the consultations was the need for appropriate information and consistency of data capture across jurisdictions to provide a demographic profile of the diversity of the population. This data consideration applied to both population data as well as service usage data. Once a diversity profile is established, the strong and consistent view expressed in all three areas of research was the need to guarantee consumer participation to inform decision-making and planning.

Another area of concern was that of language (interpreting, translation and bi-lingual staff) services. This was raised in the literature review as well as the consultations. There was a strong feeling that current language services were not being utilised to the extent that they should be, to support good culturally competent practice, due to a number of issues. Most notably, this was due to their accessibility and cost, as well as more structural issues such as prevailing policy, role definition and management support. For these reasons, attention to adequately funded language services was considered essential in order to provide high quality, easily accessible and affordable services that professionals within the sector would be more likely to access.

Cultural competency in health communication requires a systemic capacity to capture, enumerate and measure diversity. It requires diversity considerations in programming, planning and resource allocations.

4.2.2 Competency Specifications

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Systemic Cultural Competency	<p><b>Policy/Evaluation</b></p> <ul style="list-style-type: none"> <li>• A prerequisite policy infrastructure exists to direct and support culturally competent practice in the health system.</li> <li>• The policy infrastructure needs to embed and give life to the notion of reciprocity to ensure the active participation of culturally diverse communities in matters affecting their health and environments.</li> <li>• The policy is integrated into the management planning and evaluation mechanisms in the health system.</li> <li>• There is a demonstration of practical commitment to cross cultural practice through evaluation and monitoring mechanisms for the policy.</li> </ul> <p><b>Budgeting</b></p> <ul style="list-style-type: none"> <li>• Budget and resource provisions are in place to support cross-cultural practice.</li> </ul>	<ul style="list-style-type: none"> <li>• Considering culturally and linguistically diverse communities as part of the approach to address obesity prevention.</li> <li>• Considering the effect of culture and language issues in terms of project and activity design and implementation.</li> <li>• Resources to target culturally and linguistically diverse communities in obesity prevention are identified as part of core funding.</li> </ul>

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Systemic Cultural Competency	<p><b>Consumer Participation</b></p> <ul style="list-style-type: none"> <li>• There is an understanding of the importance of harnessing community capacity in achieving healthier living and environments.</li> <li>• There is an appreciation of the role of participation by vulnerable populations.</li> <li>• There is a structural involvement of culturally and linguistically diverse representatives in the planning and service development process followed by health organisations.</li> </ul> <p><b>Information</b></p> <ul style="list-style-type: none"> <li>• Population data and relevant health data that captures culturally and linguistically diverse information exists and is made accessible to health organisations.</li> </ul>	<ul style="list-style-type: none"> <li>• Engaging culturally and linguistically diverse communities to participate in the design and implementation of interventions to prevent obesity.</li> <li>• Encouraging culturally and linguistically diverse communities to articulate issues relevant to obesity and their views on the most effective community approach.</li> <li>• Accessing and analysing ethnicity and incidence data relevant to obesity and healthier living to establish priority cultural and linguistic community targets.</li> </ul>

## 4.3 ORGANISATIONAL CULTURAL COMPETENCY

### 4.3.1 Findings

At an organisational level, a common thread linking all three research areas was the need for strong partnerships within the sector; partnerships between health organisations and community groups. This helps to ensure the validity of both the health message and its appropriate dissemination.

*The client is the cultural expert about themselves. (Gold Coast)*

As well as these partnerships, it was noted that health organisations are able to develop and benefit from other strategic and creative partnerships either from other issue sectors or jurisdictions (local government) as well as key intermediaries (media).

During the consultations there was a strong feeling that the idea of cultural awareness had to 'filter through an organisation'. For this reason it was considered important to 'establish endorsement' at the top levels and train managers in the area of cultural competency. Developing awareness and hopefully enthusiasm at a managerial level was seen to be required if there was to be any real institutional change.

*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)*

Diversity, was described (during the consultations), as a 'tack on' or 'add on' to mainstream client based services. For this reason it was also considered important to establish a consumer charter that was inclusive of cultural diversity. Again, this was considered to only be possible with the backing of senior management. For these reasons it was important organisations make clear their cross cultural expectations through tiered and mandatory professional development for culturally competent practice.

*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)*

The consultations as well as the literature also highlighted the need for closer community involvement and control in the overall design and implementation of health programs. This idea was reinforced on numerous occasions, the common feeling being that in order to have successful and culturally competent information delivery, clients needed to take ownership and management of the information that was ultimately designed to be delivered to them.

*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)*

However, a number of articles in the literature warned that whilst community organisations do play an important role it is important to note that limited resources can become a barrier to service provision and factional and political issues can inhibit the reach of some organisations (Department of Premier and

Cabinet, Victoria, 2001, Worthington, Miralles, & Jensen 2001, Departments of Social Security, Human Services and Health and Immigration and Ethnic Affairs 1997). For these reasons, young people for example, may prefer to access mainstream organisations with bilingual workers (Cain and Miralles 2002) as long as they meet with a 'friendly and respectful' response (p14).

Following on from this idea of community involvement, organisational use or employment of bilingual staff and peer educators (to deliver health messages) were also considered very important in all stages of the research process. It was understood that messages would be taken up and embraced more willingly if delivered by someone from within one's own cultural background; this allows the educator to align messages (with greater ease) to the experiences of people from their own community.

The literature also identified the important notion of reciprocity or mutual respect. It was seen that valuing the benefits of diversity and dialogue across cultures were important steps towards true culturally competent practice.

*An example however modest, of a sense of reciprocity, was offered to us by a ....pilot study, in Fontenay-sous-Bois....where not only Portuguese children were learning French but where French children were given the opportunity to learn Portuguese. (Rey, 1996, p.5)*

Tied into this was also the need to value bilingualism as a skill and not see bilingual people as 'problematic' or an impediment. This issue was brought up in the literature as well as the consultations.

*Culturally skilled counsellors value bilingualism and do not view another language as an impediment to counselling (monolingualism may be the culprit). (Arredondo 2004)*

The issue of advocacy (on behalf of community organisations) was one acknowledged throughout both the literature and consultations. In the Sydney, Melbourne and Adelaide consultations it was understood that, currently, advocacy rarely comes from outside the health sector. It was suggested that the drive for culturally competent practice within organisations generally came down to individual passion. It was felt that, in order to achieve effective program delivery, a two-way exchange process was necessary. The idea that programs should be constantly instigating debate within the community was mentioned as being far more effective than a top down approach, in this way it was believed possible for communities to receive the kind of assistance they wanted and required. It was felt that this approach would lead to greater opportunities to raise important community issues.

Culturally and linguistically diverse communities need to be at the centre of organisational approaches to communicating healthier living and environments.

This will result in health communications that are efficient in terms of appropriate media use, effective in terms of the message being communicated and culturally relevant in terms of understanding the sensitivity factor of healthier living issues in individual communities.

Inter-agency collaboration was also identified in the consultations as another important area and was deemed to be an appropriate way to 'maximise the reach and effectiveness of health sector resources'

In the area of message delivery, it was also deemed important to consider varying literacy levels when communicating health messages. The consultations and the submissions brought up the issue of culturally and linguistically diverse health materials and resources. It was felt that if written, these should be developed from scratch, in the target language or with the target group in mind (not necessarily with text) and not simply translated directly from English. It was also suggested in the submissions that organisations utilise ethnic media as a dissemination tool for various messages and that consideration be put into the possibility of using other multimedia in the delivery of health messages.

Health communications is far broader an area than information delivery and needs to fully appreciate the capacity of the audience to receive information, existing information consumption behaviour and preferred sources of information for specific health messages.

It was also mentioned in the consultations, that GPs were not making adequate use of professional interpreting services due to a lack of information about their availability and incorrect notions of the cost of interpreters. This came up in the consultations as an area in need of substantial assistance in terms of funding and accessibility. Participants at the consultations believed the importance of such services should be understood within the health sector and more priority given to improving the services currently available to GPs and other health professionals. (The discussion in this area was based on interpreters rather than translated information.)

Further to this, GPs were identified (in consultations) as very important contributors in overall health message delivery. Adequate assistance and support to provide quality cross cultural services, including the ability to work effectively with interpreters was felt to be of extreme importance if cultural competence is to be achieved.

The role of the GP in the provision of health communications to culturally and linguistically diverse communities cannot be overstated. They are a critical nexus in the delivery of better health outcomes. As a consequence, they need to be centrally positioned in communications design.

It is important, when looking at message delivery, to recognise the longer-term framework required for culturally and linguistically diverse message delivery and results. The literature and consultations identified the need for strong organisational commitment to long term, ongoing strategies and projects to avoid the constraints associated with short-term project funding. The 'bombardment' of information (in the form of multiple messages from all three tiers of government) to newly arrived Australians (who have, at times not ever been exposed to preventative health messages) is a factor in the overall slower take up of health messages.

Related to this was an acknowledgement that investment in the maintenance of good health is long-term. Participants at the consultations expressed the view that it was important to move away from a 'quick fix' mentality and allow time for change.

A major focus in the submissions and consultations was the important role that managers have in fostering culturally competent practice in their organisations. Their role is critical not only in setting the priorities and resourcing activities; it also extends to creating a workplace culture that values cross cultural practice and resources and rewards good practice. As such there was a belief that cultural competency at management level was at the higher end of the cultural competency matrix.

Cultural competency at management level has particular relevance as it affects planning, performance expectations, resources and service values within organisations; in a word, the service culture of the organisation.

**4.3.2 Competency Specifications**

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Organisational Cultural Competency	<p><b>Policy/Evaluation</b></p> <ul style="list-style-type: none"> <li>• Commitment to cross cultural policy exists and is captured in a relevant client/consumer charter.</li> <li>• Program planning is inclusive of cross-cultural considerations and requires community input.</li> <li>• Culturally sensitive considerations and outcomes are central to program evaluation and review.</li> </ul> <p><b>Budgeting/Resources</b></p> <ul style="list-style-type: none"> <li>• Health organisations have the capacity in the area of human resources, material resources and financial resources to provide culturally competent practice.</li> <li>• Health organisations reinforce their expectations in culturally competent practice through tiered and mandatory professional development addressing knowledge, capacity and conviction issues.</li> </ul>	<ul style="list-style-type: none"> <li>• Organisations concerned with healthier living are required to consider the relevance of the issue to culturally diverse communities.</li> <li>• Giving cultural considerations priority within the overall policy approach to healthier living and environments interventions.</li> <li>• Identifying resource levels relevant to culturally and linguistically diverse priority groups.</li> <li>• Preparing the health and community service structures to support and resource responses to the health communication e.g. opportunities for gentle exercise, the identification of sports facilities that accommodate religious and cultural needs.</li> </ul>

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Organisational Cultural Competency	<p><b>Consumer Participation</b></p> <ul style="list-style-type: none"> <li>Population data and relevant health data that captures cultural and language information exists and is used to identify culturally and linguistically diverse communities.</li> <li>Health organisations have the skills, knowledge, resources and existing networks to mobilise community resources.</li> <li>Health organisations understand the importance of harnessing community capacity.</li> </ul> <p><b>Management</b></p> <ul style="list-style-type: none"> <li>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.</li> <li>Performance within their competency is measured and assessed.</li> <li>There is organisational endorsement and support for key competency building initiatives such as bilingual staff recruitment, cultural competency development, and partnership processes.</li> </ul>	<ul style="list-style-type: none"> <li>Identifying the level and type of participation required with reference to jurisdictional coverage and issue sensitivity.</li> <li>Actively seeking community resources to establish partnerships to address healthier living and environment issues.</li> <li>Program managers requiring the involvement of people from diverse language and cultural backgrounds make the appropriate allocation of resources to foster this.</li> <li>Identifying the appropriate organisational resources required to engage communities and empowering them to address healthy living and environments issues.</li> </ul>

## 4.4 PROFESSIONAL CULTURAL COMPETENCY

### 4.4.1 Findings

Professional development was brought up in all three fields of the research. The importance of it was stressed, in particular, during the consultations and submissions where it was strongly recommended that cultural competency units be built into all health sector training. By doing this, the importance of cultural competence would become clear to health professionals from an early stage and be integrated into their practice as a result.

The literature review uncovered numerous reports that defined 'cross cultural training' to include generic as well as specialist skills pertaining to the health sector – verbal and non verbal communication styles; values and beliefs; knowledge of family structures; gender issues; use of non-traditional methods of assessment; an understanding of how race, culture or religion affect personality, life and health choices, attitudes to wellness, illness, diet and physical activity (Benson 2003, Arredondo 2004, Pai et al 2000, Gow 1999, Eisenbruch 2004, Eastern Perth Public and Community Health Unit 1999, Graves & Sutor 1999).

It was also mentioned in the submissions that skills enhancement should include not only professional training but also programs within the health sector such as international exchange programs for health professionals.

All stages of the research process pointed to a need for adequate information (to be used by health professionals) to be available to organisations. This information would ideally come directly from the specific culturally and linguistically diverse group and include information on the impact of settlement; demographic data; and information on differences in values and beliefs including different notions of diet, exercise and preventative health. It was felt that this would make professionals within the sector more confident about working with culturally and linguistically diverse communities.

However, it is important to note that there was also some concern from within the consultations that this may lead to generalisation and cultural stereotyping. Taking this into account, it was seen to be important that any information distributed amongst professionals was understood not to be providing 'absolutes' about different cultural groups but instead be designed to teach people to understand how culture may act as a 'blueprint for action' (Jayasuriya 1990)<sup>1</sup>.

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<sup>1</sup> Jayasuriya, L., 1990, *The problematic of culture, ethnicity and identity in cross cultural theorising*, Department of Social Work and Social Administration, UWA, Nedlands, Perth.

There is a need for training and practice standards to deliver the competency necessary to use information on people from diverse language and cultural backgrounds as a context for interaction not as a tool to predict or assume behaviours or attitudes.

#### 4.4.2 Competency Specifications

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Professional Cultural Competency	<p><b>Self Reflection</b></p> <ul style="list-style-type: none"> <li>Health professionals are respectful and empathetic when dealing with patients from culturally and linguistically diverse backgrounds.</li> <li>Health professionals have the capacity to understand the potential impact of the cultural and linguistic background of clients (health behaviours, communications styles, treatment options, decision-making).</li> <li>Health professionals have the conviction, skills and understanding to adapt practice to cross-cultural requirements (context considerations, time, resource requirements, alternative approaches).</li> </ul>	<ul style="list-style-type: none"> <li>Professional and practice standards are inclusive of diversity considerations as they apply to healthier living and environments.</li> <li>Professional practice is defined as being inclusive of cultural understanding.</li> </ul>

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Professional Cultural Competency	<p><b>Information</b></p> <ul style="list-style-type: none"> <li>• Health professionals have acquired knowledge and can access information about culturally and linguistically diverse communities, their histories and specific health issues as required.</li> <li>• Health professionals know about the range of resources to support cross-cultural practice (interpreters, translated resources, community partners).</li> </ul> <p><b>Skills</b></p> <ul style="list-style-type: none"> <li>• Health professionals include cultural and linguistic considerations in their diagnosis, treatment options, and decision-making processes</li> <li>• Health professionals have the capacity to use resources to allow cross-cultural communication (interpreters, translated resources, community partners).</li> </ul>	<ul style="list-style-type: none"> <li>• Accessing information sources and experts on culturally and linguistically diverse communities in the area of healthier living and environments.</li> <li>• Experience and readiness to utilise access measures and use information materials relevant to the issue.</li> <li>• Cultural considerations are taken into account in proposing treatment options.</li> <li>• Appropriate information tools are utilised to deliver a culturally appropriate set of messages about health promotion, health supporting environments, prevention strategies, management and treatment options.</li> </ul>

## 4.5 INDIVIDUAL CULTURAL COMPETENCY

### 4.5.1 Findings

When looking at competence issues relating to individuals within the health sector, a key issue raised in all three stages of the research was the importance of cultural understanding in order to achieve effective levels of communication. Identified as of particular importance were understanding the impact of settlement; differences in cultural beliefs; values; and notions of healthy living. The consultations placed a great deal of emphasis on the importance of the health professional's communication skills.

Another key attribute was the ability to advocate on behalf of clients:

*Culturally skilled counsellors should attend to as well as work to eliminate biases, prejudices, and discriminatory practices. They should be cognizant of socio-political contexts in conducting evaluation and providing interventions and should develop sensitivity to issues of oppression, sexism, elitism and racism. (American Counselling Association, 2004, p.3).*

It was also stressed in the consultations that confidence was at times a cornerstone to cultural competence. It was maintained that it was not neglect but a lack of confidence that inhibited health professionals from working effectively with culturally and linguistically diverse groups. The idea was that, for many, the fear of making mistakes was the biggest barrier to working with people from culturally and linguistically diverse communities. In order to overcome this fear, health professionals would benefit from training that developed cross cultural skills and knowledge and taught the individual how to transfer information in a culturally sensitive way.

*Health professionals that genuinely care and want to help can at times be overly sensitive in being insensitive - due to a lack of confidence - they are scared of making mistakes. (Melbourne)*

Both the literature and the consultations noted that, in order to communicate effectively with clients, it was sometimes necessary to involve an interpreter should there be a language barrier. Participants at the consultations saw this as a key competence for the health sector. They spoke of the need to do away with the practice of using family members to translate; this was universally condemned as there is no guarantee the correct message is passed on to the client.

It was also mentioned in both the literature as well as the consultations that health professionals must recognise that for many culturally and linguistically diverse people, the importance of involving family in health related issues and the decision-making process is paramount.

*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, p.477).*

Green et al noted intergenerational changes in diet and physical activity and the bi-directional nature of that influence across three generations.

It was argued in one submission that there was a need for equal significance to be given to technical and cultural competence. For effective practice, a health professional must be confident in each area and recognise the importance of both in terms of their service provision.

*Attempts to achieve better health outcomes for culturally and linguistically diverse communities must not gloss over the technical competence of the health professional as a key determinant. (Royal Melbourne Hospital)*

The submission noted that an approach to health needs to move beyond a simple cultural consideration to one that positions culture within a comprehensive set of health outcome factors.

The concept of self-reflection was raised in both the consultations as well as the literature. Self-reflection was deemed to lead 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, p.21).*

Beyond self-reflection as an important starting point, the consultations and submissions provided a fair amount of information about the skills necessary for culturally competent practice. At the individual level, it was seen to be important that health professionals understand how differences in culture, language and migration experience may impacts on how health communications are developed. The value of this knowledge being the ability to determine the level of sensitivity and expectations around individual issues and through this structure approaches more likely to succeed.

At the level of implementation, professional development was seen to be essential to developing the necessary skills set to foster culturally competent practice. While this factor was widely acknowledged there was a consistent reservation about the training presently delivered and the low value accorded to it by many health organisations. The generic nature of some cross-cultural training was criticised. Instead, targeted and contextualised professional development reflecting adult learning principles was seen to be the model to be supported.

There is a policy imperative to increase both the quality and resourcing of professional development as a key strategy in achieving culturally competent practice.

The submissions and consultations indicated that there was a lot of activity with respect to delivering healthier living communications to culturally and linguistically diverse communities, but that there was a

limited sharing of this information especially in terms of evaluated exemplars. The result of this was a sense of inefficiency as there was minimal learning from the experience of other practitioners.

Cultural competency will be enhanced by a more consistent level of information exchange on the outcomes of health communications approaches for healthier living and environments targeting culturally and linguistically diverse communities.

**4.5.2 Competency Specifications**

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Individual Cultural Competency	<p><b>Self reflection</b></p> <ul style="list-style-type: none"> <li>• Individuals have the capacity to consider cultural and language specific issues in health communication activities.</li> <li>• 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).</li> </ul> <p><b>Information</b></p> <ul style="list-style-type: none"> <li>• Individuals have acquired knowledge and can access information about culturally and linguistically diverse communities, their histories and specific health issues as required.</li> <li>• Individuals know about the range of resources to allow culturally competent practice (interpreters, translated resources, community partners, face-to-face sessions).</li> </ul>	<ul style="list-style-type: none"> <li>• Considering the cultural, linguistic and migration issues around food and activity access, knowledge and choices.</li> <li>• Considering that there are differing perceptions about body image and the role of specific programs of activity as recreation.</li> <li>• Understanding the significant place that food, diet, and activity behaviours play in processes of cultural maintenance.</li> <li>• Understanding intergenerational differences with respect to attitudes to food and physical activity.</li> <li>• Identifying priority culturally and linguistically diverse groups through data acquisition and analysis relevant to service jurisdiction.</li> <li>• Understanding diet and exercise issues relevant to these groups; and the differences within groups – gender, age, education, generational.</li> </ul>

Dimension	Description of Competency	
	Generic	Applied to Obesity Prevention
Individual Cultural Competency	<p><b>Skills</b></p> <ul style="list-style-type: none"> <li>• Individuals can position health promotion within a linguistic, cultural and migration context.</li> <li>• Individuals have the skills to mobilise community resources to inform the communication process.</li> <li>• 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.</li> <li>• Individuals can identify and implement best practice approaches to health communications with a specific consideration of the most effective strategies and communications components including audience segmentation, message design, media use, partnership arrangements, and response and activity design.</li> <li>• Individuals have the capacity to use resources to allow cross-cultural practice (interpreters, translated resources, community partners).</li> </ul>	<ul style="list-style-type: none"> <li>• Working with communities to identify ‘risk’ and ‘protective’ environments and behaviours to improve healthy eating, increase activity and prevent obesity.</li> <li>• Designing a communications approach and messages that are informed and developed from within the specific cultural context.</li> <li>• Developing health promotion and illness prevention messages that resonate with communities and build on protective environments and behaviours to affect risk environments and behaviours.</li> <li>• Identifying both formal media and type of informant who will carry the message, with a particular consideration of authority voices in the culturally and linguistically diverse communities.</li> <li>• Allowing for message reinforcement by equipping health professionals responding to food, activity, psycho-social and wellbeing issues with the necessary resources.</li> </ul>

## 5. CONSIDERATIONS FOR NHMRC PRODUCT

### 5.1 FINDINGS

The consultations brought up some concerns about the usefulness of tool kits in general; the question of whether it would be used was of primary interest to many. There was a common feeling that tool kits tend to 'just end up sitting on a shelf'. It was also felt by some that a tool kit would have little relevance unless systemic issues were addressed.

An effective tool kit, it was widely agreed, would need to provide information that goes beyond cultural awareness. It would need to be productively effective; that is, provide practical skills to assist the user to work effectively with people from diverse backgrounds.

There was a general feeling that the resource should be organic, on-going and updated at regular intervals. It was suggested that, to encourage use and accessibility, it should be in an electronic format and should utilise more immediate information tools such as hyper-links to relevant community and professional resources.

It was considered important that the language used in the tool kit be simple and straight forward and that the content not be too prescriptive. It should include information in all of the following areas; (brought up repeatedly in all three stages of the research):

- information on the extent of diversity within the community,;
- population data;
- self reflection exercises;
- examples of best practice;
- information on working partnerships with culturally and linguistically diverse groups as well as the importance of consulting with these communities in order to provide relevant services;
- information on cultural understanding (including cultural issues associated with health, understanding of settlement, general communication);
- advice on working with interpreters; and
- appropriate referral information and advice about specialist organisations.

Any tool kit produced should be able to be used as both a planning and evaluation tool. This would maximise the integration of culturally competent practice as an organisational core activity.

## 5.2 TOOL KIT SPECIFICATIONS

<b>Tool kit Consideration and Summary</b>	
<b>Generic</b>	<b>Applied to Obesity Prevention</b>
<p>In terms of content for the tool kit the research and consultations identified the following requirements:</p> <ul style="list-style-type: none"> <li>• Information on the cultural, linguistic and immigration profile of individual groups.</li> <li>• Specific health considerations relevant to each group.</li> <li>• Information about available resources to assist in health promotion, such as community infrastructure and prominent leaders/informants.</li> <li>• Best practice approaches in cross-cultural communication, with specific requirements for demonstrated capacity to achieve desired results.</li> <li>• Planning and evaluation templates requiring the consideration of cultural and linguistic issues in health communications.</li> <li>• Skills based material such as working with interpreters, how to undertake cross cultural assessments.</li> <li>• The format should be electronic based and 'living', it should not be only paper based. It also should stand out from the other myriad of resources that have been developed.</li> </ul>	<p>The obesity perspective relevant to this would require a focus on issues relevant to food access, knowledge, choices, activity, body image, religious practices, migration experience and acculturation considerations relevant to communities. Issues of relevant to differentials by socioeconomic background need to be considered with issues related to culture.</p>

## **6. APPENDICES**

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## APPENDIX 1 - PUBLIC SUBMISSIONS

### INTRODUCTION

As part of the Increasing Cultural Competency for Healthier Living project the consultants have undertaken an analysis of the submissions received by the NHMRC on the issue of communicating health messages to culturally and linguistically diverse communities.

This process invited organisations and interested individuals to make submissions on the topic by addressing three key factors critical to the development of a competency framework and tools to facilitate its adoption. The three factors were:

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

The following report provides an analysis of the submissions. Along with the initial literature search (detailed in appendix 2), this analysis will be used to inform and direct the consultative phase of the project.

#### *Profile of the submissions*

In all 24 submissions were received by the NHMRC. The profile of the submissions is provided in Table 1.

*Table 1*

Characteristic	Categories	Numbers
<b>Organisation Type</b>	Individual	2
	Ethnic Specific Organisation	1
	Multicultural Community Organisation	2
	Mainstream Community Organisation	3
	Academic Institution	2
	Health Department – Hospital etc	3
	Health Department – Policy/Area Management	5
	Government Department (other than Health)	5
	Local Council	1

Characteristic	Categories	Numbers
<b>Nature of Submission</b>	Document addressing the factors	14
	Document describing examples of communication projects	4
	Submission of an existing project report	3
	General Discussion paper with associated literature review	1
	Letter	1
	Submission for funding	1
<b>State/Territory of Origin</b>	ACT	4
	NSW	9
	QLD	2
	SA	1
	VIC	4
	WA	4
<b>Length of Submission</b>	1-2 pages	5
	3-5 pages	8
	6-9 pages	2
	10-20 pages	6
	20+ pages	1

There was a high degree of variability amongst the submissions. While just over half of the submissions addressed their comments to the specific factors identified in the request, a large number took different approaches that included previously prepared reports on relevant research, as well as a submission that took the form of a request for funding.

This difference was also evident in the length of submission, resulting in 13 submissions of between 2 to 5 pages. A consequence of this was that some submissions tended to be fairly narrow in the range and number of issues addressed.

**Comments on the consultative process**

Three of the submissions commented on the efficacy and relevance of the submission process as a means of accessing appropriate input from ethnic communities or from relevant community intermediaries. The reasons identified included:

- The idea that submissions should be evidence based with copies of references would tend to result in responses from research/academia and those currently in the health sector;
- As a result many service organisations with examples of good practice models might not submit;
- Some jurisdictions collect insufficient ethnicity data to provide any evidence base for their submissions; and
- The lack of a clear definition of the term cultural competence, and the scope of the three factors provided made it difficult to respond.

It should be noted that the large majority (21 submissions) did not comment on the methodology being used to seek input.

## IMPORTANT INTERVENTIONS, SKILLS AND KNOWLEDGE

### *Recognising diversity*

The strong message contained in 5 submissions and implied in a range of other submissions was that culturally diverse communities are incredibly diverse and that this diversity needs to be acknowledged when considering the advancement of healthier living. This diversity was characterised as:

- Differing levels of **acculturation** and **food consumption** changes between linguistic and cultural groups.
- The existence of **high levels of diversity** in common language communities such as Chinese, Spanish and Arabic affecting modes of expression, attitudes and values that impact on food, leisure and exercise.
- Differences based on **migration experience** with the most notable being the experiences of refugees of entrants having been victims of torture and trauma.
- Taking into account both cultural assumptions and socio-cultural, linguistic and religious composition of the community.

The clear message from these submissions is that any approach that seeks to homogenise the culturally and linguistically diverse communities runs the risk of not connecting to the different communities in terms of delivering intended health messages. (Decies Management Consulting)

There is no easy answer to communicating effective messages to the culturally and linguistically diverse community that is contemporary in Australia. Without wishing to appear negative, the only certainty is that a snappy, 'one size fits all' message may please its inventor, but will not be effective.

### ***Ethnic Specific Organisations***

One submission argued that ethnic specific organisations were crucial in meeting the growing demands for care support for culturally and linguistically diverse communities because they possess the cultural and linguistic skills to most appropriate delivery certain types of health care. The submission argued that this role should be assisted through a **higher level of resourcing**.

### ***Development of Health Messages***

The area of developing and delivering health messages received the greatest level of attention from the submissions. The analysis of these issues is structured around a standard communication design framework including:

- development of messages;
- correlating messages to experiences and expectations;
- message approach;
- message delivery and
- message follow-up.

The process undertaken for the development of health message was seen as an essential component for both relevance of the health message and its success in changing behaviour (11 submissions).

Two submissions argued that the best approach is to **develop materials** from scratch **in the target language** based on discussions within focus groups, especially when materials are being used to motivate changes in behaviour.

A number of submissions argued that the best messages were those developed in **partnership with culturally and linguistically diverse communities**. This approach would not only provide the cultural and linguistic skill set to make the message appropriate, it would also ensure the validity of both the message and its dissemination. While this was held up as the best practice approach there was some concern voiced about other unsound practices.

We understand that appropriate partnerships are crucial, however we have discovered that different agencies define the term “partnership” in different ways. NSW Health needs to endorse and implement a broader definition of partnership, which would allow its staff to work cooperatively with other agencies on a range of initiatives, using this opportunity to foster strong relationships with local stakeholders. To date, it seems Health staff are mandated to work on specific issues, at designated times, with the expectation that they are the drivers or experts and their partners are simply there to help do the work. This approach has left services/workers feeling disempowered and reluctant to work with Health. (Fairfield City Council)

Given the diversity within culturally diverse groups (referred to previously), **target audiences need to be clearly defined**. That is, within cultural linguistic groups, messages need to be clearly targeted at the subgroup most at risk of obesity, or at the subgroup judged most easily influenced by the chosen message and medium.

This notion of targeting was specifically mentioned in only one submission, though its relevance is supported by the number of submissions keen to stress the diversity within and between cultural and linguistic communities.

### ***Message composition***

Seven submissions provided comments on the actual composition and style of the message and offered the following advice:

- If being developed in English, avoiding puns and idiomatic language that may not be translated well.
- The use of trained and competent translators who can convey the meaning and not just a literal translation noting the “potential difficulty of translating concepts even as simple as ‘diet’ or ‘exercise’ with the intended connotations”.
- Considering the person delivering the message and determining whether there is a need for an authoritative voice from the individual cultural group.
- Considering the use of different techniques such as dance, music and storytelling.
- Considering the essence of the message:

Whether messages should celebrate and appeal to the individual, or recognise the importance of the collectivist approach, by addressing the extended family or some other wider group that might determine the acceptability of behaviour including changed eating or exercise plans. Would adults take changing their ‘bad’ diet more seriously if their children or their aging parents presented it as not doing their duty, if they were to suffer foreseeable medical complications? (Decies Management Consulting)

### ***Message delivery***

In total, nine submissions made specific reference to how information messages should be delivered. The most favoured approaches were:

- Using **ethnic media**, with a number of references and examples to the efficacy of radio to provide an immediate medium as well as its potential to result in tape based resources for more diverse community use.
- Through established community information dissemination channels such as **community organisations**, especially those providing face-to-face opportunities for group sessions.
- Utilising **bilingual community educators** as a strong preference over interpreters.
- Including health messages within **English language programs** for new arrivals through the AMES and other providers (a number of examples were given).

- Considering place based activities:

Health promotion initiatives need to be extended to incorporate practical activities in the community. If, for example, we are looking at obesity and physical activity, how can we develop programs to help people get started and address the barriers stopping them from participating? Council's Parks Redevelopment Program is an example of attempting to do this. Not all residents are interested in going to gyms/sporting clubs, nor can they afford to do so. Ideally, there should be place based activities, focussing on a neighbourhood and having a practical component. These activities should be free, with coordinators available to initiate and run activities. These would be run in conjunction with broader regional/state wide health promotion campaigns. (Fairfield City Council)

### ***Cultural capacity of health professionals***

The cultural capacity of health professionals was not given as high a priority in the submissions as other issues (5 submissions).

Where it was identified it was defined as fitting into the following areas:

- A **lack of a shared set of values** and beliefs that can constitute a barrier to cross cultural communication.
- **Inadequate information** on culturally diverse communities to inform the health professional's expectations in cross cultural settings.
- The lack of **specific information** on the health needs of migrants and refugees from particular regions and circumstances.
- The need for a range of professional training and skills enhancement such as,
- cultural competency units in undergraduate course,
- cross-cultural training course for health professionals and
- international exchange programs for health professionals.

**The lack of coverage of this area in the submission is in part reflective of the orientation towards information provision rather than direct service provision, and as such this area should be given more attention in the consultative stages of the project.**

## **ORGANISATIONAL STRUCTURES AND POLICIES**

Three of the submissions identified principles or core ideas that need to be considered as impacting on the cultural competency framework. These were:

- The understanding of culture and its health impacts needs to **precede** the development and implementation of strategies for **primary prevention**.
- Communications approaches need to be informed by and reflect the cultural practice relevant to information dissemination in different cultural groups.
- The cultural competency framework needs to be flexible enough to accommodate the practical difference between **State/Territory jurisdictions** and the nature and level of linguistic and cultural diversity in these different jurisdictions.
- The cultural competency framework should consider the relevance and applicability of the health concepts at the core of addressing obesity such as **collective health, individual health, body image, nutrition** relevant to life in Australia and the role and relevance of **exercise** for health.
- The ultimate success of a cultural competency will depend on the existence of government policies and programs in place to support the practical application of the competency.

While only three submissions specifically identified principles as the basis from which to address the three identified factors, a range of other submissions implied the need for the framework to contain overarching principles to both define and focus the framework considerations.

**Message testing** was considered essential practice in a number of submissions. In conducting research for the development of communication messages one submission suggested that when a topic is introduced the group members should first be asked to explain their understanding of the issue, e.g. diarrhoea, i.e. where it comes from, what the symptoms are, how it is treated, etc. 'In this way the group can appreciate the wisdom already in existence in their midst. As the facilitator reviews the answers any misconceptions are cleared away with explanation and time is allowed for discussion, so no one feels pushed around or insignificant. Then the facilitator gives a comprehensive explanation of the condition including where possible the points made previously by group members'.

### **Access issues**

Access issues were seen as critical in a large number of submissions with the notion of access including both information access and service access.

In terms of information access, there is a stated need to improve and build on best practice in the provision of health information to advance healthier living. The provision of health information needs to consider the following:

- The type and complexity of language used,
  - Health information can be difficult to understand, even for native speakers. For community members for who English is their second, third, fourth, ... language, there may be a

significant lack of confidence that they have correctly understood the message, even if it appears straightforward to the native speaker: 'Exercise more? Does this mean I need to exercise until I am puffing? Then I'd better not keep walking with my friend because we talk ... Maybe then I won't walk after all! It's not safe on my own ... (Decies Management Consulting)

- The consideration of **literacy levels** of individual language groups and the impact of this on the choice of communication medium and response mechanism.

People may be highly literate in the own language, and speak several other languages. They are understandably sensitive to being thought illiterate simply because they do not read English, particularly if they are people of status in their own community. (Decies Management Consulting)

- The consideration of **multiple media** use to ensure the delivery of health messages. An examples of this was a comprehensive localised communications campaign run by a Council in South West Sydney. This included:
  - Developing a language aid program across Council staff to communicate with bilingual residents.
  - Having a standard practice of translating articles in *Our City Life* (resident) newsletter in a variety of languages.
  - Standard initiatives such as using the telephone interpreter service (TIS).
  - Developing arts based programs. e.g. targeting pre-school aged children and mental health and wellbeing and poetry and arts workshops for carers culminating in a published book of works and a video.
  - Facilitating partnership/networking initiatives with local services and volunteer groups.
  - Conducting training workshops for local Non Government Organisations (NGOS) to build their skills in seeking and securing funding for programs that benefit local residents.
  - Running Health Orientation Tours for local residents from culturally and linguistically diverse backgrounds in conjunction with the local Health Service.
  - Developing initiatives for key weeks throughout the year, such as Mental Health Week, Carers Week and Seniors Week.
  - Providing opportunities for local groups to promote positive health initiatives, such as local radio interviews, Council's monthly 'What's On' calendar.
  - Piloting new methods for delivering information, utilising existing media, such as SBS radio and conferences.

- Working with local Health Services to run the Physical Activity and Nutrition Network, and subsequent initiatives developed by that group.
- Redeveloping local parks with a focus on consultation with a broader range of stakeholders, to ensure the parks are “user friendly” for a broader range of residents (e.g. Heart attack survivors, young families, adolescents, disabled).
- Expanding our extensive network of cycle-ways.

A final issue for this section is the importance of creating a **longer-term framework for message delivery**. Culturally and linguistically diverse communities are increasingly being targeted with all types of messages and many of these campaigns are one-off or highly episodic. There is a need to develop a longer-term approach in which messages are delivered through a number of appropriate media over a longer time frame.

#### **FACTORS IMPACTING ON TAKE UP OF HEALTHY LIVING**

Five submissions identified how health status is affected by the settlement process, and the need to understand these impacts when considering better health issues. The types of issues raised in this regard included:

- Adoption of local behaviour as a means of demonstrating socio-economic status (e.g. such as using cars to travel short distances rather than walking which would have been the norm in the country of origin).
- Increasing the frequency and volume of consumption of food types which were more expensive or scarce in the country of origin.
- Lower priority given to better health in comparison to other settlement issues such as employment, housing, child care, and financial security.

The submissions argued that there is a need to consider length of residence, settlement issues and the degree of difference between the immigrant’s settlement experiences as part of the better health considerations.

For some immigrant groups in Australia, markers of socio-cultural status can mean rapid acceptance of the new culture’s cultural norms. Thus, an immigrant from one third world country, on being asked why he did not walk or do his shopping as it was assumed he would have done ‘back home’, responded readily ‘Australians do not walk to the shops. Why should I?’ It may be the case that, as a male, he would not have done the shopping, ‘back home’. (Decies Management Consulting)

Health education can only take place within a larger framework of social discussion ... People's lifestyle and consequently their health is determined by many factors including, but not exhaustively, employment, education, self-esteem and social status, security and culture. How can any health messages be effectively communicated without at least taking some of these factors into consideration? (Sophie E Francis)

Three submissions suggested that a factor in achieving better health outcomes for people from culturally diverse communities was to consider the need to develop an educative approach on the concept of **self-managed health** and **personal responsibility** for health behaviour.

One submission addressed the importance of finding a **balance between technical competence and cultural competence**. Attempts to achieve better health outcomes for culturally and linguistically diverse communities must not gloss over the technical competence of the health professional as a key determinant. The submission noted that an approach to health needs to move beyond a simple cultural consideration to one that positions culture within a comprehensive set of health outcome factors.

The authors of the submission felt that cultural sensitivity is often made paramount and over-privileged, while biomedical competence is seen as ethnocentric and subsidiary. Given this, it is their opinion that health practitioners are told to avoid ethnocentrism and respect other cultural understandings. They note that the extent to which cultural sensitivity is considered by patients as important however, has not been adequately discussed in the literature, with one exception. In Hawthorne, Toth and Hawthorne (2000) it was noted that despite patients expressing a preference for bicultural and bilingual nurses, patient interviewees were seen to be willing to sacrifice cultural sensitivity and knowledge in the interests of better, or technically more competent, health care.

**The issues raised in this submission are also important because they provide a consumer perspective that is not reflected in other submissions.**

Eight submissions made comment on the issue of how cultural perceptions of body shape and body image are a significant factor in how people from a language other than English background address obesity. The comments in this regard were quite varied and covered three areas, body shape and image, exercise and food and nutrition.

With regard to **body shape** the following issues were raised

- Not all cultures consider being overweight as a negative physical feature.
- Beauty and attractiveness are culturally defined and as such being overweight may not be perceived as having negative social consequences.
- Being overweight can be seen as a demonstrating affluence, and high socio-economic status.

Scott et al. (2001) in a study of the emotional effect of tooth loss in denture wearers in the UK and Hong Kong found significant similarities in both countries but attributed lower inhibitions to denture wearing and greater restrictions on daily lives to cultural values and expectations. (Dr Gavin Melles)

With regard to **exercise** the points raised were:

- Differing cultural perceptions on the role of exercise as a health activity rather than an aspect of work.
- Differing approaches to exercise most notably in the form of 'gentle exercise'.
- Limited opportunities for exercise as a functional activity such as bicycle riding for transport, or leisure activity such walking as a social interaction.

With regards to **food** and **nutrition** the points raised were:

- Increases in food intake based on availability and relative low price.
- A level of acculturation in terms of local food consumption.
- An increasing tendency to consume fast foods, and especially for children.

Six submissions addressed the need to align messages to the experiences and expectations of people from culturally and linguistically diverse backgrounds. This issue is consistent with previous issues raised about the inefficacy of health messages if they do not take into consideration cultural beliefs and values. The following factors were identified as fundamental to increasing the likelihood of takeup of health messages:

- Considering the cultural predisposition towards the health issue:

Two of the key lifestyle factors that can result in obesity – unhealthy diet and lack of exercise – are remarkably heavily influenced by culture. For this reason, any message which is culture specific, particularly the use of humour and other shared cultural values such as status symbols, may well lack appeal to a different cultural audience. (Decies Management Consulting)

- Considering the delivery of unfamiliar concepts in culturally appropriate ways, in part, by ensuring that the extended family or wider community is involved in imparting information and education;
- Identifying informants who can overcome message resistance through their status as experts and voices of authority,

If diet is to be the focus of an 'obesity' message, the first question from most communities which have not assimilated to Australian eating habits will be, 'All very well, but which of my traditional foods are good for me, and which are not?' A message with no follow up is likely to provoke more anxiety than any other behaviour change. Until the nutrition expert have gained community members' confidence, there is little point to telling them that they are

asking the wrong question; that exercise, too, is part of a healthy lifestyle. Or that it's all about a 'balanced' diet, without explaining what this means in terms of their daily and weekly food purchasing, cooking and eating practices. (Decies Management Consulting)

- Directing messages at meal providers and shoppers.

The issue of cultural beliefs as a determining factor in health messaging is central to the whole project and is equally valid when looking at issues that act as potential barriers to better health. The cultural issues raised as barriers in seven submissions include:

- the use of cultural presuppositions that are incorrect e.g. that obesity is incurable, or fatness is a factor of ageing.
- Physical activity is not seen as a leisure activity.
- Perceptions of meats and fats as being high status foods.
- Cultural and religious observances that limit opportunities for exercise.
- Limited experience with potable drinking water.
- Cultural perceptions affecting consideration of prevention as opposed to notions of fate.

Immigration and settlement issues were identified in three submissions as potential obstacles as new arrivals were seen to be more likely to have a differing set of cultural expectation around health and healthy living. This set of pre-existing beliefs would necessarily act as a barrier to any form of health message.

The appropriateness of a negative or cautionary message also needs to be addressed in the target community's cultural terms: is death or disability (un) mentionable? What is the role of traditional medicine? Is obesity somehow associated inevitably with living in Australia, to which there is no alternative: 'No-one back home was fat'; 'I eat because life in Australia is stressful'; 'In Australia I am too busy to 'exercise'? (Decies Management Consulting)

It should be noted that there was a fair degree of overlap in submissions with respect to the identification of barriers to behavioural change and the discussion on interventions to advance healthier living and environments. The report has sought to minimise the repetition.

#### **OTHER DOCUMENTS / REFERENCES PROVIDED:**

- Still there's no food! food insecurity in a refugee population in Perth.
- Charter of Public Service in a Culturally Diverse Society (1998) (DIMIA).

- Multicultural Health Program conducted by the Centre for Culture and Health (University of NSW) (includes the development of benchmarks of cultural competence and best health practice to ensure that medical graduates and, as appropriate, other health professionals have achieved a defined level of cultural competence, based on evidence-based practice).
- Aboriginal health and nutrition: the process of developing new materials to train Aboriginal health workers in Western Australia.

## APPENDIX 2 – LITERATURE REVIEW

### Frame of reference

The initial systematic review has 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. As agreed in the first meeting with the Working Committee, the review included a limited number of exemplars from the allied fields of nursing and counselling as well as the management and education sectors. The primary focus has been evaluated examples of good practice in Australia, with some readings of international articles for comparative purposes. Some policy documents and conceptual studies have also been read.

The overarching question framing the literature review was:

- Are there evaluated models of communication of healthy living options to people from culturally and linguistically diverse backgrounds in the health sector with proven effectiveness?

### Limitations

It should be noted that some reports analysed during this literature review used data based on self-reported observations. Such data have limitations for people's perceptions are not always accurate. Some report findings are thus indicative and would benefit from quantitative data to test the hypotheses.

Evaluation design limitations of some projects reviewed were that they were limited in scope, in opportunity for longer-term evaluation and it was difficult to identify generalisable intervention strategies.

### IMPORTANT INTERVENTIONS, SKILLS AND KNOWLEDGE

A number of articles, (many but not all from the counseling field) highlighted the importance of **self-reflection** to move from an ethnocentric position to being able to understand the culture-bound nature of values and behaviour and identify personal prejudices and bias (Benson 2003, Eisenbruch 2004, Byram 1997, Gow 1999, Pai et al 2000, Arredondo 2004, Spence 2001).

Eisenbruch (2004), Eisenbruch et al (2001), Spence (2001) discuss an important outcome of **self-reflection**, *cultural safety* and *cultural security*:

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 p21).

The issue of mutual respect, a valuing for the benefits of diversity and dialogue (Eisenbruch 2004, Audigier 2000, Pai et al 2000, Carillo et al 1999, Perotti 1998, Rey 1996, (is encapsulated by Rey through the term '**reciprocity**') Rey gives an example of how the education sector has put this into practice:

[An] example however modest, of a sense of reciprocity, was offered to us by a ....pilot study, in Fontenay-sous-Bois....where not only Portuguese children were learning French but where French children were given the opportunity to learn Portuguese (p5).

The Multicultural Counselling Competencies identified by the Association for Multicultural Counselling (USA) highlights the skill of being able to **see benefit in bilingualism** and of not seeing the use of a language other than English as an impediment or a deficit. (Arredondo 2004). Gow (1999), also includes this in her analysis of the literature on cultural competence.

Identified as useful interventions in the literature were forming **partnerships** with community organisations and also **using existing activities / groups within community organisations**. The ability to piggy-back on to existing friendship groups, schedules and venues was seen to be a way of minimising the impact of travel, individual / community concerns about the credibility of the program / health professional and other factors. (Eastern Perth Public and Community Health Unit 1999, Kondos 1994, Graves & Suitor 1998, VicHealth 1997, von Hofe, Thomas & Colagiuri, 2002, Karantzas n.d., West Bay Alliance n.d., US Office of Minority Health *National Standards for culturally and linguistically appropriate services (CLAS) 2000*, Kondos 1994, Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004, Green et al 2003). This was felt to be important in programs dealing with healthy eating choices as community organisations were seen to have the cultural expertise to facilitate effective program outcomes (Graves & Suitor 1998, von Hofe, Thomas & Colagiuri, 2002, Green et al 2003). The report, *Out of the mist; Young people emotional wellbeing and life choices*, by the Youth Affairs Council of South Australia (n.d) strongly recommends collaborative inter sectorial partnerships to ensure a coherent approach to youth from diverse language and cultural backgrounds experiencing or at risk of experiencing mental health problems.

Other research however has found that whilst community organisations play an important role, limited resources can constrain the extent of services provided and factional and political issues can curtail the reach of some organisations (Department of Premier and Cabinet, Victoria, 2001, Worthington, Miralles, & Jensen 2001, Departments of Social Security, Human Services and Health and Immigration and Ethnic Affairs 1997). Young people for example may be more comfortable accessing mainstream organisations with bilingual workers (Cain and Miralles 2002) as long as they meet with a 'friendly and respectful' response (p14).

A number of reports highlight the centrality of **cultural understanding** underpinning communication skills – defined by Byram (1997), as the ability to access the taken for granted knowledge underpinning communication. For example when talking about the importance of a 'healthy diet', both interlocutors would

understand how the other person understood it and would adapt their communication to ensure there was no possible misunderstanding. Reports defined **cross-cultural training** to include generic as well as specialist skills pertaining to the health sector– **verbal and non-verbal communication styles; values and beliefs; knowledge of family structures; gender issues; use non-traditional methods of assessment; an understanding of how race, culture or religion affect personality, life and health choices, attitudes to wellness, illness, diet and physical activity** (Benson 2003, Arredondo 2004, Pai et al 2000, Gow 1999, Eisenbruch 2004, Eastern Perth Public and Community Health Unit 1999, Graves & Sutor 1998, Salimbene 1999).

A number of reports emphasise the importance of involving **family members** in the health program / activity (Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004, von Hofe, Thomas & Colagiuri 2002, Graves & Sutor 1998, Karantzas n.d, Youth Affairs Council of South Australia n.d). The Eastern Perth Public and Community Health Unit report (1999) highlighted a positive intervention emanating from an understanding of the importance in some cultures, of the family unit in the decision making process. Eastern Perth Public and Community Health Unit identified the strategy to include the women's husbands in the decision making as an important variable in the success of the swimming program.

Green et al (2003), report on the influence of grandparents on children's physical activity and diet in migrant communities and argue for a multigenerational approach. They go on to say:

....[G]iven 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 (p447).

Eisenbruch (2004) however, warns against the pitfalls of a reductionist approach to cultural / ethnic 'differences'. The Eastern Perth Public and Community Health Unit report (1999) also stresses the importance to be placed on the actuality of the culture as lived by each individual in the group rather than on a generalised knowledge of cultural differences pertaining to the group.

Other reports go on to include the skill to **recognise the limits of one's knowledge** and seek further training (Arredondo 2004, Gow 1999).

Some articles extend the notion of cross-cultural training to specifically target health professionals and community intermediaries from diverse cultural and linguistic backgrounds (Ming & Ward 2000, Rowley et al 2000, Centre for Community Child Health 2002, Reijneveld, Westhoff & Hopman-Rock 2003, Barnettby telephone communication February 2005, Graco telephone communication February 2005, Migrant Health Service 2003a,). These authors and professionals emphasise the benefit of using **peer educators**,

conversant with the cultural values and language of the target group and able to establish networks with community groups.

The capability to effectively manage workforce diversity is mentioned by Eisenbruch et al (2001). Articles from the management field classify skills according to work responsibilities. Nicholas et al (2001) write that managers need to be competent in **managing culturally diverse teams**. The writers go on to discuss how a critical management competency is the **ability to recognise and capitalise on the potential value of workforce diversity**. The Public Services (2003), Health (2002) and Community Services (2002) Training Packages comprise units of **competency for working and managing diversity at all qualification levels**. For example, the Public Services Training Package outlines competencies from basic awareness and understanding of obligations and responsibilities to the senior management capabilities in designing, implementing and evaluating a diversity management policy.

The importance of a multiplicity of approaches, spelled out by the Victorian Department of Human Services in its *Cultural diversity guide* (2004) is no where more evident than when articles deal with the need for health sector staff to understand the value of adequate **communication strategies** (Migrant Information Centre Eastern Melbourne n.d., Brawley in Moseley et al 1997, North Central Metro Primary Care Partnership n.d., *Culturally Equitable Gateways Strategy* 2003, Worthington, Miralles, & Jensen 2001, Department of Premier and Cabinet Victoria 2001, South Western Sydney Area Health Service 1998).

An integrated approach to communication is a primary consideration. Not only does this mean integrating, whenever possible (and relevant) with complementary English-language campaigns but also attempting to convey the message via a **diverse number of communication channels, appropriate to specific ethnic audiences** [our emphasis] (Department of Premier and Cabinet Victoria 2001, p1).

The accompanying unpublished report to the above publication (Worthington, Miralles, & Jensen 2001), goes on to state that a 'blanket template approach is unlikely to be successful' (p3) and thus a vital skill for anyone developing information campaigns is the ability to inform oneself about the specific **demographic characteristics** and in particular the **information consumption preferences** of the group/s being targeted by the campaign.

The **ability to advocate** for clients is identified in the Multicultural Counselling Competencies of the USA's Association for Multicultural Counselling (Arredondo 2004). Gow (1999), in providing a snapshot of work on the subject of cultural competence and its potential application in an Australian context, also includes the advocacy role as an important individual skill. Eisenbruch (2004) similarly includes this competence in the resource *The lens of culture, the lens of health: Toward a framework and toolkit for cultural competence*. So does the Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004.

**Understanding the institutional barriers** that inhibit use of health services is included in the Multicultural Counselling Competencies of the USA's Association for Multicultural Counselling (Arredondo 2004). Gow (1999) and Eisenbruch (2004) also mention the importance of this intervention.

A commonly cited skill is the ability to **work effectively with interpreters** (Karantzas n.d., Arredondo 2004, CLAS, Ross 2001, Kondos 1994, Gow 1999, Eisenbruch 2004, Department of Human Services *Culturally Equitable Gateways Strategy* (2003), *Cultural Planning Tool* 1996, *Cultural Diversity Guide* 2004, Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004,).

## ORGANISATIONAL STRUCTURES AND POLICIES

**Cross-cultural training** is seen as a key organisational driver supporting effective service delivery to people from diverse cultural and linguistic backgrounds (Gow 1999, Arredondo 2004 CLAS, Nicholas et al 2001, the Department of Human Services, *Cultural diversity guide* 2004 and *Cultural Planning Tool* 1996, Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004, Spence 1999).

Like, writing as a general practitioner, states that integrated cross-cultural training is critical in managed care settings and sees cross-cultural training as a foundation skill for organisational cultural competence (1999).

The **employment of bilingual staff** is mentioned as an important organisational input (Department of Human Services, *Cultural diversity guide* 2004, and *Cultural Planning Tool* 1996, Centre for Community Child Health 2002, Reijneveld, Westhoff & Hopman-Rock 2003, Nicholas et al 2001, Arredondo 2004, Karantzas n.d.).

Poss (1999), calls them 'health promoters' and writes:

[As] nursing has not succeeded in incorporating culturally sensitive content into all nursing curricula , what other solutions might be available to address the problem of providing culturally competent nursing care in our increasingly diverse society? One approach to the dilemma is for the nursing profession to consider incorporating health promoters in health care settings that serve large numbers of multicultural patients. Health promoters are persons of the same cultural and linguistic background as the patients with whom they work.....Leinenger has observed that when nurses and patients share a cultural tradition, patients appear to be more comfortable and have a sense of solidarity and mutual concern. This shared experience also serves to enhance the work of health promoters with patients (p32).

Eisenbruch et al (2001), refer to the New Zealand strategic review of nursing and education and to some specific issues identified for Pacific peoples. The authors state:

It is necessary to reflect upon the capacity of broad, generally focused education in multicultural education health to bring about a change in practices based on cultural biases – focusing instead on the need for a cultural mix in the nursing profession that matches the local cultural diversity (for example, will have as a minimum a complement Pacific Nurses). This is an issue for student recruitment (p10).

In the same article, a key example provided by Flinders University of the teaching of cultural safety in Australia in Indigenous nursing education was given:

The School of Nursing and Midwifery acknowledges the unique nature of Aboriginal and Torres Strait Islander peoples' culture and traditions. Further, the School has prioritized cultural safety as a specific factor to be monitored within the ongoing development of the Bachelor of Nursing. Whereas cultural awareness and cultural sensitivity are processes, cultural safety in education and practice refers to the outcome that can be measured by people receiving the service (p 11).

Sammartino et al (2001, 2002) identify the need for policy level interventions to ensure successful recruitment and retaining of bilingual staff. Diverse workplaces are only effective when the diversity is recognized, factored into planning and supported and rewarded (Sammartino et al 2001). Not much was found in the literature about the need for **diversity to be reflected at all levels of the organisation**. An exception was the USA National Standards for Culturally and Linguistically Appropriate Services (CLAS) which include the following:

Health care organizations should implement strategies to recruit, retain and promote at all levels of the organisation a diverse staff and leadership ....representative of the demographic characteristics of the service area (Standard #2)

Eisenbruch (2004) also emphasises the importance of diversity in all levels of the organisation.

**Adequately funded language services** were seen as another key organisational input – at a minimum this meant access to interpreters, translated material and bi-lingual staff (Department of Human Services, *Cultural diversity guide 2004* and *Cultural Planning Tool 1996*, CLAS, Arredondo 2004, Gow 1999, Karantzas n.d, Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia 2004*).

Access to an **interpreter** and **translated materials** is reinforced by the discussion about the need for in-language materials to be more than literal translations, and incorporate sensitivity to cultural nuances:

A simple translation of anti-smoking resources designed for English speakers from a predominantly Anglo-Celtic culture is unlikely to meet needs of ethnic Chinese smokers who, as shown by our data, are typically not ready to quit. Neither will it effectively engage unique cultural values such as the family as a powerful force to reduce prevalence of smoking in this community (Ming & Ward 2000, p440).

**Integrated, multifaceted and properly planned communication strategies** were seen to have led to successful outcomes. A number of programs documented that scheduling of **face-to-face sessions** with targeted groups were particularly useful as a means of disseminating information and recruiting members

(West Bay alliance n.d., North Central Metro Primary Care Partnership n.d., Department of Human Services *Culturally Equitable Gateways Strategy* 2003). The Department of Human Services *Culturally Equitable Gateways Strategy* (2003) seeks to provide practical support to HACC funded agencies to communicate effectively to people from a language other than English background. It lists a number of characteristics to be taken into account such as impact of patterns of migration, varying levels of isolation, literacy and different pathways into services (p3).

An article by Monteiro et al (2004), reviewing studies on obesity and the role of socio-economic status (SES) conducted in adult populations in developing countries, whilst not directly relevant to this project, makes interesting reading with respect to the conclusion reached by the authors that multi-sectorial measures are required to:

....improve the access of all social classes....to reliable information on the determinants and consequences of obesity; and design and implement consistent public actions on the physical, economic and sociocultural environment that make healthier choices concerning diet and physical activity feasible for all (p.12).

Another way of getting the “message out” is to distribute information in relevant community languages within the community itself, via their own **formal and informal community information networks**; through community organisations as well as ethnic mass media. (Karantzas, n.d.).

Organisations or programs that had undertaken **research** into their community felt that this data had helped to secure positive outcomes. A number of reports also identified such interventions as fundamental organisational practices (Gow 1999, CLAS, Department of Human Services, *Cultural diversity guide* 2004 and *Cultural Planning Tool* 1996, von Hofe et al 2002, Ross 2001). The VicHealth report, *Promoting the mental health and wellbeing of new arrival communities: Learnings and promising practices*, (2003) and Eisenbruch (2004) point out the culture bound nature of research methodologies and argue for the need to develop new approaches. The Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* (2004) also stresses the importance of **common data measures**.

Established **consultative processes** were cited as important organisational practices. The Migrant Health Service, (2003a) wrote that the ‘previously established trust’ with culturally diverse communities underpinned the success of the consultations held to scope their project targeting men from a language other than English background. A few reports further defined this to include **community control over the design and implementation** of programs (Department of Human Services *Cultural diversity guide* 2004, CLAS, North Central Metro Primary Care Partnership n.d., Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004, Migrant Health Service 2003a, Adelaide Central Community Health Service, 2002, VicHealth 2003). Too many times it was felt, communities were consulted after the fact (Rowley et al 2000 (writing in an indigenous context)).

**Formalising the participation in decision making** of people from culturally diverse backgrounds through their appointment to committees of management was also noted as important in ensuring a culturally sensitive and effective organisation / program (*Cultural diversity guide 2004*, CLAS, Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia 2004*, Karantzas n.d., Ross 2001).

North Central Metro Primary Care Partnership (n.d.) mentioned that organisations should put aside funds to **formally recognise the advice** and other support provided by communities.

Rowley et al (2000) documented the positive impact on program participants of the on-going **evaluation and feedback** to the group. This was seen to signal the commitment of the program staff to the needs of the group; as Eisenbruch (2004) and Eisenbruch et al (1997) defined it, it showed their cultural respect for the participants.

**This initial scan of the literature has not identified any articles on the individual level factors affecting take up of culturally competent practice. The consultation phase will seek to address this gap.**

## **FACTORS IMPACTING ON TAKE UP OF HEALTHY LIVING**

A constant thread in much of the following analysis was the long-term process of **settlement** – the lack of an extended family network, the urgency of securing employment and gaining a financial foothold in this new society, unfamiliarity with the Australian health and allied sector, low English language skills.... – all are factors leading to low awareness of services, difficulties with transport and childcare, low self-esteem, lack of time for activities outside work and family responsibilities. Furthermore, a number of reports have described how **settlement impacts differently on different ethnic groups as well as on different members within the group**. Research commissioned by the Department of Immigration and Multicultural and Indigenous Affairs (Richardson et al 2002), the Departments of Social Security, Human Services and Health and Immigration and Ethnic Affairs (1997) and the Department of Premier and Cabinet (2001) have shown that personal characteristics may result in very different experiences of settlement within the same ethnic group. These reports point to complex interrelationships between variables that lead to major intra-group differences. For example, it is suggested that whilst English language proficiency and educational background are both significant enablers; it is educational background rather than English language proficiency that better facilitates the settlement process, especially people's ability to seek out information (Departments of Social Security, Human Services and Health and Immigration and Ethnic Affairs 1997). The Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* (2004) and the Department of Human Services *Culturally Equitable Gateways Strategy* (2003) also emphasise the importance of tailoring campaigns and programs to account for such variables.

Projects using peer educators were cited as useful examples (Centre for Community Child Health 2002) of **community capacity building**, by recognising people's existing life skills whilst providing opportunities to develop new one's relevant to the Australian context.

Important factors impacting positively on people taking up a physical/health activity were the **opportunities to increase confidence and general skills** and to see **practical benefits**, for example; cooking classes, store tours etc. This 'building blocks' approach meant that programs targeting health issues could also address wider life-skills (and settlement issues) (Rowley et al 2000, Graves & Suitor 1998).

The literature suggests that for a variety of reasons such as **access to transport, time restrictions and family commitments**) proximity to home is an important factor in determining participation levels (especially women) from diverse cultural and linguistic backgrounds (Eyler, 2002, Taylor & Toohey 1997, Migrant Information Centre Eastern Region 2001).

For many women, **family responsibilities** were their first priority. Family obligations had to be met before leisure activities were undertaken and with no encouragement (sometimes disapproval) from their families, there was little or no time for sport or recreation. (Taylor & Toohey 1997, Lee & Brown, 1998, Eyler, 2002, Migrant Information Centre Eastern Region 2001). The women taking part in these projects agreed that with better access to **low cost childcare facilities** they may find the time to take a break from their role as carers. (Taylor & Toohey 1997, Lee & Brown, 1998).

Research conducted by Vic Health has shown that a **wide variety of activities** held in the one venue suitable for a range of different ages, genders and skill levels encourages participation (VicHealth 1997, von Hofe Thomas & Colagiuri 2002). This may be due to the fact that in this way, children as well as other family members are also able to take part, thus solving transport, family support and childcare issues. Some Muslim women may be significantly disadvantaged as a result of the lack of suitable activities due to special requirements for participation (Migrant Information Centre Eastern Region 2001).

The research also highlights that **cost** is an issue for many and that it does affect participation. Respondents interviewed in a number of research projects stated that "more affordable" programs would motivate them to take up a health activity. (VicHealth 1997, Migrant Information Centre Eastern Region 2001, Bayly 2001).

**Isolation** has been found to be an inhibiting factor in health activity participation among people from diverse cultural and linguistic backgrounds. Thus **enablers** or **supporters** are important in the early stages of joining a health activity / group especially for those people who are socially isolated or lack confidence or motivation (VicHealth1997, Moseley et al 1997, Eastern Perth Public and Community Health Unit 1999, Kondos 1994).

**Perceived lack of safety** was noted as impacting on participation in physical activity amongst females (Bungum et al 1999, Bayly 2001, Eyler 2002)

Taylor and Toohey writing about the interface between women, ethnicity and sport, identified the **lack of companionship**, i.e. having no one to accompany one to the health activity as an impediment to maintaining or even beginning a health activity / program. Studies have shown that women from a language other than English background may be more reliant on social support and found it hard to attend activities “alone” (Lee & Brown 1998). The impact of gender differences in attitudes to and experiences of physical activity were underlined by the responses of many of the women taking part in these projects; although things are beginning to change, they were never really encouraged to take part in physical activity as it was not considered important in their cultural group. (Taylor & Toohey 1997, Lee & Brown, 1998, Bayly 2002,).

Another associated factor but in this case affecting males also was the importance of **role models** and **champions** (Moseley 1997, Eyler 2002, Bayly 2001). This is especially the case for those communities where

....there is not a well established relationship between sport and public culture....[in such] communities, sport is a marginal element of community identity, popular culture or public celebration (McCoy in Moseley et al 1997 p 137).

However, the **different cultural understandings** and valuing of physical activity that lead to low participation in organised ‘mainstream’ sports or physical activities need not be an impediment to an active lifestyle activity for as Eyley (2002) writes, going to the gym may be alien whilst dancing is not BUT both are valid.

Participation as mentioned, previously was much improved when **family members were involved** in the decision making surrounding the activity / program (von Hofe, Thomas & Colagiuri, 2002, Eastern Perth Public and Community Health Unit 1999, Graves & Sutor 1998, Eyler 2002).

With respect to physical activity, role models were felt to be important to counteract **negative school sports experiences** that were another inhibiting factor. Most interviewees were first introduced to sport at school and for some this proved to be a site of racial discrimination. This in turn deterred many from any sport or physical activity outside of school and well into the future (Taylor & Toohey 1997).

Due to the significant lack of awareness about existing programs, easily **accessible information** (in both English and other community languages) about activities is an important factor in participation (VicHealth 1997, Ross 2001, Bayly 2001 Department of Health and Aging *Framework for the implementation of the National Mental Health Plan in multicultural Australia* 2004).

**Language difficulties** create problems for various reasons. Problems and concerns range from not being able to read English to find out about the services available, being unable to understand instructions and feeling uncomfortable about expressing ideas in English (Bayly 2001, Karantzas n.d., Reijneveld, Westhoff & Hopman-Rock 2003, Department of Premier and Cabinet Victoria 2001, Eyer 2002).

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**Table 1: Selective Summary of cultural competencies literature**

Title: Culturally and Linguistically Diverse Local Diabetes Resource and Service Development Project – Final Report.

Project Report	Target group/s	Project Components	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Project Outcomes
<p>This report produced by Eleni Karantzas on behalf of Migrant Resource Centre North West Region Inc. (2003)</p> <p>The author describes a project lead by the Migrant Resource Centre North West and supported by ISIS Primary Care that focused on Type 2 diabetes -</p>	<p>The project targeted:</p> <p>Maltese, Vietnamese &amp; Filipino communities.</p>	<p>Major components of the project included:</p> <p>A Steering committee established with representatives from the CALD communities.</p> <p>Identification of communities' needs.</p> <p>Needs assessment involved the conduct of 11 focus groups with 123 participants. Focus group discussions facilitated by bilingual facilitators and professional</p>	<p>CALD Communities involvement from planning stage onwards.</p> <p>Engagement of ethnic community members and ethno specific organizations to develop and pilot models of service provision which had relevance and accessibility to the target community.</p> <p>Consumer participation</p>	<p>Capacity building for communities.</p> <p>Support offered to CALD community/ Agencies.</p> <p>Professional training of community leaders.</p> <p>Training provided on e.g.</p>	<p>Use of Project leaders Flexibility to adapt to community feedback throughout project lifecycle</p> <p>Enabling factors – accessible; use of culturally appropriate promotional strategies and media; linguistic needs identified and met e.g. development of radio script in collaboration with</p>	<p>Evaluator stated that:</p> <p>"Evaluation process confirmed that the CALD the project has offered high quality, appropriate and accessible models of self management care of their diabetes.</p> <p>Project demonstrated improvement to the delivery of diabetes</p>

INCREASING CULTURAL COMPETENCY FOR HEALTHIER LIVING: FINAL REPORT - APPENDICES

<p>developing, piloting and evaluating culturally appropriate strategies.</p> <p>The project sought to improve delivery of diabetes prevention and management services to CALD communities; enhance self management;</p> <p>increase understanding and access to diabetes prevention and management strategies and services in primary care sector</p> <p>Setting: Brimbank Local government area (Melbourne, Victoria)</p>		<p>interpreters.</p> <p>Differing methods of consultation used throughout project to identify needs and once assessment was made culturally appropriate strategies were undertaken e.g. lack of current dietary resources that were specific to the cultural and eating preferences of the Filipino community in Victoria- action- to develop a state-wide Vietnamese radio campaign.</p> <p>Evaluation methodology included quantitative data (analysed using descriptive statistics) and qualitative data (analysed using content analysis).</p> <p>The project was evaluated through:</p> <p>Health Professional Diabetes Services questionnaire; focus</p>	<p>approach – focused on developing specific strategies for different communities.</p> <p>Development of culturally appropriate resources</p> <p>Promotion via ethnic media/radio</p> <p>Linguistically appropriate telephone service for target group</p> <p>Peer leaders/Education program (5 week)</p> <p>Development of CALD Diabetes Resource Directory</p>	<p>conducting focus groups.</p> <p>Professional interpreters utilized.</p> <p>Cultural awareness training for health professionals.</p>	<p>Vietnamese community</p> <p>The author reported that the Project Worker was key factor in success of the project.</p>	<p>prevention</p> <p>And management services to the targeted communities” p36.</p>
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		Group discussions; Team discussions; Project worker log books.				
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Title: Promotion of health and physical activity improves the mental health of elderly immigrants: results of a group randomised controlled trial among Turkish immigrants in the Netherlands aged 45 and over.

Journal Article	Target group/s	Study Design	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Reijneveld et al. 2003</p> <p>Researchers report on a randomised controlled study to assess the effect of a short health education and physical exercise programme on the health and the physical activity of Turkish first generation elderly immigrants.</p> <p>Setting: Welfare services in 6 Dutch cities.</p>	<p>The project targeted:</p> <p>Turkish</p> <p>First generation elderly immigrants</p>	<p>Randomised controlled study</p> <p>Main outcome measures:</p> <p>Physical and mental wellbeing, and mental health based on the SF-12/36;</p> <p>Knowledge on health and disease; physical</p>	<p>Interventions:</p> <p>Eight, two hour sessions consisting of health education and exercises.</p> <p>Topics in health education focused on means to maintain good health.</p> <p>Education was adapted to culture and knowledge of older Turks and offered by a Turkish</p>	<p>Training offered in Turkish by a Turkish peer educator.</p>	<p>Cultural differences and practical problems such as language barriers/literacy.</p> <p>Difficult to reach these groups through health promotion and other preventative services.</p>	<p>Researchers reported:</p> <p>Participants were highly disadvantaged; 52% had not completed primary school and 49% had considerable problems speaking Dutch.</p> <p>Participants in the intervention group showed an improvement in mental health (effect size: 0.38 SD (95% confidence intervals 0.03 to 0.73), p=0.03); the oldest subgroup also in mental wellbeing (effect size 0.75 SD</p>

		activity.	peer educator, in Turkish.			<p>(0.22 to 1.28), p=0.01).</p> <p>No improvements were seen in physical wellbeing and activity, or in knowledge.</p> <p>Researchers' concluded that health education and physical exercise improve the mental state of deprived immigrants.</p>
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Title: Social, Cultural and Environmental influences on child activity and eating in Australia migrant communities

Journal Article	Target group/s	Study Design and Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/ processes in place	What factors impacted on take up of health activity	Results

<p>Green et al. study published in 2003.</p> <p>The researchers describe a study to examine the socio-cultural, familial and environmental factors influencing health, eating habits and patterns of physical activity contributing to child and adolescent overweight and obesity.</p>	<p>Turkish</p> <p>Greek</p> <p>Indian</p> <p>Chinese</p>	<p>Community based qualitative study.</p> <p>Data Collection:</p> <p>Semi-structured, community-based interviews were conducted with contrasting key informant three-generation families; and generation focus groups of grandparents, parents and children from four cultural communities.</p> <p>8 semi-structured key informant family interviews</p> <p>12 semi-structured focus groups</p> <p>Purposive sampling occurred from Turkish, Greek, Indian and</p>	<p>Authors state to achieve successful intervention design, childhood obesity researchers need to collaborate with diverse groups and communities.</p> <p>Considerations in interventions:</p> <ul style="list-style-type: none"> <li>• Role and influence of extended family</li> <li>• A multigenerational, whole-of-community approach beyond that of parent and child populations.</li> </ul>		<p>Physical activity levels of parents:</p> <ol style="list-style-type: none"> <li>1. Time</li> <li>2. Family responsibilities</li> <li>3. Modern modes of transport i.e. use of car</li> <li>4. Work responsibilities</li> </ol>	<p>Researchers reported:</p> <p>Evidence of two-way influences on eating across the span of three generations P 443.</p> <p>Dietary restrictions reported. P.444</p> <p>Efforts to foster healthy eating</p> <p>Cross-generational changes in eating patterns.</p> <p>Socio-cultural influences on physical activity. P445.</p> <p>Researchers concluded that "eating, physical activity and recreation are a result of an accumulation of exposure – familial, intergeneration, social and environmental.</p>
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		Chinese communities that have migrated to Australia within the last 3 generations (n= 160, eight families, 47 children aged 5-15 years, 29 parents, 42 grandparents).				
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Title: Third Culture Personalities and the Integration of Refugees into the Community: some Reflections from General Practice

Journal Article	Target group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Benson J. 2003</p> <p>The author describes the techniques used to assist new arrivals and refugees through "a combination of Western notions of health and illness and inter-personal relationship build around their stories as told to me." pp 3.</p>	<p>The project targeted: new arrivals and refugees.</p>		<p><b>Socio-cultural position</b></p> <p>Reflect on own socio-cultural position i.e. "If General Practitioners are to meet the needs of refugees and asylum seekers in Australia they must consider their own socio-cultural position as well as prerequisite knowledge of their core discipline" pp. 4.</p> <p>GPs need to "have the knowledge, skills and ability to use appropriate cultural as well as medical diagnostic skills to guide treatment, as mistakes can be made without taking the time to respond effectively to language, cultural or psychosocial concerns." P. 20</p>			

			<p><b>Team work &amp; Knowledge of specialist services</b></p> <p>When dealing with patients who have suffered trauma – author argued for GPs to maintain a strong coordinating position and adopting a team approach utilizing rehabilitation services, pain clinics and other specialist hospital outpatient services pp20.</p> <p>This means GPs need to have knowledge about support services. Author argued that there is a need for adequate training, reflection about the way GPs practice and knowledge about the specialist support services available.</p> <p><b>Active Listening Skills</b></p> <p>“Good active listening skills and a firm non-judgmental stance are the most useful therapeutic techniques (the author spoke about these skills in</p>			
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			relation to assisting refugees in finding meaning and purpose to their lives).			
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Title: Environmental, Policy, and Cultural Factors Related to Physical Activity in a Diverse Sample of Women: The Women's Cardiovascular Health Network Project

Book	Target or study group/s	Study Design and Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/ processes in place	What factors impacted on take up of health activity	Results
<p>Eyler, A  (Editor.) book published in 2002.</p> <p>The authors describe a qualitative study of factors influencing physical activity.</p>	<p>The study participants:</p> <p>African American, American Indian, Latina, and White Women</p>	<p>Community based qualitative research involving:</p> <p>Data Collection:</p> <p>A literature search to identify knowledge and gaps in knowledge about correlates of physical activity in the subgroups of interest (Eyler et al. 2002).</p> <p>Data collection also involved</p> <p>Focus groups with 2- 10 participants from the</p>	<p><b>Focus on environmental, social, cultural</b> not personal factors.</p> <p>Need to consider diversity across the similarity among cultures in creating programs and supportive environments for physical activity.</p> <p><b>Socio-cultural interventions</b> (role models, social support, from spouse or significant other, tangible support, with chores, cultural acceptance</p> <p><b>Individual interventions:</b> self esteem, self-motivation, time</p>	<p>Work site policies eg facilities, flexible hours; financial assistance, childcare, address safety concerns</p>	<p>Family commitment, responsibility, lack of time.</p> <p>Lack of childcare lack of positive role models.</p> <p>Lack of social, cultural support (community, family, gender differences).</p> <p>Distance, cost,</p>	<p>Correlates of physical activity identified by focus groups included social environment, guilt and family responsibility, social support and environmental and policy barriers.</p> <p>Focus group participants did not equate physical active with exercising.</p>

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		community groups.  Self report methods.  Asian women not represented.	management.  <b>Environmental/policy interventions:</b> improve safety, increase access, work program, and address cost issues, child care, transportation, community members' input for interventions.		language, settlement issues.	
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Title: Positive Images of Men's Health Pilot Project 2002-2003

Report	Target or study group/s	Methods	Competencies/ Skills/  Interventions deemed to be important	Organisational structures/  processes in place	What factors impacted on take up of health activity	Project Outcomes
<p>A report on the Positive Images of Men's Health Pilot Project presents the findings of an action research based project targeting men from a wide range of CALD backgrounds in Adelaide.</p> <p>Pilot project began in Feb 2002 and ended in March 2003.</p>	<p>The project targeted: 60 CALD men from:</p> <p>Albania, Bosnia, Cambodia, Chile, China, Colombia, Croatia, El Salvador, Iran, Iraq, Liberia, Philippines, Russia</p>	<p>Initial consultation with community members to plan the PILOT project.</p> <p>In addition to consultation activities the project had five other components:</p> <ul style="list-style-type: none"> <li>• The production of photos depicting men in a positive light, through their relationships, interests, studies and work.</li> <li>• The production of children's portraits depicting the positive male role models in their lives.</li> <li>• A survey of women and men about the positive contributions men have made in their lives.</li> <li>• The development of a</li> </ul>	<p>Community development skills.</p> <p>Appreciation of the role of participation by vulnerable populations.</p> <p><b>Project Activities including;</b></p> <p>Articles and interviews in mainstream and</p>	<p>Bi-cultural/multi-lingual community health workers</p> <p>Established networks with CALD men.</p> <p>Community development work already undertaken with</p>	<p>Consultation with CALD men about their health needs.</p> <p>Working with men in culturally sensitive way and appropriate ways from a holistic view of health.</p> <p>Methods for working with men must be flexible and</p>	<p>The authors identified the Project outcomes as:</p> <p>A positive approach to men's health achieved.</p> <p>Men were engaged in a process of identifying their health needs and concerns.</p> <p>The participation rate</p>

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<p>Overall aim of the Project-</p> <p>To raise awareness of men's health and wellbeing through a positive approach to men and their health.</p> <p>And involved CALD men and community members in a range of social, educational, recreational activities eg school poster competition</p> <p>Walkathon promoting the theme Talking About Men.</p> <p>Artwork produced by community groups.</p>	<p>And Serbia</p> <p>Included CALD men who were newly arrived refugees and Temporary Protection Visa holders</p> <p>Australian men also participated in the pilot.</p>	<p>holistic health model used in the information session identifying men's health issues.</p> <ul style="list-style-type: none"> <li>A men's health session involving 60 men in discussion session addressing issues related to their health.</li> </ul> <p>HEALTH INFORMATION SESSION:</p> <p>Language specific small groups were formed to facilitate ease of discussion. Group facilitators and interpreters supported each small group. Participants were asked to identify positive and negative aspects of their</p> <p>Physical, Emotional, Social &amp; Spiritual.</p> <p>(Holistic Health model was a tool used during the session involving a consideration of all dimensions of men's health; physical, emotional, social, cultural, environmental, economic, political and spiritual.) A priority list of men's health concerns was developed.</p>	<p>ethnic media – radio and print.</p> <p>Key websites.</p> <p>Billboards, bus stops, community buses and taxis displaying advertisements.</p> <p>Community organisations' newsletters.</p> <p>Theatre productions.</p> <p>Utility bills presenting positive messages of men's health</p>	<p>the targeted groups.</p>	<p>non-threatening.</p> <p>Non-threatening social activities help to address the power imbalance that can be associated with service provider/client relationship.</p>	<p>far exceeded expectations, with approximately 500 men from a wide range of cultural backgrounds participating in the project.</p> <p>The photographs and children's artwork become a practical resource.</p> <p>Project participants links with key health and community service providers further developed and strengthened.</p> <p>Service providers</p>
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						developed links with project participants.
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Title: Promoting a Healthy Life for Our Community

Guide	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Results
<p>This is a Social Marketing Guide produced by the North Central Metro Primary Care Partnership- Promoting a Healthy Life for Our Community that provides information on social marketing.</p> <p>The Guide is designed to help service providers; health professionals etc who want to develop, implant and evaluate a social marketing campaign.</p> <p>The Guide highlights lessons learnt from the NCMPC Partnership – “An</p>	<p>The project targeted:  Older Adults in the Yarra, Darebin and Whittlesea LGA</p>		<p>Marketing to CALD communities:</p> <p>Practitioners need to understand that their own ideas and understandings of themselves are formed by culture.</p> <p>Commit to learning about these assumptions and to accept that your truth may or may not be another’s truth.</p> <p>Learn from the target community about how they see their community, what their aspirations and needs are, what health beliefs and practices the community currently undertake and what the community thinks about the practitioners understand of the issues.</p>	<p>The authors believe that this approach sees the process and relationship building of social marketing as, in itself, a health enhancing and community capacity building exercise.</p>

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<p><i>Active Life Project.</i></p> <p>This project focused on promoting physical activity to older adults. Using a social marketing process.</p>				
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Title: Clearing the Air 2003 – Tobacco Awareness Project

Report	Target or study group/s	Methods	Competencies/ Skills/ Interventions deemed to be important	Organisational structures/ processes in place	What factors impacted on take up of health activity	Project Outcomes
<p>The authors describe a project addressing the need for culturally appropriate tobacco control strategies targeted to newly arrived refugees and migrants from the former Yugoslavia, Middle East and Africa.</p> <p>The project began in Jan 2003 and ended in Sept 2003.</p>	<p>The project targeted: New arrivals from: Afghanistan, Bosnia, Croatia, Iran, Iraq, Lebanon, Macedonia, Serbia and Sudan.</p>	<p>The program components included: needs assessment and the identification of culturally appropriate interventions. During the project a peer education approach was utilised and the development of a range of resources.</p> <p>For example, community artists produced artwork conveying tobacco control messages and to coordinate children's art workshops.</p>	<ol style="list-style-type: none"> <li>1. Community development skills.</li> <li>2. Appreciation of the role of participation by vulnerable populations.</li> <li>3. Peer educator approach.</li> <li>4. Culturally appropriate resources developed.</li> </ol>	<p>Migrant Health Service's Community Development Program – i.e. community development work already undertaken with the targeted groups.</p>	<p>Community participation and involvement and engagement of members of the target populations, their extended communities and community associations, schools, health and other service providers.</p>	<p>The authors identified the Project outcomes, some of which included:  800 (approx.) community members participated in project.</p> <p>Project participants reported that their awareness of the harmful effects of tobacco had increased</p>

<p>Aims of the Project included:</p> <p>Increase community awareness of the harmful effects of tobacco use and involved community members in a range of tobacco control activities, including educational, social, recreational and sporting activities.</p>		<p>Evaluation of the project involved documenting activities.</p>	<p>5. Skills for mobilizing community resources</p>			<p>Many hundreds of smoke-free hours were generated by the project</p> <p>Culturally appropriate tobacco control resources developed</p>
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Title: A Systematic Review of Issues Impacting on Health Care for Culturally Diverse Groups Using Diabetes as the Model

Systematic Literature Review	Target or study group/s	Methods	Competencies/Skills/ Interventions deemed to be important	What factors impacted on take up of health activity	Results
<p>This review was prepared by: B. von Hofe et al.</p> <p>Australian Centre for Diabetes Strategies Prince of Wales Hospital</p> <p>In collaboration with South East Multicultural Health Unit. 2002.</p> <p>The Review aim was to expand and augment the available evidence</p>	<p>The population groups identified as a focus for this review were:</p> <p>Asian- people from the Indian Subcontinent</p> <p>Chinese</p> <p>Pacific Islanders</p> <p>Mediterranean</p> <p>Various-outside the above categories.</p>	<p>The key project components were:</p> <ul style="list-style-type: none"> <li>• Steering Committee established</li> <li>• A local multicultural profile developed</li> <li>• Multicultural groups of particular interest to SESASHS identified</li> <li>• Key themes, issues and questions to guide literature review</li> <li>• Conduct of lit review</li> <li>• Collation and synthesis of the results of the reviews.</li> </ul>	<p>From the literature reviewed – models of culturally specific interventions and education programs identified as producing successful outcomes in their participants, such as increased compliance and health improvement were:</p> <ol style="list-style-type: none"> <li>1. Culturally specific;</li> <li>2. Incorporated diets, beliefs, and attitudes of the cultural groups they were directed at;</li> <li>3. Fostered increased understanding and interest and participation. (P3)</li> </ol> <p>Recommendations made included:</p> <p>Where possible, all family members be involved in patient education programs;</p>	<ul style="list-style-type: none"> <li>• Cultural barriers to patient compliance and adherence to recommendations for diabetes self care – applicable across all groups –</li> <li>• Language and literacy rates</li> <li>• Effects of stigmatisation</li> <li>• Lack of access to appropriate culturally specific care</li> <li>• Religious beliefs and cultural attitudes</li> <li>• Cultural factors that influence access to clinical, education and support services:</li> <li>• Lack of culturally appropriate services;</li> <li>• Limited range of services;</li> <li>• Language difficulties;</li> </ul>	<p>The key findings of the review as reported by the authors are summarised as:</p> <p>The studies reviewed identified a variety of models of culturally specific interventions and education programs that produced some improvements in outcomes: Models included:</p> <ul style="list-style-type: none"> <li>• Nurse led clinics in general practice setting</li> <li>• Community education programs combined with family support</li> <li>• One on one teaching interventions</li> <li>• Focus groups</li> <li>• A diabetes club</li> <li>• Use of a bilingual community health</li> </ul>

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<p>base about needs for, and barriers to, health care for people from CALD community groups and possible approaches to addressing those needs with a view to contributing to and informing the development of: improved approaches to patient education for people with CALD groups; Cultural diversity/sensitivity training for providers of clinical care;</p> <p>Multicultural community health education and health promotion policy;</p> <p>A prioritised multicultural research agenda.</p>			<p>Provision of education and written instructions in appropriate languages, with representation of culturally specific foods, traditions, people;</p> <p>Establishment of Community based services;</p> <p>Development of cultural and/or language specific tools and measures of the outcomes of diabetes care;</p> <p>Further research on the quality, accessibility and acceptability of diabetes services to CALD groups;</p> <p>An infrastructure needs to be developed to support the systematic generation, dissemination and exchange of information about the impact of cultural diversity in health</p>	<ul style="list-style-type: none"> <li>• Lack of acculturation;</li> <li>• Culturally mediated perceptions</li> </ul>	<p>worker.</p> <p>The authors stated that it is also important to develop cultural measures for addressing the effectiveness of those models such as the Diabetes Quality of Life Questionnaire (p 34).</p>
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Title: Evaluation of the culturally and linguistically diverse (CALD) peer educator injury prevention training program

Program Report	Target group/s	Project Components	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>This Project report prepared by the Centre for Community Child Health. (2002), describes an injury prevention program. The purpose of the program was to offer a comprehensive package for 13 peer educators to increase the capacity and effectiveness of health promotion in the area of injury prevention in CALD communities in</p>	<p>The project target groups: Greek, Maltese, Latin American/Spanish, Cantonese, Serbian, Arabic, Vietnamese, Macedonian, Sudanese, Turkish, Somali, Italian and Croatian.</p>	<p>Major components of the project were:</p> <ul style="list-style-type: none"> <li>• Training program (over 12 days) for Peer educators covered 4 areas: Knowledge about injury prevention; designing a project; presentation skills and administration skills (p3).</li> <li>• Preparation of project proposals</li> <li>• Implementation of Peer educators Project</li> <li>• Evaluation and reporting</li> </ul>	<ul style="list-style-type: none"> <li>• Peer Educators Approach to identify, implement injury prevention project <b>for</b> and <b>with</b> their CALD communities</li> <li>• Culturally appropriate activities</li> <li>• Use of ethnic media – print and radio</li> <li>• Provision of education and written materials in appropriate languages</li> </ul>	<p>A training program for peer educators based on adult learning principles. (p2).</p>	<p>Authors of this report strongly argued the significance of “knowing and understanding” the CALD community when identifying an area of need.</p>	<p>Evaluation findings – Pre and Post Training – showed increase in knowledge levels attributed to the training.</p> <p>Positive participant feedback about training was reported.</p> <p>13 Peer educator projects implemented and evaluated.</p>

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<p>Victoria.</p> <p>The program also aimed to support the peer educators to design and deliver injury prevention programs to their communities.</p>		<p>The evaluation of the program through:</p> <p>Participant evaluations to determine change in knowledge; continuous process evaluation; documenting the number of grant proposal accepted (skill development measure) and evaluation and documentation of each peer educator project.</p>				
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Title of the chapter – Cross-cultural competencies for counsellors in Australasia (in a book titled: Culture, Race and Community: Making it Work in the New Millennium)

Book Chapter	Competencies/Skills/Interventions deemed to be important	Organisational Structures/Processes in place	Results
<p>This book on cross-cultural competencies for counselors in Australia</p>	<p>From her review of the literature she highlights basic</p>	<ul style="list-style-type: none"> <li>• Ongoing Training</li> <li>• Data and information collection</li> <li>• Research</li> </ul>	<p>Effective communication- author stated that to be effective counselor and</p>

<p>by Kathryn Gow (2002) describes cultural awareness expertise based on a comprehensive review of available literature.</p> <p>3 Chapters in this book :</p> <ul style="list-style-type: none"> <li>• Chapter 1 addresses some of the beliefs and theories that people have about race and cultural diversity.</li> <li>• Chapter 2 focuses on issues of the 'effects and realities' of racist policies and interpersonal behavior that discriminates against people.</li> <li>• Chapter 3 explores some of the practicalities involved in taking a stance against racism.</li> </ul>	<p>cultural awareness expertise:</p> <p>Possessing including:</p> <ul style="list-style-type: none"> <li>• Awareness/understanding of own cultural values and biases</li> <li>• Recognise and recover from mistakes and a willingness to keep learning</li> <li>• Awareness of others' world view and of own negative and positive emotional reactions towards other racial and ethnic groups and of own stereotypes and preconceived notions</li> <li>• Working in an interdependent way</li> <li>• Using non traditional methods of assessment</li> <li>• Specific knowledge and information about the particular group with whom they are working</li> <li>• Understanding the meaning and importance of cultural difference</li> <li>• Recognising the importance of validating the diverse world view of others</li> <li>• Having knowledge of social roles in other cultures, cultural sensitivity and about the ways that cultural differences affect verbal and non-verbal communication</li> <li>• Being able to identify and openly discuss cultural and to assess the impact of cultural differences on communication and effectively communicate across those differences</li> <li>• Having a capability to empathize and genuinely connect with individuals who are</li> </ul>		<p>communicator when working with CALD communities it is necessary to have a range of cultural communication skills and knowledge and the appropriate attitudes towards, and valuing of, cultural diversity. (p3).</p>
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Title: Swimming for Muslim Women - evaluation report

Report	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/ processes in place	What factors impacted on take up of health activity	Results
<p>This Project report prepared by the Centre by Migrant Information Centre (2001)</p> <p>A Collaborative Project between Migrant Information</p>	<p>Muslim Women – Turkish Palestinian Lebanese Iraqi Pakistani Somali Afghan</p>	<p>The evaluation of the project involved: qualitative evaluation methodology.</p> <p>Data collection involved feedback via survey.</p> <p>Self report</p> <p>Measures included:</p> <p>Level of participant satisfaction with the</p>	<p><b>Planning of Project</b></p> <p>Process undertaken</p> <p>Convening of discussion group of Arabic speaking women</p> <p>Establishment of a women's group</p> <p>Identification of need to access swimming facilities that met religious and cultural needs</p> <p>Consulting with target group and identification of need and culturally appropriate strategy to address</p>	<p>Community grant.</p>	<ol style="list-style-type: none"> <li>1. Cost</li> <li>2. Transport/travel</li> <li>3. Availability of appropriate facilities</li> <li>4. Enablers:</li> <li>5. Reduced cost to make service more affordable;</li> <li>6. Use available facilities in local area</li> <li>7. Promote effectively</li> <li>8. Involve community members</li> </ol>	<p>The Authors of the report concluded that Muslim women and their children do not have equal access to public swimming facilities and that public swimming facilities need to develop strategies for providing privacy to Muslim women and their children. P5.</p>

Centre (Eastern Melbourne) and the Network of Australian Muslim Women	Syrian  Australian  Iranian	activities  24 respondents	need.  <b>Implementation</b>  Subsidizing costs so women could afford to attend  Using people from targeted communities as organizers			
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Title: Effectiveness of a community-directed 'healthy lifestyle' program in a remote Australian Aboriginal community'

Study	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Researchers, Rowley et al. (2000) report on the evaluation findings of a Community wide program focusing on diabetes.</p> <p>The report describes a community directed healthy lifestyle program and associated changes in body weight and biochemical</p>	<p>The target group</p> <p>Primary</p> <p>2 groups i.e. high-risk overweight and diabetic people.</p> <p>Secondary</p> <p>And wider</p> <p>Aboriginal community members</p>	<p>Evaluation study of a community wide program.</p> <p>The evaluation methodology included both qualitative and quantitative methodology.</p> <p>External evaluators utilised.</p> <p>Intervention among high-risk overweight and diabetic people.</p>	<p><b>Community-directed program</b> i.e. control and ownership enabled embedding and ownership of the program. (p 1)</p> <p><b>Interventions</b> among high-risk overweight and diabetic people: included formal and informal education sessions, regular physical activity groups and dietary changes.</p> <ul style="list-style-type: none"> <li>• Cooking classes and store tours.</li> <li>• Physical activity was promoted via hunting trips; participation in</li> </ul>	<p>Several sporting teams were reactivated and the council appointed a sport and recreation officer (p 3)</p> <p>Council support in the form of an office for program workers to use as a base, and allowed the use of council facilities for screening procedures (p3)</p> <p>Health education classes conducted by Aboriginal Health Workers were held in the community school (p3).</p> <p>Technical advice, data analysis</p>	<p>Interventions in the wider community:</p> <p>Dissemination of messages about diet and physical activity to family members by those persons taking part in the high-risk intervention program (p 3).</p> <p>Health promotion activities, arising from the initial intervention and in which all community members were invited to participate, were undertaken to initiate normative change and</p>	<p>The authors reported key findings as:</p> <p>After 2 years, there was an increased awareness in the wider community about the importance of diet and physical activity for prevention of chronic disease and this led the community to renaming the program Looma Healthy Lifestyle program (p 3).</p> <p>The program was “associated with sustained, if modest, improvements in several important biochemical and behavioural risk factors for diabetes CVD” (p9).</p> <p>The authors reported that there</p>

<p>measures of glucose metabolism in a remote setting. The program developed over time and at the direction of the community, from one focusing on body weight and metabolic control in overweight and diabetic people to a more holistic, community wide approach to management and prevention of chronic disease.</p>		<p>96 volunteers screened at two or more 6-month intervals over 24 months, starting in late 1993. Of the 96 volunteers, full sets of follow up data obtained from 49 people.</p> <p>Measures included body weight and height. 75 g oral glucose tolerance test, fasting plasma triglyceride and insulin concentrations, and diet and physical activity questionnaires.</p> <p>The primary</p>	<p>sport. Walking groups. Informal education sessions.</p> <ul style="list-style-type: none"> <li>• Weekly body weight and blood glucose checks (p3)</li> <li>• Activities included: i.e. store management policies (appointment of a community member to manage the community store.</li> <li>• Art competitions and sporting festivals based on the theme 'Fitness Fights Diabetes' were conducted several times each year (p3).</li> </ul> <p><b>Sustainability</b> of the program – the degree to which it is embedded in and directed by the community i.e. community control over both design and implementation (p 9).</p> <p>Ongoing commitment from Aboriginal Health Workers, the community council, store management and other community groups; and (p9)</p>	<p>and feedback of results and advocacy to health and funding bodies was provided by researchers (p 3).</p> <p>Analysis of data by academic staff associated with the program and prompt feedback of results to the community, particularly in the early stages. (p 9)</p>	<p>enabling conditions (p 3).</p>	<p>was a lack of success in reversing obesity and diabetes, however, important improvements were observed for several coronary risk factors (p8).</p> <p>Some unpublished data reports significant improvements in diet-related markers of CVD risk (Rowley et al., unpublished data- Dr K. G. Rowley, Centre for Population Health and Nutrition, Monash Medical Centre.) (p 9).</p>
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		<p>evaluation question in cohort analysis was change in outcomes over 24 months. A secondary question was differential change between persons classified according to diet and physical activity habits as the first follow-up.</p> <p>Evaluation included:</p> <p>Process, impact and outcome.</p> <p>Note - Authors conceded that the evaluation design used has limitations. Difficult to identify generalisable</p>				
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		intervention strategies. (p 9).				
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Title: Smoking among ethnic Chinese patients and their recall of quit advice by Chinese-speaking general practitioners in Sydney

Journal Article	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>This study was undertaken by Ming &amp; Ward (2000). The researchers report on a study to collect smoking-related data from Chinese patients attending Chinese-speaking general practitioners</p>	<p>The study participants were:  1084 Ethnic Chinese patients (18-70 years old)</p>	<p>Research Study- this descriptive research involving self-administered waiting-room questionnaires and a second self-administered question to examine behavior in that most recent consultation.</p> <p>Information collected including self-reported smoking status, recall of a question about smoking status during the previous six months by their GP and, for smokers, their recall of quit advice in their most recent consultation (p 437).</p>	<p>Study authors argued that “simple translation of anti-smoking resources designed for English speakers from a predominantly Anglo-Celtic culture is unlikely to meet needs of ethnic Chinese smokers who, as shown by our data, are typically not ready to quit. Neither will it effectively engage unique cultural values such as the family as a powerful force to reduce prevalence of smoking in this community” (p440).</p>		<p>Chinese speaking GPs</p>	<p>Findings suggest Chinese-speaking general practitioners need greater support to maximize their clinical opportunities to advise Chinese smokers to quit ...via culturally sensitive advice e.g. provision of culturally specific resources (p 440).</p> <p>Study found that only 33% of all Chinese patients and 57% of those who smoked recalled a question about their smoking status (p 440).</p>

Title: Travelling the world over eight evenings: a cross-cultural mental health training program for General Practitioners

Journal Article	Target group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Pai et al. (2000) are the authors of this Article that describes a cross cultural training program (pilot project) for general practitioners.</p> <p>The training program was designed after conducting a training needs analysis among</p>	<p>General Practitioners.</p> <p>Setting – Perth, WA.</p>	<p>Case Study of a cross cultural training program.</p> <p>Rationale for choice of intervention i.e. cross cultural training program by project staff was based on a comprehensive literature review.</p> <p>The program was designed after conducting training needs analysis among GPs which posed a series of questions related to the needs identified by</p>	<p>Cross Cultural awareness training program</p> <p>The intervention used – a specifically designed cross cultural training pilot program for GPs in WA. The broad aim of this training program was “to improve the general practitioner’s ability to better understand and communicate with their patients from culturally and linguistically diverse backgrounds” p 27.</p>	<p>CME points for GP participants.</p> <p>GPs were also given a choice of either registering for individual sessions, or for all eight sessions at a discounted price.</p> <p>Training locations were chosen for reasons of convenience and accessibility. To help make it easier for GPs to attend.</p>	<p>CALD community members choose mainly GPs of the same ethnic background or who speak the same language (p 3).</p> <p>Authors stated that due to a less stigmatizing effect associated with consultations with general practitioners, people from culturally and linguistically diverse (CALD) backgrounds consider GP as the preferable service provider for mental health care.</p>	<p>Evaluation methodology not reported in this article however the authors stated the authors concluded that “cross-cultural awareness training in primary care is imperative in an increasing multicultural Australia. P31.</p> <p>The authors state that the process they have implemented is one way of improving mental health for a culturally and linguistically diverse population.</p>

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<p>GPs.</p>		<p>GPs for a training series about mental health issues in CALD patients.</p> <p>Needs analysis also examined which cultural groups GPs felt were needed to be included in the training.</p> <p>Relevant statistics on e.g. recent migrants were also reviewed.</p> <p>Program designers also consulted with relevant stakeholders and a Steering Committee – the groups identified to be included in the training program were: Polish, Italian, Vietnamese &amp; Chinese Indian Subcontinent, Croatian, Indian African Communities, and Australian Aboriginals.</p> <p>Delivery of the training program was undertaken by GPs from the same cultural origin and allied</p>	<p>“The professional must be able to understand his/her own culture bound feelings, avoid stereotyping the client into a cultural group and objectively observe the difference between the two” (authors cited Bland &amp; Kraft 1998).</p> <p>Promote among GPs the fundamental attitudes of curiosity and respect into their consultations with patients from CALD backgrounds (Carillo et al. 1999) in order that a non-judgmental and safe environment be generated in which explanatory models may be reconciled” P28.</p>	<p>Training was structured in 2 hour blocks and held fortnightly.</p> <p>Each session divided into 2 parts with meal provided in between.</p>	<p>Cross cultural consultations take more time than is normally available (p27).</p>	
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		<p>health professionals.</p> <p>Trainers – GPs and allied health professionals (e.g. social workers, occupational therapists, mental health nurses, psychologists).</p> <p>CME points could be obtained by the GP participating in this cross training program.</p> <p>2 hour sessions – interactive process; experiential learning.</p> <p>First part of the training program covered ‘universal themes’ about the similarities and differences between ethnic and mainstream cultures. The second section was for the case study to the related to the theme or topic assigned to the cultural group presented (e.g.</p>				
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		for Polish, Loss and Grief).				
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Title: Correlates of Physical Activity among African-American and Caucasian Female Adolescents

Journal Article	Target group/s	Study Design/Methods	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Bungum T et al. (1999) conducted this study.</p> <p>Researchers describe a study to identify determinants of participation in moderately, and vigorously intense physical activity among African American and Caucasian</p>	<p>African-American and Caucasian people.</p>	<p>Cross sectional study involved participants (n=626 African-American and Caucasian) who completed an 81-item survey that assessed influences on physical activity and a 1-week recall of physical activity. Multiple regression was used to identify correlated of physical activity.</p>				<p>The researchers reported that differences in psychosocial predictors of physical activity and ethnic group. Self-efficacy and school sport participation were robust predictors of physical activity.</p> <p>The researchers concluded – different strategies may be appropriate when promoting activity to African-American and Caucasian female adolescents.</p>

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adolescent females.						
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Title: Evaluation report on a Muslim Women’s Learn to Swim Program

Evaluation Report	Target group/s	Methods	Competencies/Skills/Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>This evaluation report was prepared by Eastern Perth Public and Community Health Unit (1999).</p>	<p>The project targeted:  Muslim women</p>	<p>Evaluation design was a triangular procedure – data from 3 sources was combined.</p> <ol style="list-style-type: none"> <li>1. Quantitative data on participation and demographics;</li> <li>2. Qualitative data from Muslim women participants (focus group) and</li> <li>3. Qualitative data from program enablers – a focus group.</li> </ol> <p>The Evaluators report difficulties in conducting the</p>	<ul style="list-style-type: none"> <li>• Investment in time and resources in the task of developing trust between the program enablers and the women.</li> <li>• Good communication between enablers and participants.</li> <li>• High level of cultural appropriateness of program.</li> <li>• Valuing cultural differences</li> <li>• Local level health promotion is important.</li> <li>• Focus on collaboration and partnerships between local government and Arabic speaking community.</li> <li>• Include the women’s husbands in decision-making process and provide information to them.</li> <li>• Recruit from various local community organizations.</li> </ul>	<p>Key informants from ‘within the community’</p> <p>Instructors and pool staff were culturally aware and respectful of cultural and religious differences.</p>	<p>Consultation with the community.</p> <p>Implementation at a very local level.</p> <ul style="list-style-type: none"> <li>• Child care</li> <li>• Transport</li> <li>• Location and class length</li> <li>• Family commitments</li> </ul>	<p>Authors reported that program objectives had been achieved.</p> <ul style="list-style-type: none"> <li>• Good attendance;</li> <li>• Culturally appropriate venues/ services;</li> <li>• Skill development and self-efficacy.</li> </ul>

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		evaluation i.e. recruiting appropriate bi-lingual, Arabic speaking facilitators; and in obtaining data from Muslim women participants				
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**Title: Australian Migrant Women and Physical Activity: Attitudes, Barriers, Preferences and Participation**

Evaluation Report	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Lee et al. (1998) undertook a Qualitative study about their perceptions of physical activity.</p>	<p>The study group included: Polish, Dutch, Greek, Macedonian women.</p>	<p>Qualitative research - involving 200 women from non-English speaking backgrounds (either participants/controls) in 4 heart health intervention programs.</p> <p>Asked to complete a pre-intervention surveys - questionnaire based on that used in the DASET (1992) Pilot Survey of the Fitness of Australians – to assess attitudes to and perceptions of physical activity relevant to the adoption and maintenance of physical activity among mainstream Australians, -</p>	<p>The selection of appropriate activities and the provision of programs in community languages.</p> <p>Large demographic differences between the ethnic groups, particularly in education and English competence, indicate the inappropriateness of community programs which assume that all NESB Australians will respond equally to the same interventions.</p> <p>Authors suggest written materials will be inappropriate for some groups, such as middle-aged Macedonia and Greek born</p>		<p>NESB women more in need of social support and assistance of a group; language – i.e. limited English competence</p>	<p>Main difference between migrant women and the DASET women was in preferences for types of physical activity.</p> <p>Consistent with the findings of Taylor and Toohey (1998), these responses showed significant differences between ethnic groups.</p> <p>Authors state that these differences indicate that exercise programs which target specific groups need to be designed with an awareness of participants' preferences.</p>

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		to assess if these were endorsed by women from Polish, Dutch, Greek, Macedonian backgrounds.	women in Australia, who have low levels of literacy in their own language and low English competence.  Authors recommend that barriers to communication should be addressed by having bilingual leaders who can provide programs in community languages.			Less time for family (may inhibit exercise);  Family disapproval (Macedonian – high %)  Less time for household tasks (Macedonian)
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Title: Celebrating Diversity: Approaching Families through Their Food

Book	Target group/s	Methods	Competencies/Skills/Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
Graves & Sutor (1998). This book describes communication skills/strategies to help provide nutrition education to CALD groups.			<ul style="list-style-type: none"> <li>• Using food to create a common ground;</li> <li>• Communicating with familiar topics in a trusting environment;</li> <li>• Sharing experiences (foods, meals, recipes);</li> <li>• Identifying changing food patterns and 'acculturation' ;</li> <li>• Use listening and observational skills;</li> <li>• Identifying how different groups make food choices;</li> <li>• Rely on cultural experts</li> <li>• Use family interaction</li> <li>• Work within the community;</li> <li>• Define the community;</li> <li>• Work with para professional and professionals from the community including peer educators and community outreach workers;</li> <li>• Use pictures, foods, videotapes and demonstrations to communicate nutrition information when language is a barrier;</li> <li>• Use interpreters or translator when appropriate</li> </ul>			

Title: VicHealth Active for Life Program: State Consultations Report

Report	Target /study group/s	Methods	Competencies/Skills/Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
VicHealth Active for Life Program State Consultations Report (1997).	Consultations were conducted with people from NESB; older people, people with disabilities; women and children and men	Consultation methodology involved:  229 people who attended 9 consultations (held in all DHS regions in Victoria);	Strategies recommended included:  Participants as 'ambassadors' spreading the word  Utilize local newspapers / council and community health centre newsletters and local media		Cost  Transport  Accessibility/  Geographic proximity of opportunities  Availability of pleasant and safe	

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	<p>over 40.</p> <p>Cultural Groups represented included – Philippines, China, Vietnam, Russia, Poland, Holland, Greece, Peru, and Bosnia.</p>	<p>Specific consultation was held with the Koori Community in East Gippsland</p>	<p>Broad public education campaigns</p> <p>Ethic and community radio</p> <p>Develop local partnerships and local strategy</p> <p>Target group members and community leaders should be involved in the design and development of projects.</p> <p>Good Practice Criteria identified as:</p> <ul style="list-style-type: none"> <li>• Understand and respond to people’s needs fairly;</li> <li>• Managing specific actions and programs competently;</li> <li>• Promotion;</li> <li>• Encourage participation and ownership;</li> <li>• Reorienting key decision-makers;</li> <li>• Connecting with all sectors and settings;</li> <li>• Using complementary approaches at individual and environmental levels;</li> <li>• Providing technical and managerial support.</li> </ul>		<p>facilities and amenities;</p> <p>Lack of information and knowledge;</p> <p>Lack of confidence and motivation, loneliness and depression;</p> <p>Lack of supporter, facilitator and organiser, and lack of funding</p> <p>Enabling factors would address these factors listed above eg ensuring affordability, geographic accessibility, choice and opportunity etc.</p>	
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Title of Book – Sporting immigrants: Sport and ethnicity in Australia

Book Sections	Target group/s	Methods	Competencies/Skills/Interventions deemed to be important	Organisational structures/processes in place	What factors impacted on take up of health activity	Results
<p>Mosely P, Cashman R, O'Hara J, Weatherburn H eds. (1997) book focuses on the sports and ethnicity.</p> <p>The sections of the book reviewed were the chapters on Better Communication and Promotion by Duncan and Weatherburn (p 219 to 229) and the chapter on Surf Lifesaving) p 210 to 218 by Sean Brawley.</p> <p>And Women, Ethnicity and Sport by Taylor and Toohey (282 to 291)</p>	<p>CALD Communities</p>		<ul style="list-style-type: none"> <li>• Duncan and Weatherburn highlight the need for better communication and promotion</li> <li>• Brawley emphasizes how important it is to establish connections with CALD communities</li> </ul>		<ul style="list-style-type: none"> <li>• New sports introduced to Australia necessary for 'affirmation of identity and social outlet.</li> <li>• Leisure activities create support networks</li> <li>• Different waves of Migration</li> <li>• Generational change</li> </ul> <p>McCoy states that relationships between ethnic community and sport are not static and changes over time with changes in social status, gender roles, place of residence (p48).</p> <p>McCoy suggests that some ethnic groups eg Vietnamese support sports that can be used to promote 'desired</p>	

					<p>cultural and political values' (p. 49).</p> <p>Taylor and Toohey identified barriers to participation for women as:</p> <ol style="list-style-type: none"> <li>1. Lack of companionship</li> <li>2. Lack of facilities and programs</li> <li>3. Language difficulties</li> <li>4. Family responsibilities</li> <li>5. Gender issues</li> <li>6. Negative schools sports experience (pages 280-291)</li> </ol> <p>Proximity to home is a factor identified by Sean Brawley.</p>	
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Title: Health is Gold

Program Report	Target	Methods	Competencies/Skills/Interventions	Organisational	What factors impacted on	Results
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	group/s		deemed to be important	structures/ processes in place	take up of health activity	
<p>The "Health Is Gold" – a smoking cessation intervention among Vietnamese Australians was an initiative of South Western Sydney Area Health Service</p> <p>This project aimed to reduce the harm associated with smoking amongst the Vietnamese community in both areas South West and Central Sydney.</p> <p>A priority was to reduce the</p>	<p>Vietnamese men 18 years and over in South West and Central Sydney</p>	<p>Ongoing Evaluation</p> <p>Evaluation Methodology included:</p> <p>Between 1993 and 1997</p> <p>3 surveys were conducted to assess changes in knowledge, attitudes and behaviour associated with smoking among Vietnamese men in South West Sydney</p>	<p>Multi-strategic approach-interagency initiatives, community involvement, GP education and information dissemination through TV, SBS radio and other media (Cheng 1999).</p> <p>Key strategy:</p> <p>Development of antismoking media campaigns that were culturally and linguistically appropriate, targeting Vietnamese male smokers and their families.</p> <p>Process:</p> <ul style="list-style-type: none"> <li>• Consultation with the Vietnamese community in the development of the messages</li> <li>• Extensive use of the Vietnamese media and community networks</li> <li>• Training of Vietnamese GPs in smoking cessation strategies</li> <li>• Employment of a full time Vietnamese project worker to</li> </ul>	<p>Training programs for health workers Health professional</p> <p>Project also supported the NSW QUIT campaign at the local level</p>	<ul style="list-style-type: none"> <li>• Cultural appropriate interventions</li> <li>• Development of culturally appropriate resources</li> <li>• Use of ethnic media including print and radio</li> <li>• Strong partnerships between area health services, Vietnamese community and organisations</li> <li>• Reinforcement of project messages at community groups and local events such as Vietnamese New year</li> </ul>	<p>As reported by Cheng 1999-</p> <p>First project evaluation used data collected from 1993 and 1995 surveys and the results demonstrated a great improvement in quit attempts (8%) and a reduction in smoking prevalence (8%)</p> <p>Second evaluation study examined data from 1993, 1995, 1997 surveys – Cheng (1999) reports increased knowledge of health problems related to active and passive smoking and in support of non smoking at public places and homes among Vietnamese men aged 18 years and over.</p>

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prevalence of smoking among Vietnamese men.			implement project			
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Title: Promoting a Healthy Life for Our Community

Guide	Target or study group/s	Method	Competencies/Skills/ Interventions deemed to be important	Results
<p>This is a Social Marketing Guide produced by the North Central Metro Primary Care Partnership- Promoting a Healthy Life for Our Community that provides information on social marketing.</p> <p>The Guide is designed to help service providers; health professionals etc who want to develop, implant and evaluate a social marketing campaign.</p> <p>The Guide highlights lessons learnt</p>	<p>The project targeted:  Older Adults in the Yarra, Darebin and Whittlesea LGA</p>		<p>Social marketing skills and knowledge.</p> <p>Using the Active Life Campaign as an example– social marketing processes are described as:</p> <ol style="list-style-type: none"> <li>1. Research your audience.</li> <li>2. Audience segmentation was recommended.</li> <li>3. Different audiences/different strategies.</li> <li>4. Design messages that are appropriate to your target audience</li> <li>5. Identify how to effectively reach your target audience.</li> <li>6. Utilise a variety of approaches.</li> <li>7. Ensure linguistic needs are met.</li> <li>8. Translation and interpretations into languages other than English</li> <li>9. Use models of behavior change to inform the strategy.</li> <li>10. Market test your potential produces, materials, services.</li> </ol>	<p>The authors state that social marketing is an important tool in the world of public health and health promotion..</p>

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<p>from the NCMPC Partnership – “An Active Life Project”.</p> <p>This project focused on promoting physical activity to older adults. Using a social marketing process.</p>			<ol style="list-style-type: none"> <li>11. Build partnerships with key allies.</li> <li>12. Evaluate.</li> </ol>	
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Title: Partnering with Ethnic Communities

Pamphlet	Target Group	Method	Competencies/Skills/ Interventions deemed to be important	Results
<p>This pamphlet authored by Eleni Karantzas .No Date.</p> <p>Is a practical guide to service providers, health professionals, managers and health promotion staff involved with planning, implementing and evaluating a project/program for CALD communities.</p>	<p>Service Providers, Health professionals and health promoters</p>		<p><b>Planning</b></p> <ol style="list-style-type: none"> <li>1. Demonstrate ongoing networks and relationships with CALD community groups and agencies that provide services to CALD communities.</li> <li>2. Research target groups based on community demographics and keep regular CALD population statistics as part of a demographic profile.</li> <li>3. Consult or seek feedback and information from targeted CALD communities and consumers.</li> <li>4. Problem definitions, direction of program planning and strategy selections incorporate community consultation findings and demographic profile of CALD target group.</li> </ol> <p><b>Implementation</b></p> <ol style="list-style-type: none"> <li>1. Support partnerships with CALD</li> </ol>	

			<p>community leaders and representatives through training and mentoring strategies integrated into program design.</p> <ol style="list-style-type: none"> <li>2. Select and use culturally sensitive strategies in partnership with ethnic communities.</li> <li>3. Ensure linguistic needs of CALD target group are met via use of accredited interpreters and in language or translated resources where appropriate.</li> <li>4. Use culturally appropriate promotional strategies and media for program recruitment and social marketing campaign.</li> </ol> <p><b>Evaluation</b></p> <ol style="list-style-type: none"> <li>1. Establish timelines and performance indicators measures based on community expectations and goals.</li> <li>2. Ensure evaluation methodologies are formulated in consultation with CALD community leaders and representatives.</li> <li>3. Implement evaluation procedures in partnership with CALD community representatives and leaders.</li> </ol> <p>Demonstrate that initiatives, work practices or achievements meet the needs expressed by CALD communities.</p>	
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## APPENDIX 3 - NATIONAL CONSULTATIONS

### ORGANISATIONAL STRUCTURES & POLICIES (SYSTEMIC ISSUES)

A great deal of discussion concerned the organisation wide and systems wide issues that impact on the capacity of the health sector to successfully deal with cultural and linguistic diversity. The following issues were raised in all consultations to date:

#### ***Diversity as a 'tack-on'***

Diversity issues were often seen to have a 'tack on' character rather than being core to the operation and management of health organisations. They are quite often the domain of dedicated people in designated positions.

A common theme throughout the consultations was the need for organisations to have a consumer charter that is inclusive of cultural diversity. Many participants believed that more often than not organisations saw culturally and linguistically diverse clients as a 'tack on' to an Anglo client base, rather than appreciating that the client base is multicultural.

Barriers to cultural competence are generally seen as a consumer issue. 'They [the culturally and linguistically diverse communities] have the barriers and we provide the services.' The attitude is that we provide the services to a largely Anglo population with NESB as an add-on, rather than accepting that we are a diverse society." (Sydney consultation)

"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)

There was a perception that services need to be made more accessible to health professionals (for example, translation services), as they are not always used, often because no money has been allocated for them.

#### **Comprehensive diversity approach**

There is a need for a more comprehensive diversity approach, with diversity issues being reflected in policy, priorities, resourcing and reporting.

#### **Policy environment**

There was a perception, made most strongly in Sydney, Melbourne and Adelaide that multiculturalism has fallen off the agenda, and that "we have gone back 20 years in what we are able to provide". Many felt that Australia is less tolerant and willing to embrace diversity now, than in the 1980's. There was a perception that the idea that "if you are in Australia you should act like an Australian" is one that is highly politicised and prevalent at the moment due to the current political climate, and this is a barrier to cultural competence and inclusive practice.

Participants spoke of a push for the ‘mainstreaming’ of the health sector. It was felt that the policy environment does not support the sector to embrace and respond to diversity, rather it is left to individuals’ passion to drive change from the bottom up.

From a policy perspective, there were a number of policy initiatives that were seen as important in creating a policy environment that supported culturally competent practice within the health sector:

- **Diversity management framework:** the most effective context for the practice of cultural competence would be the adoption of a diversity management framework that would provide the functional structure and reporting framework against which performance could be monitored.
- **Accountability:** while participants acknowledged that there are initiatives in place at a systemic whole-of-government level that encourage inclusive practice, for example *Ethnic Affairs Priority Statements (EAPS)*, aged care standards, etc. there is no legislative framework to enforce or monitor the health sector’s or organisations’ performance in relation to them.
- **Mandated training:** training is important, but it was acknowledged that senior staff and management do not want to attend training. Therefore a strong policy position needs to be taken to mandate this
- **Recruitment targets at a policy level:** university places to train workers, etc.

### Planning

A few participants discussed the need for services to be pro-active with respect to diversity, that is, preparing for changes in their client base (eg: and expected influx of migrants coming from Africa). The general feeling was that health services tend to react to issues once they have happened, and there is not a great deal of forward planning with respect to diversity within client bases.

Related to this was discussion about the need for the health sector to value processes that brings to bear strengthening of communities.

“The time has gone where health services open doors and wait for people to come. Have to go to them.” (Perth consultation)

Related to the need for commitment to long term planning was the recognition that this is only possible if the numbers justify it – “if there are not numbers there from communities there will be no support from management”. Others felt that this was the wrong argument because smaller communities who have less access to community resources have higher needs, but are not represented in the needs-based data.



## **Motivation**

The motivation for the approach will rest on legislation or strong policy positions as there was an impression that external advocacy and client side demands were not evident.

It was acknowledged in the Sydney, Melbourne and Adelaide consultations that advocacy does not necessarily come from outside the health services anymore. When asked where the driver was for culturally competent practice, most often participants believed it came down to individual passion to “push and believe”.

Participants strongly felt that there needs to be both legislative commitment at a policy level around these issues, and communities have to start *demanding* rights in this area.

## **Articulation of benefits**

A cultural competency approach should be promoted in a ‘What’s in it for me’ approach that would include the articulation of the long-term benefits to the health system of getting the messages and service provision right, as well as the personal benefits of competence in this area being both recognised and rewarded.

There was a sense in the consultations that health sector applies a productive diversity model to culturally and linguistically diverse issues, i.e. appropriately servicing culturally and linguistically diverse communities is only of value if there is an economic benefit. If it starts costing organisations, ‘then it is a nuisance’. There was a real sense in the consultations that a lack of incentive, (either economic or legislative), to work effectively in cross-cultural situations. In relation to this it was felt that there was a need to promote cultural competency as a positive economic benefit, or to introduce an accreditation system that attracts funding.

If there is no quantifiable performance indicator, there is no incentive to do it. If how many people who don’t speak English come through the door is positive, things might improve. (Sydney consultation)

Others felt that rather than talking about economics it is better to talk about ‘richness’, that is, all things that make life ‘good and interesting and fun’.

## **Management**

Across the consultations managers were seen extremely important in this process and there needs to be an appreciation of specific competencies in the management area. There was a general feeling that there was lack of training for managers in this area, as well as awareness and enthusiasm at a managerial level.

The need for broader understanding of the issues at a managerial level, and at that level their main role is in providing leadership. There was a perception that leaders only need to make a small move for others to make a large improvement, and to view this area as one of importance.

There was also a recognition that this leadership needs to be delivered in a genuine way, rather than 'go and do this because we have EAPS coming up'.

Top down endorsement for culturally competent practice was seen as crucial, and this had to be both value driven and provided structurally – 'believe it, sell it, implement it'.

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 effectively. (Brisbane consultation)

Building cultural competencies into job descriptions was also mentioned commonly across the consultations.

### **Resourcing**

There is a need for more substantial resourcing of this area with a short term priority being dedicated funding and a longer term priority being the development of accountability in diversity management that would need to be reflected in the way that all resources are utilised and expended.

The consultations in all states were framed by a unanimous perception that the industry is overworked, underpaid, time poor and reactive. There was also a feeling that there is very little money put into preventative health generally. Given this there was a perception that practitioners were hesitant to use interpreter services, bilingual workers, specialist services, etc, as they are seen as expensive and difficult to obtain.

While there was much discussion about the need for training and policies in this area, there was also discussion about organisational constraints that firstly affect the ability of organisations to fund training, and secondly to implement policies even if they were in place.

There was a sense that there were fewer translated resources available, smaller budgets for interpreters, etc. and therefore the cost of servicing clients is higher. Participants felt there was no financial incentive for professional development and no incentive for the sector to 'skill up'.

Time restrictions were a huge issue, particularly in relation to GPs, which lead many in the discussions to wonder how to educate practitioners to accommodate for an overall lack of time.

### **On-going strategies**

Another common theme among the consultations was the need for on-going long term projects. Participants discussed the constraints associated with short-term project funding. Related to this was an acknowledgement that in investing in the maintenance of good health, outcomes take a long time to show a result. There was a perceived need to move away from a 'quick fix' mentality and to allow time for change.

Related to this was discussion about the many culturally and linguistically diverse communities we may not have had the benefit of prior exposure to preventative health messages to the same extent as the wider Australian community. Therefore the rate of message acceptance is likely to differ in different communities, as well as the intensity in which the message is delivered.

There were also discussions about the pace at which culturally and linguistically diverse communities should be expected to accept messages, particularly new arrivals. There was an acknowledgement that when people arrive in Australia they are often bombarded with information, and that for information to have resonance it needs to be 'drip fed' over time.

### **IMPORTANT INTERVENTIONS, SKILLS AND KNOWLEDGE**

The issues raised in this section were those that were seen to impact on the individual in the health sector; what motivates and what impedes professionals in their capacity to deal with cultural and linguistic diversity?

#### **Cross cultural training**

Cross-cultural training was seen as an imperative for competence to be developed. There was a myriad of issues around this including:

- lack of priority given to this type of training;
- participation is not mandatory;
- it is too long, too PC and it is not a priority;
- it is badly done, too 'one way' i.e. it is always about the other and what the individual is doing wrong and not based on good adult learning principles;

In terms of trainers there are serious questions about both the competency and expertise of trainers with corollary questions being who accredits the cross-cultural training and the trainers?

Cultural awareness training was generally accepted as the 'means through the maze'. Participants felt there was a need for a greater patient focus to service delivery and communication, and that training was required to do this. Current approaches to cross cultural training were seen as ad hoc, rather than positioned as core aspects of compulsory medical education for all health professionals.

#### **Positioning**

It was expressed in all consultations that cross-cultural training should be a mandatory part of health professionals' medical education.

Across the consultations it was clearly articulated that a policy was required that ensured cross cultural awareness training is a key requirement (quality assurance) of any organisation working in the health sector. From an organisational perspective there was a general perception across the consultations that there should be no hierarchy of skill levels that dictates who should take part in this type of training. Instead cross-cultural training needs to be imposed from a higher level and must involve all within an organisation from management to front of house staff.

In delivering cross-cultural training it was believed that there needed to be an accountability process so that educators are properly certified, and that there needed to be some form of accreditation associated with training for it to be valued by practitioners.

Another strong theme from the consultations was that training in this area should be on-going, and not 'just a one-day luxury'.

Need to oil tools, polish them, maintain them. Constantly refresh it. Make it relevant for the time. Have to market it as something people/organisations want and need. (Perth consultation)

## **Components**

Participants discussed a number of components of appropriate cross-cultural training:

- the extent of diversity within the community;
- what it means to work cross-culturally;
- self-reflection;
- the benefits of this type of training also need to be articulated, and not assumed;
- cultural interpretation of health issues;
- historical issues associated with various health issues;
- general communication;
- when and how to work with interpreters, and the role of interpreting services; and
- Appropriate referral information, as well as knowledge about specialist organizations. There was a perception that both people within the medical profession and from community groups need to be made aware of what services are available and what the costs involved are. There was a perception that currently there is a lack of understanding/knowledge in this area and people are not utilising services as a result.

## **BARRIERS**

While participants saw cross-cultural training as integral to the health sector and cultural competence, there was acknowledgement in all consultations that cross-cultural training was not necessarily valued highly by health professionals. In the Sydney consultation the results from a survey of training needs for GPs, cross-cultural training was the lowest scoring item.

The key barriers to undertaking cross-cultural training were:

- Lack of commitment within organisations to promote the importance of such issues
- Time – ‘too busy’
- Resources
- Lack of support to implement training
- Lack of interest – ‘already done it’
- Short-sightedness – ‘we don’t need it’
- Entrenched racism

## **THE INDIVIDUAL**

The individual sector worker and his/her set of perceptions values and beliefs have a strong bearing on their competency in this area. Individuals are likely to have a set of passions, commitments and prejudices that affect their view of cultural competency and their willingness to attain and value the individual skills sets. Their motivation in this regard is affected by,

- personal beliefs;
- lack of management endorsement or value of cross cultural practice and skills;
- perception that training takes too long, is not useful and is too ‘politically correct’;
- a lack of reward from acquiring skills either in skills recognition in the workplace or within a more formal training accreditation; and
- lack of value in a performance management context.

For those who are willing to develop cultural competency the priority issue is information that will allow them to operate effectively in such a context (this had specific application in terms of the discussion of health promotion and obesity issues).

Some participants viewed confidence as the cornerstone of being culturally competent. Some felt that lack of confidence came from fear of making mistakes or 'fear the ragging of racism', others felt it stemmed from regimented training about approaches to clients.

There is goodwill amongst staff however a fear to work with communities – need to be comfortable enough to admit that yes, they do not know/are not familiar with a certain culture and may make mistakes at first. (Hobart consultation)

Health professionals that genuinely care and want to help can at times be "overly sensitive in being insensitive" due to a lack of confidence – they are scared of making mistakes. (Melbourne consultation)

Participants recognised that while practitioners are often technically capable, they cannot transfer information sensitively, and this impacts on their ability to work effectively. There was a perception across the consultations that there was a need for cultural training to be built into medical education.

We need to have empathy – try to understand where they are coming from, don't try to abolish their culture and beliefs and replace it with our own ideals. We need to find a way to focus in on their beliefs and turn it around on itself to get the desired response. (Gold Coast consultation)

### **Basic communication skills**

In relation to communication participants were asked what a practitioner has to bring to be able to work in a culturally competent way. Most often the skills required were general communication skills, rather than language skills (although these were raised), for example:

- Sensitivity
- Acceptance
- Ability to listen and to hear people's stories
- Ability to accompany person on a journey
- Ability to develop sense of trust very quickly
- Genuineness
- Being open to the other person
- Modes of inquiry
- Tone – ie a raised voice does not make people understand jargon

Do we know what questions to ask? Becoming culturally competent is not just about getting information 'about a community' – communities are so incredibly diverse. It is a basic communication issue. People's excuse is often that

they don't know enough about ethnic communities, but what they need is an understanding to respond to individuals, with individualised needs. (Sydney consultation)

Participants mentioned that one of the most important principles for effective communication with people from culturally and linguistically diverse backgrounds was for communication to be a two-way process/exchange. Based on reciprocity / community development models, the need for an equal power relationship was felt to be vital between the health sector and culturally and linguistically diverse communities.

### **Self-reflection**

All consultations raised the importance of self-reflection; the ability to have an insight into how one's own culture affects your own practice. Participants believed that to learn about the 'other' people had to self-reflect to learn about themselves.

Participants also acknowledged that that this can be a challenging process for people and that there is often a need to 'nurture' people through the process.

We need to understand the journey to becoming culturally competent can be hard for people – need to do it in a compassionate way. (Sydney consultation)

### **Information on cultural and religious beliefs**

Information of the cultural and religious beliefs around particular issues was seen as important though all participants were aware of the danger of cultural stereotyping. This information was seen as most useful if coming directly from the specific group. Types of information included:

- community composition and sub groups;
- issue specific cultural and religious beliefs;
- knowledge of the effect of migration experience: lifestyle, eating, exercise, psychology;
- awareness raising in relation to existing resources and services;
- relative value given to cultural competency compared to clinical competency; and
- information for planning including demographic Census data, immigration arrival data, epidemiological data and service usage data .

Participants felt there was a need to arm people with information, as information makes people feel more confident. This also ties into fear of making mistakes. There is a need to acknowledge and recognise people's lack of confidence in this area.

A number of participants mentioned that while there was a desire from many practitioners for specific information about communities, mainly as a way of increasing confidence, it was important not to stereotype or homogenise communities. The need to recognise diversity within diversity was stressed throughout the consultations.

Participants spoke of the need to teach people to understand aspects of culture, for example the impact of migration, settlement, acculturation, torture and trauma, cultural mores. Rather than providing people with absolutes about different cultural groups. In relation to specialist skills for the health sector, equipping practitioners with appropriate referral information, as well as knowledge about organisations, was mentioned.

### **Resources necessary for cultural competence**

A range of resources were also considered necessary and in this regard there was a clear effectiveness hierarchy in terms of what was seen to work best. The approximate ranking is:

- The employment of bilingual/bicultural education staff
- Partnerships with culturally and linguistically diverse communities
- Trained and sensitive staff with access to language based resources
- Availability of interpreters
- Availability of materials printed in other languages
- Human resources
- Culturally competent General practitioners

Human resources were consistently identified as valuable and effective in meeting the needs of culturally and linguistically diverse communities

General practitioners were identified as important in the delivery of better health information due to their role in primary care. Issues around their cultural competency and the operational factors that limit their capacity as health information providers were also discussed.

### **Bilingual/bicultural staff**

Bilingual workers were consistently raised as one of the key strategies in culturally competent health delivery. It was often expressed that bilingual workers should not only be someone who speaks the language, but also someone who understands and can negotiate the culture. It was also stressed that bilingual workers need to have both technical and cultural competence in order to be effective.

In discussions about bilingual workers, other issues were raised:

- The mainstreaming of organisations represents a danger for staff with language or cultural skills to become the unofficial cultural and linguistic expert. Participants cited examples of other staff members deferring responsibility for culturally competent practice to these workers. There was a sense that if this is the role that staff are taking, they need to be rewarded for it. Moreover, it was strongly felt that all staff members should have cross-cultural skills, otherwise people get pigeonholed and burnt out, and culturally and linguistically diverse communities continue to be seen as the 'other'.

Let's not mainstream, but mainstream the competencies that we hold" (Melbourne consultation)

- Sometimes community members do not want to be referred to bilingual workers from their community because of privacy/confidentiality issues.

### **Consultation with people from diverse language and cultural backgrounds**

Throughout all discussions about culturally competent information delivery, the need for clients to have ownership and management of the information that is delivered to them was reinforced.

Participants unanimously agreed on the need for dialogue between the health sector and communities in order for information delivery to be effective. The general consensus was that this practice is rare in the health sector, and needs to be addressed if the health sector is serious about cultural competency.

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)

It was felt that programs should be constantly instigating debate within the community, and that communication as to be a two-way exchange, rather than a top down approach. In discussions about best practise information or program delivery, this approach was always taken. If done effectively it is felt that this type of consultation can generate advocacy and gives greater access to raise issues of community concern.

Bilingual workers and peer educators were seen as very important in facilitating effective community consultation. The need to give culturally and linguistically diverse workers flexibility to do what the community wants rather than what organisations prescribe them to do was also reinforced.

The client is the cultural expert about themselves. (Gold Coast consultation)

A few participants, while agreeing with these sentiments, cautioned about identifying people to speak for a whole cultural group, or champion information, as this can sometimes homogenise a community and 'hijack' other members of the community. Remembering that there is no 'one size fits all' message was considered very important. Working with communities to identify community priorities was seen as very important, and an on-going process.

### **Inter-agency collaboration**

A number of participants discussed the importance of inter-agency collaboration and partnerships to maximise the reach and effectiveness of health sector resources. Others agreed, but added a caution:

Inter-agency collaboration – this is great in theory, but it makes organisations compete for the same bag of money.

The government is cheeky the way they do it. (Adelaide consultation)

Nevertheless partnerships between the health sector and community organisations were seen as intrinsic to capacity building. While resource issues were raised throughout the consultations, there was recognition that the effect of this is made worse by the lack of sharing and communication within the sector. Participants felt that organisations, agencies and departments should be working together to share resources, develop new ways of getting the message across and learning from each others' mistakes and successes.

## **FACTORS IMPACTING ON TAKE-UP OF HEALTHY LIVING**

The reporting on this area of inquiry will be in two specific frames of reference. The first of these is the need for an effective communication model to improve the take-up of health living, while the others are a range of cultural and linguistic barriers identified as relevant to culturally and linguistically diverse communities in their ability to take-up healthier living.

### **The need to improve communications practice**

There was a number of issues raised in relation to improved communication practice. These are summarised below:

- **Heterogeneity:** An understanding that culturally and linguistically diverse groups are not homogenous.
- **Ethnographic approach – don't start with the strategy:** It was seen as important to start with an understanding of cultural and religious beliefs and practices prior to the development of both an

approach to the communication and the messages to be used. It is important that messages are owned as they have a higher likelihood of being more effective than messages that are imposed.

It was also considered important that services work with communities to establish trust, and to let communities know they understand and respect culture. The basic model expressed was:

- Establish needs of the community
- Establish confidentiality
- Bring in services to meet those needs
- Opens doors to Australia, establishes trust
- Learn from communities
- Draw in resources to community
  
- **Sensitivity framework:** Appreciating that there is a need to consider communications within a sensitivity framework in which there is a relationship between individual issues and both the time and authority required to achieve a change in behaviour on the issue. As such the rule would be that the more sensitive the issue, the more time necessary to achieve any outcome, the greater the need for incremental stages in the change process and the higher the level of authority of the voice delivering the message.

This was expressed in the consultations as the difference between communicating a message on immunisation to communicating a message on FGM (female genital mutilation).

- **Bilingual educators:** There is a clear premium placed on the use of bilingual educators as the best approach to communication, with other media considered useful but less important. In this regard the full array of media was canvassed including non-English press and radio, translated information and the use of community events as information opportunities.
- **General practitioners:** The need to include General practitioners as an important health informant.

## Settlement

There was a lot of discussion about the impact of settlement on the uptake of healthy living messages. For people who have never lived in a city or seen a doctor on a regular basis, prevention messages might be very foreign.

For refugee migrants who have experienced torture, trauma or poverty obesity messages can be difficult, insofar as people feel they 'finally have food' or 'came to Australia not to be hungry'. There are also a

number of acculturation factors in which adopted behaviours are followed even though they have a negative obesity outcome because they are seen as the 'norm', i.e. driving short distances rather than walking, drinking 'coke', eating high sugar, high salt, high fat foods. In considering the issue of obesity, it was felt that thought needs to be given about how to overcome conflicting messages about consumerism and good food.

To some, these 'bad habits' (over eating, fast foods, soft drinks, smoking etc) are considered the benefits to being affluent; they can become indicative of status and financial prosperity. It is therefore hard to change these behaviours as they are not considered 'bad' to all.

### **Notions of diet, exercise and preventative health**

There were a number of issues raised in relation to notions of diet, exercise and preventative health:

- Perceptions that fat is healthy, with examples including behaviour in one community that involved feeding infants nutrition supplements as a means of getting them chubby and this being equated with being healthy.
- Difference in the culturally defined notion of physical beauty and body size and the impact on this on obesity messages.
- Concepts of exercise can put off, rather than encourage.

Call it physical activity – when you have worked on a farm the idea of exercise is ridiculous.

- The need to understand the relative importance of personal health to the cultural group – where does the topic fit within an individual's cultural background.
- Preventative health concepts versus treatment concepts needs to infiltrate culturally diverse communities – 'if it isn't broke, why fix it?'
- Many communities are not used to talking to General practitioners about lifestyle issues.

### **Other barriers to message take-up**

The discussion around other cultural and linguistic barriers focussed on the obesity issue. The following points were raised:

- The affect of previous circumstances on attitudes to food and fat. This was expressed through a number of examples depicting experiences with famine, poverty or recent experience of war.
- The need to acknowledge positive elements of traditional diet as a means of developing better nutrition in an Australian context. The need to balance harmful and beneficial behaviour was expressed.

- Negative messages around obesity as these are considered a less effective means of changing diet behaviour in culturally and linguistically diverse communities. Participants felt that 'guilt' and 'blaming' in messages should be avoided. For example the label of 'obesity' in Australia has very negative connotations, whereas it is associated with beautiful, healthy and happy body images in other cultures. This can create confusion and alienation, and mediators are needed to begin breaking down these barriers. Bilingual educators are ideally positioned for this as they have the relevant understanding of the community and their culture, and tend to be respected by the community group.
- The need to ensure that programs that are developed are designed to introduce people to an area of concern, but are at the same time going to be easy to maintain on an individual level.
- The importance of family responsibilities and how they impact on take up of healthy living activities. An example was cited where an exercise program for Turkish women was developed; childcare was organised as part of this. However neither the childcare worker nor the notion of childcare was accepted, and the service had to accept that the fitness class had to be delivered with children climbing over the equipment.
- Lack of transport and social isolation was also seen to impact on diet and exercise habits. In addition, it was felt that the desire not to participate in activities by one self was a barrier to physical activity, attending education sessions, etc. Promoting the social aspects of good health was considered very beneficial.
- Safety was also raised as an issue in relation to physical activity outside the home. An exercise program for Afghan women where they danced in each other's homes was found to be both culturally relevant and appropriate for their other familial responsibilities.
- Low levels of literacy in some communities were another factor. Participants stressed the need to look at alternative means of information delivery beyond translated written materials.

### **Toolkit**

There were mixed opinions about the usefulness of toolkits. Many questioned whether people would use a kit, with many expressing fear that it would become yet 'another resource to sit on a shelf'. Others felt that a toolkit was of little relevance unless systemic issues were addressed.

The overall perception was that a toolkit has to provide information that goes beyond cultural awareness. It has to be productively effective, that is, giving users the ability to work effectively with people from diverse backgrounds.

There was some consensus about the best approach for delivering a toolkit:

- It should be electronic, and hyper-linked to relevant community and professional resources.
- It should be organic, on-going and updated regularly.
- It needs to be supported with additional resources and strategies – a toolkit cannot be delivered in isolation.
- The language used should be simple and straightforward.
- It should not be too prescriptive.
- It should include examples of best practice.

It should include information on:

- the extent of diversity within the community – population data;
- what it means to work cross-culturally;
- self-reflection exercises;
- cultural interpretation of health issues;
- historical issues associated with various health issues;
- understanding of settlement issues;
- general communication;
- when and how to work with interpreters, and the role of interpreting services;
- appropriate referral information, as well as information about specialist organizations;
- methods of communication;
- consulting with culturally and linguistically diverse communities;
- working in partnership with culturally and linguistically diverse communities; and

**APPENDIX 4 – LITERATURE REVIEW TEMPLATE**

READING GUIDE

**Reviewer:**

**DATE OF PUBLICATION:**

**BIBLIOGRAPHIC CITATION:**

Example:

Doe, J. 2004, 'The search for cultural competence', *Journal of cultural competence*, vol. 1, no.1, pp. 1-20.

Doe, J. 2004, *The search for cultural competence*, Global Press, New York.

<b>PRACTICE BASED ARTICLE</b> <input type="checkbox"/>	<b>THEORETICAL/CONCEPTUAL ARTICLE</b> <input type="checkbox"/>	<b>RESEARCH ARTICLE</b> <input type="checkbox"/>
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**7. TOPIC / ISSUE**

Health

Management

Education

- Nutrition
- Exercise
- Smoking
- Other .....



WHAT FACTORS IMPACTED ON TAKE UP OF HEALTH ACTIVITY / MESSAGE? (*e.g. proximity to home, ethnic community champions...*)