CULTURAL COMPETENCE ASSESSMENT TOOL
FOR
CLINICAL GUIDELINE DEVELOPMENT

September 2009

Endorsed by:
The Program Delivery Group
Nova Scotia Department of Health and Wellness
March 3, 2010

REVISED JANUARY 2011

NOVA SCOTIA

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CONTENTS

1. ABOUT THE CULTURAL COMPETENCE ASSESSMENT TOOL

The *Cultural Competence Guidelines for the Delivery of Primary Healthcare in Nova Scotia* (2006) require healthcare to be respectfully delivered and responsive to cultural history, health beliefs, practices, lived experiences, health disparities, and linguistic differences. This *Cultural Competence Assessment Tool* supports this 2006 inaugural work by bringing cultural competence into the foundational guideline development work of the Nova Scotia Department of Health and Wellness* Provincial Programs. The *Cultural Competence Assessment Tool* includes a list of opportunities where culture in its broadest interpretation can be embedded into the process, content, and outcomes of guideline development. Also included is a reporting form where observations and recommendations can be made explicit and shared among Provincial Program team members. This is also available as an electronic reporting form.

How was this tool developed?

Three members of the ad hoc Provincial Programs Guidelines Committee guided this work (see Appendix 1). To inform the development of the tool, a search for examples of cultural competence assessment in clinical guidelines was conducted nationally and in the United States, Scotland, New Zealand, Australia, and England. Key elements of the tool, including questions and the reporting format, are based on the findings of this search. A sample tool was first developed, applied, shared, and then further refined for ease of use. A summary of individuals and organizations consulted and their contribution to this tool is acknowledged in Appendix 1.

Why consider culture and cultural competence in clinical guidelines?

In Nova Scotia's cultural competence guidelines (see Appendix 2) *cultural competence* refers to the attitudes, knowledge, skills, behaviours, and policies required to better meet the needs of all the people we serve. *Culture* refers to a group or community that share common experiences that shape the way its members understand the world. It is multi-layered, evolving, and includes groups that we are born into or become. People have multiple cultures.[1] Examples include race and ethnicity, geography/location (residence, place of origin), levels of ability, gender identity, age, sexual orientation, socio-economic status, and religion/spirituality. Sex and/or gender, language, literacy, and health literacy are cross-cutting considerations within culture.

Culture, broadly defined, matters to health for many reasons. This can include the expression of disease within population groups, variations in drug metabolism, or the health implications of language barriers, racism, loss of culture, and low societal status. Cultural bias, beliefs, and practices are brought to every health encounter by providers, patients, and health systems. Aspects of culture that influence health are included as Appendix 3.

Considering cultural competence in clinical guidelines has the potential to enhance access to health services, enable more appropriate and effective care relationships, and improve health outcomes. Cultural competence is a key approach in pursuing an agenda of health equity and reducing health disparities.

For definitions of terms and concepts, please refer to the glossary.

*As of January 12, 2011, the Nova Scotia Department of Health and the Department of Health Promotion and Protection merged to form the Nova Scotia Department of Health and Wellness.

When and how to use the Cultural Competence Assessment Tool

When?   Apply the *Cultural Competence Assessment Tool w*hen developing, assessing, or adapting clinical practice guidelines.

How?   When developing guidelines, consider:

Culture: Race, ethnicity, socio-economic status and income, spirituality/religion, ability, gender identity, sexual orientation, age, geography, education, literacy, health literacy as well as *language, sex, and gender*

*Disparity***:**   Poor health status, presence of disease, outcomes or access to care among population groups

*Plus***:**   Any other factor by which a population group could be stratified showing disadvantage (for example, risk of homelessness)

Developing new guidelines?   Consider all opportunities and complete the report to document your work.

Assessing existing guidelines?   Start the report at **Section 2b.** Consult with diverse individuals and groups and seek evidence as required.

NOTE: Information about cultural groups in clinical guidelines cannot be stated as true for all individuals within a group. Each individual expresses unique intersections of culture and lived experience within a social context. As well, difference does not automatically imply disparity or disadvantage. Clients are the experts in their own culture. Avoid stereotyping by developing respectful, culturally competent relationships. Allow flexibility in guidelines to value individual circumstances.

GLOSSARY

Ethnicity: Identity with or membership in a particular racial, national, or cultural group and observance of that group's customs, beliefs, and language.[2]

Gender: The socially constructed roles and relationships and relative power and influence attributed to men and women, boys and girls, in a given society at any given period of time.

Gender identity: A person's self-image or belief about being female or male or neither. One's gender identity is their innate sense of who they are and how they perceive themselves in their world. Using the terms male or female alone excludes people who are transgender, transsexual, intersex, and others.[3]

Health literacy: The ability to access, understand, evaluate, and communicate information as a way to promote, maintain, and improve health in a variety of settings across the life course. This definition is broadening as the understanding of health literacy increases. The ability to read, understand, and act on printed materials is one of the significant determinants of health. Patients with poor health literacy tend to have poorer health outcomes.[4]

Literacy: The ability to understand and use reading, writing, speaking, and other forms of communication to fully take part in society and achieve life goals.[5]

Race: A group of persons related by common descent or heredity; any of the traditional divisions of humankind…characterized by supposedly distinctive and universal physical characteristics.[6]

Sex: The genetic, biological, and physiological characteristics that generally distinguish males and females. These are not binary distinctions and should be thought of as existing along a continuum. Influences of **sex and gender** can be interrelated.[7]

Sexual orientation: The capacity to develop intimate emotional and sexual relationships with people of the same, opposite, or both sexes.[8]

Health disparities: Population-specific differences in the presence of disease, health outcomes, or access to healthcare.[9] The human cost of health disparities is avoidable death, disease, disability, distress, and discomfort. Disparities are also costly for the health system and Canadian society as a whole. The most prominent factors in Canada are socio-economic status (SES), Aboriginal identity, gender, and geographic location.[10]

Health equity: The absence of systematic disparities in health or the major determinants of health between groups. Equity has an ethical dimension and is related to human rights. Equity supports the right to the highest attainable standard of health, as indicated by the health status of the most socially advantaged group.[11]

2. OPPORTUNITIES FOR CULTURAL COMPETENCE IN CLINICAL GUIDELINES

Opportunity 1: Process

Who develops and reviews guidelines? Have stakeholders, the public, and/or consumers who can speak to culture, sex, gender, language, and/or disparity been involved?

1. Make it possible for diverse individuals and groups to suggest new guideline topics.
2. Ensure that individuals developing, reviewing, and evaluating guidelines have taken part in sex-and gender-based analysis, diversity, and/or cultural competence training.
3. Designate a member of the guidelines development team to specifically consider culture, sex, gender, language, and/or disparity throughout the process.
4. Ensure that diverse individuals and groups review scoping and/or draft guidelines.
5. Collaborate with diverse individuals and groups on guidelines implementation/evaluation.

Opportunity 2: Content

Are culture, sex, gender, language, and/or disparity explicitly considered and included?

a)	**During scans, scoping[1] and evidence review**

6. Search for evidence by culture, sex, gender, language, and/or disparity (incidence/prevalence, diagnosis, risk factors, treatment). Note any lack of evidence. Assess whether findings can be extrapolated across groups.
7. When possible, also consider local evidence of disparity or disadvantage, such as focus group results, pilot projects, stated lived experience, patient satisfaction surveys etc.
8. Identify populations who merit explicit consideration within the guidelines. This may be because of poor health status or when cultural beliefs and practices differ greatly from those of the dominant culture (or both).
9. Identify areas where culture, sex, gender, language, and/or disparity can be addressed.
10. Consider the potential positive or negative impact of the guidelines on priority populations. For example, by focusing on a well population, will the guidelines inadvertently increase health disparities?

b)	**Within the guidelines document**

11. Explicitly address culture, sex, gender, language, and/or disparity in sections on incidence/prevalence, risk factors, diagnosis, treatment, and screening. Identify priority populations.
12. Include appropriate considerations of culture, sex, gender, language, diversity, and/or disparity throughout.
13. Include key cultural aspects of priority populations when they differ from those of the dominant culture and could affect health, such as health beliefs and practices.
14. Encourage healthcare providers and organizations to follow the *Cultural Competence Guidelines for the Delivery of Primary Healthcare in Nova Scotia*.

c)	**During guidelines launch**

15. Profile culture, sex, gender, language, and/or disparity during the launch.

Opportunity 3: Outcomes

Are data on culture, sex, gender, language, and/or disparity collected and assessed? Is disparity of access, impact, and outcome evaluated?

16. Include appropriate sex, gender, linguistic and cultural identifiers in data collection. Consider epidemiological, health utilization, quality improvement, and/or responsiveness data.
17. Assess effectiveness and outcomes by culture, sex, gender, language, and/or disparity.
18. Regularly evaluate the impact of the guidelines by culture, sex, gender, language, and/or disparity.

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[1] Scoping creates a framework within which to conduct guideline development. A scope document includes an overview of what the guideline will include and exclude; informs the development of the clinical questions and search strategy; informs professionals and the public about the expected content of the guideline; and ensures the final guideline is kept to a reasonable size.

3. CULTURAL COMPETENCE ASSESSMENT TOOL REPORTING FORM

Background	
Name of Person Completing Report Title	**Contact Information**
Organization/Affiliation	**Date**

Stage of this Review (check):

☐   New Guidelines
☐   Review of Existing Guidelines
☐   Adaptation of Existing Guidelines
☐   Other:

Opportunity 1: Process	
What is the purpose of this guideline?	
Who is this guideline written for?	
Who is this guideline meant to benefit/ affect and how?	

Name and contact of designated cultural competence lead. *(See #3*)*

Outline how individuals, including stakeholders, members of the public, and/or consumers who can speak to culture, sex, gender, language, and/or disparity will be involved in the creation, review, implementation, and evaluation of these guidelines? *(See #s 4 & 5*)*

The numbers in brackets refer to the list of items found under the Opportunity Areas on page 4 of the Cultural Competence Assessment Tool.

Opportunity 2: Content

2a)   Scoping and evidence review

Has a search for evidence by culture, sex, gender, and/or language been conducted?	☐ Yes ☐ No
Have priority groups facing disparity or disadvantage been identified?	☐ Yes ☐ No
Has a search been conducted specific to the inequalities, issues, and barriers experienced by these groups relevant to this topic? Include incidence/ prevalence, risk, diagnosis and treatment, screening and so on. *(See #6*)*	☐ Yes ☐ No

What do you know from this evidence?

If evidence is not available, can findings be extrapolated across subpopulations?	☐ Yes ☐ No ☐ Unknown

What do you know from this evidence?

Has other evidence relevant to disparity or disadvantaged groups been considered (for example, consultations, focus groups, pilot projects, review of complaints, user feedback and so on)?	☐ Yes ☐ No

What do you know from this evidence?

Have health experts within disadvantaged or cultural/sex/gender groups been involved?	☐ Yes ☐ No

Identify additional information/evidence that would fill knowledge gaps.

Specify populations that must be explicitly considered in these guidelines and why they must be considered. Highlight issues, barriers, and inequalities that must be considered for each group, including *(See #8*)*:
- Potential impact
- Incidence/prevalence
- Risk factors and screening
- Diagnosis/treatment
- Barriers, including but not limited to access
- Aspects of culture that differ significantly from the dominant cultural group

Summary of potential positive and negative impact on target groups. *(See #10*)*

*The numbers in brackets refer to the list of items found under the Opportunity Areas on page 4 of the Cultural Competence Assessment Tool.

2 b) **Within guidelines document**			
Have culture, sex, gender, language, and/or disparity been addressed in sections on incidence/prevalence, risk and screening, diagnosis/treatment, etc.? *(See #11*)*	☐ Yes	☐ No	☐ Partial
Comments:			
Are appropriate considerations of culture, sex, gender, language, literacy/health literacy, and/or disparity woven throughout the guidelines document*? (See #12*)*	☐ Yes	☐ No	☐ Partial
Comments:			
Are sections included on groups who merit special consideration (due to disadvantage, disparity, cultural/sex/ gender, or linguistic differences)? *(See #13*)*	☐ Yes	☐ No	☐ Partial
Has the need to consider the individual and not stereotype been explicitly stated?	☐ Yes	☐ No	☐ Partial
Comments:			

Are healthcare providers and organizations encouraged to follow the *Cultural Competence Guidelines for the Delivery of Primary Healthcare in Nova Scotia*? *(See #14*)*	☐ Yes	☐ No
Comments:		

2 c) **During guidelines launch**
How will culture, sex, gender, language, and/or disparity be profiled during the launch of the guidelines? *(See #15*)*

*The numbers in brackets refer to the list of items found under the opportunity areas on page 4 of the Cultural Competence Assessment Tool.

Opportunity 3: Outcomes

Are cultural, sex, gender, and linguistic identifiers included in data collection (i.e. epidemiological, health utilization, quality improvement, and/or responsiveness)? *(See #16*)*	☐ Yes ☐ No
Findings (please explain).	
Is effectiveness data gathered and assessed for culture, sex, gender, language, disparity, and/or disadvantage? *(See #17*)*	☐ Yes ☐ No
Findings (please explain). For example, has the susceptibility of a particular group to certain diseases been identified? Have sex, gender, linguistic, or cultural considerations that affect health or make it difficult to follow treatment plans been identified?	
Are outcome data gathered and assessed for culture, sex, gender, language, disparity, and/or disadvantage?	☐ Yes ☐ No
Findings (please explain). For example, is there a statistically greater number of poorer outcomes in one group as compared with another? Is there a statistically greater number of patients in any one group that did not complete treatment? Is there a statistically greater number of repeat presentations of the same complaint among groups?)	
Are consumer surveys and data collection tools easy to read and understand and in appropriate language(s) and format(s) including large print?	☐ Yes ☐ No
Findings (please explain).	
Is the impact of these guidelines on sex, gender, linguistic, cultural, or disadvantaged groups evaluated on an ongoing basis? *(See #18*)*	☐ Yes ☐ No
Findings (please explain).	

The numbers in brackets refer to the list of items found under the opportunity areas on page 4 of the Cultural Competence Assessment Tool.

APPENDIX 1:   ACKNOWLEDGEMENTS

A search for literature and resources was conducted to inform tool development. Key informants and select resources and organizations consulted are listed below.

Erin Ueffing, Centre for Global Health, Institute of Population Health, University of Ottawa. Influence on tool development: Questions 6 and 7, the focus on disadvantage throughout and the implications of health equity for practice and research. See Ueffing E, Tugwell P, Welsh V for the Cochrane Health Equity Field (2008). *C1, C2 Equity Checklist for Systematic Review Authors*. Version 2008-11-06. Accessed at www.equity.cochrane.org/files/equitychecklist.pdf on March 10, 2009.

Jenniffer Kibagendi, Equity Officer, National Health Systems (NHS) Quality Improvement Scotland. Influence on tool development: reporting format is based on the NHS Equity and Inclusion Assessment Tool (EQIA).

Jessica Berentson-Shaw, Manager, Research Services, New Zealand Guidelines Group (NZGG). Influence on tool development: Opportunity 1: Process, questions 9, 10, 13, 14, 15. Shared the *Health Inequalities Assessment tool (HEAT)*. Provided specific information on how Maori health issues and other health inequalities are explicitly considered throughout guideline development in New Zealand. This includes involving Maori in guidelines development process and identifying and addressing Maori health issues relevant to each guideline at all stages of the process. As well, ensuring guidelines specifically consider all inequalities in health, some common across all health issues and others specific to each clinical topic.

Patient and Public Involvement Team, c/o Kathleen Heppell, Communications Coordinator, National Institute for Health and Clinical Excellence (NICE). Provided detailed information on how and why equity impact assessment is carried out by NICE.

Drafts of this tool were reviewed by members of the project working group - Peggy Dunbar (Program Manager, Diabetes Care Program of Nova Scotia); Kathy Harrigan (Cardiac Consultant, Cardiovascular Health Nova Scotia); Lynn Headley (Manager of Development, Primary Healthcare, Nova Scotia Department of Health and Wellness*).

Other members of the committee provided review and thoughtful comment - Sandy Goodwin (Senior Policy Analyst, Quality and Patient Safety, Nova Scotia Department of Health and Wellness); Jill Petrella (Quality Coordinator, Cancer Care Nova Scotia); Lindsay Moore (Chronic Disease Management Coordinator, Primary Health Care, Department of Health and Wellness); Susan MacNeil (Program Manager, Nova Scotia Renal Program); Peggy MacCormack (Senior Coordinator, Adult Mental Health Mental Health, Children's Services and Addiction Treatment Branch Department of Health and Wellness); Annette Ryan (Perinatal Nurse Consultant Reproductive Care Program of Nova Scotia); Theresa Foley (Program Manager Nova Scotia Breast Screening Program); Ken Buchholz MD, (Senior Physician Advisor & Director, Quality and Patient Safety Nova Scotia Department of Health and Wellness).

In addition, this document was reviewed by Sharon Davis-Murdoch (Health Policy Advisor, Diversity and Social Inclusion, Nova Scotia Department of Health and Wellness) and Lynn Langille (Coordinator, Health Disparities, Nova Scotia Department of Health and Wellness).

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*As of January 12, 2011, the Nova Scotia Department of Health and the Department of Health Promotion and Protection merged to form the Nova Scotia Department of Health and Wellness.

Organizations/resources consulted also included:

- *Health Equity Audit,* National Health Service (NHS), Dept of Health, London, UK.
- *The Health Equity Assessment Tool: A Users Guide* (2008). University of Otago, New Zealand. Online, available at: www.moh.govt.nz/moh.nsf/0/13F2B20B719809C2CC257491000F7C15
- *The Handbook for the Preparation of Explicit Evidence-Based Clinical Practice Guidelines* (2001). New Zealand Guidelines Group. Available at: www.nzgg.org.nz/download/files/nzgg_guideline_handbook.pdf
- *The Equity Triangle Lens* (2008) Vic Health, Victoria Australia in *People, Places, Processes Reducing Health Inequalities Through Balanced Health Promotion Approaches*. Available at: www.vichealth.vic.gov.au/ ~/media/ResourceCentre/PublicationsandResources/Health%20Inequalities/PeoplePlacesProcesses.ashx
- *Cultural and Linguistic Policy Assessment* (2002), National Centre for Cultural Competence, Georgetown University Centre for Child and Human Development and *A Guide for Using the Cultural and Linguistic Policy Assessment Instrument.*
- *Cultural Competency: A Self-Assessment Guide for Human Service Organizations*. Cultural Diversity Institute, Calgary, Alberta.
- *Sex and Gender Appraisal Tool for Systematic Reviews* (SGAT-SR), Madeline Boscoe, Marion Doull, Vivien Runnels, Sari Tudiver, Canadian Women's Health Network (2009)
- *Inclusion Lens*: *Workbook for Looking at Social and Economic Exclusion and Inclusion (*2002). Malcolm Shookner for Public Health Agency of Canada- Atlantic region. Available at: www.phacaspc.gc.ca/canada/regions/atlantic/Publications/Inclusion_lens
- *CLAS A-Z: A Practical Guide for Implementing the National Standards for Culturally and Linguistically Appropriate Services (CLAS) in Health Care*. US Department of Health and Human Services, Office of Minority Health. Available at: www.omhrc.gov/assets/pdf/checked/CLAS_a2z.pdf
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- *Developing a self-assessment tool for culturally and linguistically appropriate services in local public health agencies* (2003). United States Department of Health and Human Services, Office of Minority Health Resource Center. Available at: www.cosmoscorp.co...LAS-II_LocalPublic.pdf
- *Diversity Lens*, (nd). Canadian Mental Health Association. Available at: www.cmha.bc.ca/files/diversity.pdf
- *Cultural Diversity Policy Checklist* (2008). Center for Cultural Diversity in Aging, Australia. Available at: www.culturaldiversity.com.au
- *Toolkit to Reduce Racial and Ethnic Disparities in Health Care* (nd). Robert Wood Johnson Foundation. Available at: www.rwjf.org/files/research/nhpctoolkit.pdf
- Kaiser Family Foundation (www.kff.org)
- Diversity Rx (www.diversityrx.org)
- National Multicultural Institute (www.nmci.org)
- The Center for Cross-Cultural Health, Minneapolis (www.crosshealth.com)
- Cross Cultural Healthcare Program, Seattle Washington (www.xculture.org)
- Centre for Culture, Ethnicity and Health, Australia (www.ceh.org.au)
- New Zealand Office for Ethnic Affairs, (www.ethnicaffairs.govt.nz)
- Diversity Health Institute, Australia (www.dhi.gov.au)
- University of Michigan, Program for Multicultural Health (www.med.umich.edu/multicultural/ccp*)*
- US Institute of Medicine: Minority Health (www.iom.edu/CMS/18007.aspx)
- National Guideline Clearinghouse (US) (www.guideline.gov)
- US Department of Health and Human Services: Agency for Healthcare Research and Quality (www.ahrq.gov/populations)
- Calgary Health Region/Alberta Health Services, www.calgaryhealthregion.ca
- Hamilton Health Sciences (www.hhsc.ca)
- US Dept of Health and Human Services, Agency for Healthcare Research and Quality (AHRQ) EXCEED (www.ahrq.gov/research/exceed.htm)

APPENDIX 2: CULTURAL COMPETENCE GUIDELINES FOR THE DELIVERY OF PRIMARY HEALTHCARE IN NOVA SCOTIA

Nova Scotia's *Diversity and Social Inclusion (DSI) Initiative* was a three-year project (2003 – 2006) with two main goals:
- To lead in raising awareness of diversity and social inclusion issues in Primary Healthcare.
- To consult with stakeholders including diverse populations to develop guidelines and policies.

The DSI Initiative resulted in recommendations for culturally inclusive policies and *Cultural Competence Guidelines for the Delivery of Primary Healthcare in Nova Scotia*. These are the first provincial guidelines for cultural competence in primary healthcare in Canada.

The guidelines suggest the following strategies to enable the journey towards more culturally competent providers and health systems.

Guidelines

Cultural competence refers to the attitudes, knowledge, skills, behaviours, and policies required to better meet the needs of all the people we serve.

Culture in these guidelines refers to a group or community that share common experiences that shape the way its members understand the world. It is multi-layered, evolving and includes groups that we are born into or become such as but not limited to: national origin, levels of ability, gender, sexual orientation and identity, race/ethnicity, language, socio-economic class, or religion. People have multiple cultures.

Cultural competence can work to reduce disparities in health services, address inequitable access to primary healthcare and respectfully respond to the diversity of Nova Scotians (race, ethnicity, language, sex, sexual orientation, gender identity, (dis)ability, spirituality, age, geography, literacy, education, income, etc.)

1. Nova Scotia DHAs, CHBs, the IWK, and primary healthcare organizations should ensure that their staff provide to Nova Scotia patients/consumers, primary healthcare that is respectfully delivered and responsive to cultural health beliefs, practices, lived experiences and linguistic differences in Nova Scotia.

2. The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and primary healthcare organizations should work collaboratively with culturally diverse populations, including but not limited to: First Nations, African Canadians, Acadians, Francophones and immigrant communities, to design targeted, accessible and effective health initiatives in all aspects of primary healthcare.

3. The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and academic institutions should collaborate to devise and implement strategies for the recruitment, retention, and promotion of diverse health staff, providers and leaders at all levels.

4. The Nova Scotia Department of Health and Wellness, DHAs, CHBs the IWK, primary healthcare organizations and health related, academic institutions should make cultural competence training available on an ongoing basis to all primary healthcare students, staff and providers at all levels and across all disciplines, and facilitate the development of cultural competence across the primary healthcare system.

5. The Nova Scotia Department of Health and Wellness, DHAs, the IWK, and primary healthcare organizations should offer and provide services in Canada's official languages with the phased in recruitment of French speaking, bilingual staff and the use of cultural health interpreters.

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6.   Nova Scotia DHAs, the IWK, and primary healthcare organizations should offer and provide cultural health interpretation services in languages provided by Nova Scotia's Community Health Information and Interpreting Service for any primary healthcare patient/consumer with English or French as a second language, at no cost to the patient/consumer.

7.   Nova Scotia DHAs, the IWK, and primary healthcare organizations should provide written notice of the availability of cultural health interpretation services in all of the languages provided by Nova Scotia's Community Health Information and Interpreting Service and when possible, cultural health interpretation in the Mi'kmaq language.

8.   Nova Scotia DHAs, the IWK, and primary healthcare organizations should ensure that patient/consumer family and friends not be used to provide interpretation services except at the direct request of the patient/consumer.

9.   Nova Scotia DHAs, the IWK, and primary healthcare organizations should reflect Nova Scotia's diverse populations in pictures, written information, and advertisements and post signage and provide written material for all literacy levels in the languages commonly spoken in their service areas.

10.   The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and primary healthcare organizations should ensure that their vision, mission, strategic plans, job performance expectations, and accreditation processes incorporate accountability for cultural competence and culturally appropriate services at the highest level of the organization.

11.   The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and primary healthcare organizations should work collaboratively and independently to develop public information and communication plans to explain the importance of race, ethnic, and linguistic identifiers in epidemiological and health utilization data for the purposes of effective planning, program delivery, and the development of a culturally competent, primary healthcare system.

12.   DHAs, CHBs, the IWK, and primary healthcare organizations should maintain up-to-date demographic, cultural, and epidemiological profiles of their communities in order to effectively plan and provide services that respond to the racial, ethnic, cultural, spiritual, and linguistic needs of the populations they serve.

13.   The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and primary healthcare organizations should ensure that data collected and updated through the MSI database, and other data collected by organizations, incorporates, with patient/consumer agreement, information that specifies race, ethnicity, and language of patients/consumers without individual patient identification.

14.   The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, and primary healthcare organizations should ensure that data collected and research resulting from the data, facilitate best practice in culturally competent care, movement toward the elimination of health disparities among populations, and the improvement of health status of those populations most at risk for poor health.

15.   The Nova Scotia Department of Health and Wellness, DHAs, CHBs, the IWK, provincial programs, and primary healthcare organizations should inform, increase, and facilitate culturally appropriate screening among Nova Scotia's culturally diverse populations for chronic diseases including but not limited to diabetes, cancers, cardiovascular disease, hypertension, and sickle cell anemia.

July 2008

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APPENDIX 3: CULTURE AND HEALTH

Here are some examples of aspects of culture, broadly defined, that could influence health.[12] This is not an exhaustive list and elements can be inter-related. It is provided only as a starting point.

Biomedical Considerations
Examples: disease risk and incidence, skin colour, heredity, genetics, drug metabolism

Historical Context, Systems, Status
Examples: class/societal status, income, education, stigmatized conditions, precarious life circumstances, discrimination, racism, sexism, heterosexism, ageism, able-ism, loss of culture, trauma (such as historical trauma[13] or residential school trauma), marginalization and exclusion

Access
Examples: lack of childcare or transportation, social, geographic or other isolation, disability, inadequate income, low social status, poor health status, precarious circumstances, lack of drug coverage, lack of autonomy, lack of local health services, health literacy or language barriers, distrust/disempowerment due to historical events or lived reality

Communication and Relationships
Examples: language and dialect, non-verbal communication such as eye contact and touch, modesty, literacy/health literacy barriers, cultural beliefs and values leading to miscommunication, discrimination and bias[14]

Nutrition
Examples: common foods, rituals, deficiencies

Rituals and Beliefs
Examples: death, bereavement, pregnancy, birthing and postpartum care, dress

Spirituality
Examples: religious practices, prayer, meaning of life, spirituality and health

Healthcare Practices
Examples: traditional practices and beliefs, self-medication, responsibility for health

Healthcare Practitioners
Examples: gender and care, perception of practitioners, 'folk' practitioners, traditional and/or 'alternative' healers

Family Roles and Organization
Examples: head of household, gender roles, roles of aged, extended family, social status, same sex relationships, gender roles in care, extended family care-giving

Behaviours Resulting from Marginalization, Stigma, and Exclusion
Examples: use of tobacco, alcohol, recreational and prescription drugs, physical activity, safety, self-harm

APPENDIX 4:   INTEGRATING DIVERSE VOICES IN GUIDELINES DEVELOPMENT

Stakeholders, members of the public and/or consumers who can speak to issues of gender, culture and or health disparity within priority populations must be involved in the development of clinical guidelines.

Participation and partnership at specific points throughout the guideline development process is essential. Key areas and opportunities include:
* ability to suggest new guideline topics;
* identifying research/clinical questions to address health barriers;
* reviewing summary evidence related to specific groups;
* reviewing draft guidelines, especially sections that refer to specific groups;
* collaborating on guideline implementation;
* providing input on barriers to guideline implementation;
* reviewing and evaluating effectiveness and outcomes.

The involvement of a few individuals does not, however, guarantee that guidelines will be inclusive and will adequately address issues of culture, sex, gender, language, disparity, and health equity. No single individual can represent any one group. Broad consultation must take place throughout the development process. As well, guideline development team members must explicitly consider culture, sex, gender, language, and disparity throughout the process.

The nature of the guideline development process has the potential to intimidate and exclude some consumers. For example:
* the use of complicated clinical language;
* cultural differences in perspectives on health and healing;
* power and privilege imbalances between laypersons and health professionals/researchers;
* the use of majority-rules decision-making processes; and so on.

These must be addressed in order to enable inclusion and participation. Consumer representation on guideline development teams must be supported by appropriate valuing of individuals' time in the form of reimbursement for time, transportation, and childcare. In addition, team members must discuss and come to agreement on issues such as expectations, workload, and group norms. An appropriate amount of time must be provided for guidelines to be reviewed (at least 4 – 6 weeks in advance).

Begin by reviewing and integrating findings from existing literature. Focus and reduce the work of consultation by asking some individuals to only review the sections that relate specifically to their background.

In all cases, information about cultural groups included in clinical guidelines cannot be stated as true for all individuals within a group. Intersections of gender, age, class, ability as well as individuality and experience influence expression of culture. Avoid stereotyping. Explicitly note that cultural generalizations are provided only as starting points to care. Individuals and care provider(s) must clarify if generalizations are appropriate. Individual differences must be considered.

ENDNOTES

[1] Nova Scotia Department of Health (2006). *Cultural Competence Guidelines for the Delivery of Primary Healthcare in Nova Scotia.*

[2] *The American Heritage New Dictionary of Cultural Literacy, Third Edition* (2005), Houghton Mifflin Company

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[14] Bias: Associations between individuals and groups. These can be *explicit* (we are conscious of them) or *implicit* (we may not be consciously aware of them, but they can still influence judgment and behavior). *Implicit bias* is also known as *unconscious bias*. See Green A, Carney D, Pallin D, Ngo L, Raymond K, Iezzoni L, Banaji M. Implicit bias among physicians and its prediction of thrombolysis decisions for black and white patients. *J Gen Intern Med.* 2007 Sep; 22(9):1231-8.