Transcultural competence in the Swiss health care system

Dagmar Domenig

Colophon

This article is part of the reader: ‘Overcoming Barriers – migration, marginalisation and access to health and social services’, Amsterdam, 2007.

Editors:
Dagmar Domenig
Jane Fountain
Eberhard Schatz
Georg Bröring

Publisher
Foundation RegenboogAMOC
Correlation Network
Postbus 10887
1001 EW Amsterdam
Netherlands
Tel. +31 20 5317600
Fax. +31 20 4203528
http://www.correlation-net.org
e-mail:info@correlation-net.org

Layout: s-webdesign, Netherlands

Correlation is co-sponsored by the European Commission, DG Sanco
and the Dutch Ministry of Health, Welfare and Sport (VWS)

1 Introduction

Migrants with an addiction problem, as well as their families, are underrepresented as clients of existing services in the standard drug addiction programmes in Switzerland. For example, the proportion of migrants receiving counselling and psychotherapy is well below 10%, which does not correspond to the supposed proportion of approximately 20-30% of drug dependents with a migration background (see Domenig, 2001 b: 79). In particular, undocumented migrants hardly ever turn to existing counselling centres or to any drug service, out of fear of either being discovered to be undocumented or of being unable to pay. Even when migrants do visit a counselling centre, the specialists there often do not succeed in adequately addressing their migration-specific needs. As a result, migrants turn away in disappointment and discontinue using the facilities on offer. There are fewer problems of access with walk-in services, injecting rooms and the like, which probably meet the needs of migrants more adequately because of their informal approach (Domenig, 2001b: 79).

The necessity for migrant-specific services, especially in the field of counselling and therapy, or, in other words, to give drug services a transcultural character, is increasingly accepted, even if it is not clear yet clear to most institutions how they should implement this (see also Dahinden et al., 2004: 35). For what exactly does transcultural competence imply? What does migration-specific drug work look like in real life? What must an institution do to be transculturally competent? This chapter attempts to answer these questions.

2 The meaning of transcultural competence

Transcultural competence means the ability to notice and understand ***individual life-worlds*** in a specific situation and in various contexts, and to infer appropriate ways of action from this (Domenig, 2001b: 200, Domenig, 2001a). Every individual constructs their own, individual “Lebenswelt” or life-world (Schütz, 2003) based on personal attitudes and values, biographical experiences, external living conditions and socio-cultural backgrounds. Consequently, generalised ethno-specific “cultural recipes” offer hardly any help in bridging existing gulfs in real-life encounters with migrants. On the contrary, they tend to widen these, because of intruding prejudices that most often have hardly anything to do with migrants’ real life-worlds. Thus, wearing a headscarf is not proof of being an oppressed woman; showing emotions does not mean a man is weak; being a

Muslim does not always mean not drinking alcohol nor eating pork; and a sick person being helped by the whole family does not mean that the individual is not able to do this alone. Statements which “culturalise” migrants often hide racist attitudes as well, for if so-called differences are regarded negatively, and if a person, because of these supposed differences, is marginalised and put at a disadvantage, this is racism (see Memmi, 1999; Frederickson, 2003). The culturalisation of migrant groups is therefore not always based on transcultural incompetence because of a lack of background knowledge or a lack of social competence: it can also form the basis of racial discrimination.

However, not only have the life-worlds themselves been influenced by individual circumstances, the perception of what is ”foreign” is also influenced by one’s own background. If what is “foreign” is construed as being separate from oneself, i.e. without questioning one’s own socio-cultural background, behaviour that is different from one’s own habits and daily activities often appears quite peculiar. Because of this view based on differences, similarities, and hence what could be common ground, are barely considered. Nevertheless, background knowledge about socio-culturally influenced behaviour and illness concepts can be helpful in transcultural encounters, as a form of orientation and support. However, this knowledge should always be reflected in relation to the actual situation. Specialists should therefore learn to listen to patients` or clients` stories, and with them explore to what degree their life-world influences their response to their illness or addiction. This is far more helpful than memorising lists about supposed cultural norms (Culley, 2001: 125). At the same time, it must be taken into consideration that the ethnic identities of migrants have often been influenced much more by inequalities, discrimination and the inability of institutions to deal with ***diversity***, than by any exotic, socio-cultural practices.

3 Dealing with diversity

Inequalities, as well as the marginalisation of minorities, have increased in recent years, not only between, but also within countries. Next to a more powerful advocacy for health, based on the principles of human rights and solidarity, other measures should assist here (WHO, 2005). The European Parliament and the Council of the European Union for example, have designated 2007 as "European Year of Equal Opportunities for All" with the following objectives:

- Rights – Raising awareness on the right to equality and non-discrimination.
- Representation – Stimulating debate on ways to increase the participation in society.
- Recognition – Celebrating and accommodating diversity.
- Respect and tolerance – promoting a more cohesive society.

(EU, 2005).

"Diversity-competence means that organisations have the capacity to make themselves diverse in terms of who they are (workforce), what they do (services) and whom they serve (clients)" (DeCoito/Williams, 2004: 2/8). A diversity-competent organisation is therefore able to respond to the needs of many different groups in a way that is appropriate for these groups in socio-cultural terms. However, diversity must not be reduced to differences either. It should also focus on people's individuality and consider differences not primarily as divisive, but also as opportunities to unite. In this sense, diversity competence cannot simply be limited to merely tolerating diversity, but must reflect on existing ways of thought and behaviour and change these where necessary (Stuber, 2004: 16, 19).

In recent years, the concept of diversity has made its way into the debate on migration and integration in Switzerland. Well into the 1990s, the segregation approach was pursued not only in Switzerland but also in other European countries such as Germany and the Netherlands, and often marginalised migrants in institutions that had been specially created for this purpose. This, however, has now been replaced by an integrative approach, in which migrants, like all other citizens of a state, should be taken care of by the mainstream care systems and treated according to their specific needs. However, the situation of undocumented migrants, to whom the state normally guarantees only the right to emergency aid, continues to remain unresolved. In many places, in order to close this gap in the health system, various niche schemes are being created to address the specific

need for the protection and anonymity of migrants. At the moment, the integration of these particularly vulnerable groups into the regular health care system is one of the greatest challenges to this system, especially when addiction problems are involved.

The main objective of any transcultural change must be the realisation of equal opportunities for ***all***. On the one hand, this means creating high quality services for all clients or patients (equal health opportunities), and on the other, the integration and the promotion of specialists with a migration background (equal opportunities at work). Comprehensively addressing transcultural competence is a prerequisite of this (Domenig, 2007).

4 Measures to develop a transcultural organisation

The main principles of diversity and equal health opportunities, as well as non-discrimination, must be implemented in an all-embracing development of an organisation, which is not always easy to master. The following measures are recommended for the development of such a transcultural organisation, and should always be adjusted to the actual and situational demands of the health institution in question[1]:

- *Transcultural commitment at management level.* The transcultural development of an organisation must be initiated by top-level management (***top-down*** strategy). However, each organisational development must also include those affected by these changes and their ***know-how,*** if possible right from the start (***bottom-up*** process).
- *Migration-specific ACTUAL and NOMINAL analysis.* On the basis of an analysis of the ACTUAL and/or the desired situation, the next step those at management level have to take is to lay down NOMINAL guidelines (objectives, measures, means) to realise the transcultural development of their organisation. These NOMINAL guidelines must be visible in the annual objectives of both the individual institutions and sectors, as well as in those in charge of dealing with migration.

1 The measures to be taken to develop a transcultural organisation are based on a catalogue of measures developed for the addiction sector, as part of the Migration and Drugs study carried out by the Institute for Social Anthropology at the University of Berne in 1999-2000, commissioned by the Federal Office of Public Health (Domenig et al., 2000 and Domenig, 2001b: 213, see also Domenig, 2007].

- *Migration specialists.* Transcultural competence is a task for and at all levels. Therefore, in addition to the firm establishment of this issue at management level, it requires a specialist responsible for transcultural ***mainstreaming***, who is involved in all projects and processes with the objective of integrating the transcultural angle.
- *Resources for the transcultural development of an organisation.* The organisation and initiation of a migration-specific way of working, or the enhancement of transcultural competence, require sufficient financial and staffing resources, which must be planned in the budget. These resources are required not only for a person responsible for migration issues, but also for training health professionals, the implementation of a interpreting service, the translation of existing brochures into different languages, and so on.
- *Promoting specialists who have personally experienced migration.* Employing migrants in institutions greatly contributes to the enhancement of transcultural competence. This should be reason enough to appoint migrants in leading positions not despite, but because of their background. In addition to the promotion of migrants, measures should be taken to counter (racial) discrimination, so migrants can work in an environment in which they are recognised and respected instead of being discriminated against.
- *Creating an interpreting service.* In order to cater for all migrants, a professional interpreting service must be created, which will mean that three people are present during a consultation or conversation (the client, the interpreter and the specialist). Specialists working with interpreters should also be offered internal training, including courses dealing with situations that may arise during the interpreting process.
- *A migration-specific adaptation of organisational processes*. It is recommended that the organisational processes within institutions in relation to the aspect of migration are examined and that, based on the results, appropriate changes are made.
- *A migration-specific adaptation of documents.* Strategies, guiding principles, standards, concepts concerning treatment etc., must be adapted in a migration-specific way, in order to manifest the transcultural shift both externally and internally.

- *Further training in transcultural competence.* In order to create sufficient base support for the transcultural development of an organisation, further internal training of all staff is required, not only in order to sensitise them to migration-specific themes, but also to increase their transcultural competence.
- *Transcultural group processes.* For complex situations, there should be opportunities to discuss cases under the supervision of relevant specialists or those in charge of issues relating to migration. Such opportunities are necessary because in treating and giving therapies to migrants, extremely complex situations continue to evolve. In such cases, purely general measures are insufficient to guarantee a form of care that suits and is adjusted to the situation.
- *Promoting health literacy among migrants.* The competence of migrants must be stimulated, not only to enable them to negotiate the highly differentiated and hence complex health service system, but also to encourage them to take a proactive role in their treatment and therapy. All media should ensure that migrant-specific life-worlds and symbolic contexts of meaning are taken into consideration.
- *Cooperation with migrant communities.* Working together with the migrant population and integrating what they can offer guarantees that they are familiar with regular care programmes and that informational messages are understood. Having meetings and carrying out other activities together make this cooperation visible to all.
- *Cooperation and networking in migration.* When cooperation and networking between external departments, migration projects and experts is increased, resources can be combined, and synergies can be used by all.
- *Cooperating with and promoting science and research.* It is important that migrant-specific research about problems of access to the health care system, existing gaps in this system and the quality of treatment of migrants is not only promoted throughout the health care system, but that recommendations from the research are also implemented.

5 Change management

Experience gained from various transcultural processes that were initiated in the past shows that, in addition to establishing objectives, measures and means, the transcultural

development of an organisation also requires the knowledge of how to initiate and perpetuate processes of change in both institutions and the people working there (Hinz-Rommel, 2000: 155). Adjustments, modifications and innovations are always potentially threatening in terms of a possible loss of power, additional strain, new situations, etc. In processes of change, very specific interests of individuals or groups are affected as well, and therefore conflicts of interest are created that in turn create resistance against what is new. Processes of change in which management are involved are therefore frequently marked by a high degree of emotion. In order for innovation to succeed, the objective of acceptance must at least have the same priority as that of the best possible objective decision (Schwarz et al., 2002: 187).

Within the scope of a transcultural development of an organisation, the goal of achieving acceptance is even more important where it concerns the target group of migrants, who do not always experience an acceptance of their problems. What is more, migrants with an addiction problem are doubly stigmatised. There are many different ways to increase the acceptance of a transcultural shift in an institution, such as project groups, hearings, conferences, etc. The pursuit of a participation strategy is central here, which, from the very beginning, not only involves all those concerned (including the migrants) but also their interests and know-how (Schwarz et al., 2002: 188).

6 Quality management

The transcultural quality of an institution is higher when it is effectively targeted and efficiently (economically) meets and satisfactorily fulfils the needs and expectations of both patients / clients with a migration background and those of the specialists involved. A second prerequisite is that, at the same time, the necessity for transcultural competence is also accepted and supported by all the other groups or stakeholders involved, as well as by the public. The quality check consists of reviewing the existing migration-specific standards or objectives, the services actually rendered (***output***) as well as the effect actually achieved among the migrants involved (***outcome***).

A breakthrough in transcultural competence in the health sector can only be achieved if it is closely linked to the quality management of an institution. Only then is there a guarantee that all processes are not only transculturally orientated, but that this orientation is also constantly checked and its effect measured. This does not entail a form of quality

management that is specially aimed at migrants, but specific measures should be taken within the existing quality control systems in order that this target group of migrants is automatically included. The central idea should be to improve the quality of treatment of *all* patients, not just of specific groups (see also Bischoff, 2003: 121).

The precondition for quality management is that, using specific indicators, transcultural competence can also be measured. The Lewin Group (2002) has developed such indicators for the U.S. Department of Health and Human Services. This comprehensive system of indicators forms a suitable basis for an institution to introduce a quality control system that integrates transcultural competence adapted to local circumstances.

7 Outlook

The social integration of migrants with an addiction problem and/or the avoidance of the social disintegration of especially vulnerable groups – in particular undocumented migrants and/or migrants with an addiction problem – cannot be achieved by the health sector on its own. In this respect, institutions dealing with addiction are also influenced by socio-political realities that set limits to migration-specific work. Still, hope remains that, despite some difficult conditions, as many people as possible see an institutional and structural anchoring of transcultural competence in the health sector not only as a major challenge to guarantee equitable access, experience and outcome for all, but also as an opportunity to promote more humane treatment of all people, regardless of their status of residence.

References

Bischoff, A. (2003). ***Caring for migrant and minority patients in European hospitals. A review of effective interventions.*** Neuchâtel and Basel: Swiss Forum for migration and population studies.

Culley, L. (2001). Nursing, Culture and competence. In L. Culley, S. Dyson (eds.). ***Ethnicity and Nursing Practice***. Houndmills et al.: Palgrave, Sociology and Nursing Practice Series, pp. 109-127.

Dahinden, J., Delli, Ch., Grisenti, W. (2004). ***Nationale Machbarkeitsstudie Projektmodell „Migration und Sucht".*** Schlussbericht. Neuchâtel und Basel: Swiss Forum for Migration and Population Studies / Schweizerisches Forum für Migrations- und Bevölkerungsstudien.

DeCoito, P., Williams, L. (2004). ***Developing the Diversity-competent Organization. A Resource Manual for Non-Profit Human Service Agencies in Peel and Halton Regions, a joint project of the Social Planning Council of Peel and Community Development Halton, Ontario.*** (www.cdhalton.ca/publications/diversity_competence.htm)

Domenig, D. (ed.) (2007, forthcoming). ***Transkulturelle Kompetenz. Handbuch für Pflege-, Gesundheits- und Sozialberufe***. 2., vollständig überarbeitete und erweiterte Auflage, Bern et al.: Verlag Hans Huber.

Domenig, D. (2004). Transcultural Change: A challenge for the public health system. ***Applied Nursing Research,*** 17/3, pp. 213-216.

Domenig, D. (2001a). Einführung in die transkulturelle Pflege. In D. Domenig, D. (ed.). ***Professionelle transkulturelle Pflege. Handbuch für Lehre und Praxis in Pflege und Geburtshilfe***. Bern: Verlag Hans Huber, pp. 139-158.

Domenig, D. (2001b). ***Migration, Drogen, transkulturelle Kompeten***z. Bern: Verlag Hans Huber.

Domenig, D., Salis Gross, C., Wicker, H.-R. (2000). ***Studie Migration und Drogen. Implikationen für eine migrationsspezifische Drogenarbeit am Beispiel Drogenabhängiger italienischer Herkunft. Schlussbericht.*** Bern: Institut für Ethnologie und Bundesamt für Gesundheit, EDMZ.

EU, European Parliament and the Council (2005). Decision of the European Parliament and the Council on the European Year of Equal Opportunities for All (2007) – Towards a Just Society. Brussels: ***European Union, SEC (2005) 690***.

Fredrickson, G. M. (2003). ***Racism. A short history***. Princeton, New Jersey: Princeton

University Press.

Hinz-Rommel, W. (2000). Interkulturelle Öffnung als Innovation. In: Blätter der Wohlfahrtspflege, ***Deutsche Zeitschrift für Sozialarbeit***, 7-8, p. 154.

Lewin Group, Inc. (Linkins, K. W., McIntosh, S., Bell, J., Chong, U.) (2002). ***Indicators of Cultural Competence in Health Care Delivery Organizations: An Organizational Cultural Competence Assessment Profile***. U.S. Department of Health and Human Services, The Health Resources and Services Administration, April 2002. (www.hrsa.gov/culturalcompetence/indicators / 12 september 2006).

Memmi, A. (1999). ***Racism***, Chicago: University of Minnesota Press.

Schütz, A., Luckmann, Th. (2003 [1979]). ***Strukturen der Lebenswelt.*** Konstanz: UVK Verlagsgesellschaft, Band 1.

Schwarz, P., Purtschert, R. et al. (2002). ***Das Freiburger Management-Modell für Nonprofit-Organisationen***. 4. weitgehend aktualisierte und ergänzte Auflage. Bern et al: Paul Haupt Verlag.

Stuber, M. (2004). ***Diversity. Das Potenzial von Vielfalt nutzen – den Erfolg durch Offenheit steigern.*** München/Unterschleissheim: Luchterhand.

WHO, World Health Organization (2005). ***The Bangkok Charter for Health Promotion in a Globalized World***. Bangkok, 6th Global Conference on Health Promotion.