Health competence from a transcultural perspective. Knowing how to approach transcultural care

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Abstract

Intercultural health, including intercultural competence, is a field of study which is generating a great deal of interest in the scientific community, indeed the focus on cultural competence in the curriculum, is becoming a priority. The importance of establishing political relationships with other countries, and more especially development cooperation agreements – redefined by the current recession – together with the global movement of populations, pose new challenges for health providers. This study aims to understand the social and cultural dynamics at work, essential for the acceptance and adoption of the cultural competence programmes, which are being proposed. The fieldwork was carried out in the Ecuadorian Amazon, among the Achuar people, researching an applied health promotion programme, based on the principles of development cooperation and western biomedicine. The main data collection methods were participative observation and in-depth interviews. The main findings reveal a lack of continuity in healthcare where use of indigenous methods of diagnosis and therapeutic resources coexist alongside the biomedical model, and where development agencies and healthcare professionals need to acquire cultural skills combined with specific local knowledge in order to be able to work with greater efficacy within their clients’ cultural context. There is a clear necessity to reinforce relationships, communications, and dialogue between governments and cooperation agencies, with specific regard to the health of indigenous peoples and perceptions thereof.

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1. Introduction

Intercultural health, including intercultural competence, is a field of study which is generating a great deal of interest in the scientific community. Cultural competence is now becoming a priority for inclusion in the curriculum and training syllabuses of health professionals. Current research and the concepts developed, in this field, can be used to provide input for the content to be included in such training programmes.

Concerns about studying intercultural health have been growing for a long time. In Europe the migration of various population groups and communities means the problem has become more visible and widespread, nevertheless, it is important that intercultural health concerns are not solely limited to these contexts and to minority and indigenous groups (Knipper, 2010). Given its current relevance, it is surprising, that it has not been paid more attention nor generated greater and more forceful debate (unlike in Latin America), as there is a clear need for intercultural dialogue across all areas of social, cultural and political life, starting at an institutional level, but as Fernández (2006, p. 317) says it is only ‘fashionable’ among certain programmes, movements and collectives.

This is a delicate area of debate and the common perceptions in the findings of studies addressing this issue – especially those conducted among indigenous populations (Clifford et al, 2015) – all speak of the difficulty and complexities in finding valid responses. Thus, work needs to continue along these lines, in order to be able to put into practice the recommendations of the great number of academic papers in this field.

As mentioned above, applying reductionism to the intercultural health concept, by focussing solely on minorities, foreigners and ‘problematic’ groups, means that the socio-political and economic dynamics which also come into play, get ignored or neglected. The term ‘intercultural’ is complex and it also includes those population groups likely to be subject to cultural competence care, while biomedical health culture fails incorporate intercultural competence into its educational and training programmes. While the terms “transcultural”, “intercultural” or “interculturality”, are not new, it is impossible as Guilherme and Dietz (2015) state “to establish fixed and stable lines between them, as they form a complex web of meanings that to some extent may cross each other”. According to Kleinman and Benson (2006), Kruse (2014), the same thing happens with ‘cultural competence’ which is a new ideological term, coined in response to the economic, political and sociocultural rationale of the inter-cultural discourse, expressed in different ways in different situations.

Cultural competence means taking into account all the cultural factors that come into play when anyone is involved in any interactive process (whether in the field of health or other contexts) where there is a relationship of intersubjectivity and reflexivity in which ethical considerations are involved. Interculturality envisages the co-existence, interaction and exchange between diverse cultures (Soler, 2014, p. 31). However, Gimeno et al (2010, p. 207) consider that interculturality – not only means the acceptance of otherness or the harmonious co-existence between different groups – but that it also has a political component, based on access to power, such as that demonstrated in the relationship of ‘power – knowledge’ meaning shared knowledge applied to health, in this case. In this way, we find proposals that health professional educational programmes should include aspects and content referred to as ‘transcultural competence’, a term coined by Pratt in 1952 and which means capturing the ”cultural translation of one worldview to another assuming there are only two at stake and that their borders are perceptible” (Guilherme & Dietz, 2015, p. 23). The authors brilliantly continue that “reconciling differences is the aim of the development of this set of skills described above as ‘transcultural competence’, not building upon conflicting relations, although terms such as multiculturalism, interculturality, and the transcultural, among others, are currently so widely used that they have become too elastic.”

The different tools which are being developed to assess cultural competence, particularly those related to the sphere of health, demonstrate the interest, concern and relevance that this issue holds for health professionals, researchers and academics today. The design of assessment tools to evaluate cultural competence training and the development of guides on cultural competence for educating medical students, nurses and other healthcare staff, plus the assessment and analysis of this part of the curriculum is very striking in North American. Under the slogan ‘Better communication for Better care’ the American Medical Association (AAA, 2005) offered a series of tools designed to help health organisations and institutions in general – but more particularly Health workers – to respond to the needs of diverse patient populations by enabling both health professionals and organisations to offer improved communication and relationships.
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