

The Status of Cultural Competence at a Health Care Service Setting in South West Ethiopia: The Case of Jimma University Specialized Hospital

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Abstract: Nowadays, cultural competence has become an important component of health care services. Hence, this study intends to examine the status of cultural competence at Jimma University Specialized Hospital. We used purposive sampling technique to select physicians, patients and administrative staff informants. We then conducted non-participant observation, in depth interviews, key informant interviews and focus group discussion to generate data. The findings from this study reveal that the health care service at the specialized hospital is less in touch with cultural competence. A number of barriers impede the provision of culturally competent health care in the hospital. The study suggests that national and organization level policies should be in place to integrate cultural competence into health care services.

Background

Culture is a very important concept in anthropology. It is a society's shared, learned knowledge base and behavior patterns and guides how people live, what they generally believe and value, how they communicate, and what their habits, customs, and tastes are. Culture influences the ways in which we interpret and perceive health and illness and our choices in providing and seeking care are influenced by our culture (Sobo and Loustaunau, 2010; Winklman, 2009:2). For instance, since culture greatly influences our ideas of what we think is normal or not, our interpretations of health and illness together with the processes of seeking care are contingent on our cultural background. One of the major challenges facing health care professionals is when there is a missing link between the ideas, norms and values they acquired at medical schools and that of their patients. Hence, understanding the concept of culture is instrumental to understanding cultural competence. Cultural competence in health care refers to "understanding the importance of social and cultural influences on patients' health beliefs and behaviors; considering how these factors interact at multiple levels of the health care delivery system (e.g. at the level of structural processes of care or clinical decision-making); and devising interventions that take these issues into account to assure quality health care delivery to diverse patient populations" (Betancourt et al, 2003:297). In this regard, a health care service with state of art facilities, best minds to serve patients and yet unable to consider the cultural context of its services is only half way to the provision of culturally competent health care.

Biomedicine, which is also referred to as "scientific", "western" or "allopathic" medicine, approaches health problems primarily as deviation from measures that indicate proper biological functioning. It tends to establish universal classifications of diseases that interfere with or disrupt these measurements (Winklman, 2009:38). In doing so, there is a tendency to reduce health prob-

lems to disease that disturb the biological equilibrium. The official introduction of biomedicine to the people in Ethiopia was only a little more than a century ago. Successive governments have been preoccupied to ensure the accessibility of health care service to the people, which, however, they have not fully achieved yet. Even after a century of biomedicine in the country, the physician to patient ratio, percentage of institutional delivery and postnatal care for instance, are still low (FDRE MoH, 2010:70; World Bank, 2012:xii). Hence, the government is engaged in the expansion of health care facilities as well as the mass training of health care professionals.

However, despite official reports about the efforts made to expand health care facilities and make biomedicine accessible to the people, little is raised about the extent to which the services are culturally competent. The latest national demographic and health survey for instance indicated the level of maternal health care service utilization is low which needs further investigations beyond quantifications (CSA, 2012:119-131). In fact, studies have confirmed that cultural competence in health care is essential because health care professionals and patients do not always hold similar understandings about health and the causes of ill health due to cultural difference and the existence of cultural competence in health care setting affects patients' satisfaction in clinical consultation and patients' compliance to their treatment plan (Engebretson, Mahoney and Carlson, 2008). The overall aim of the article is therefore to explore the status of cultural competence and to investigate barriers to the provision of culturally competent health care services at Jimma University Specialized Hospital.

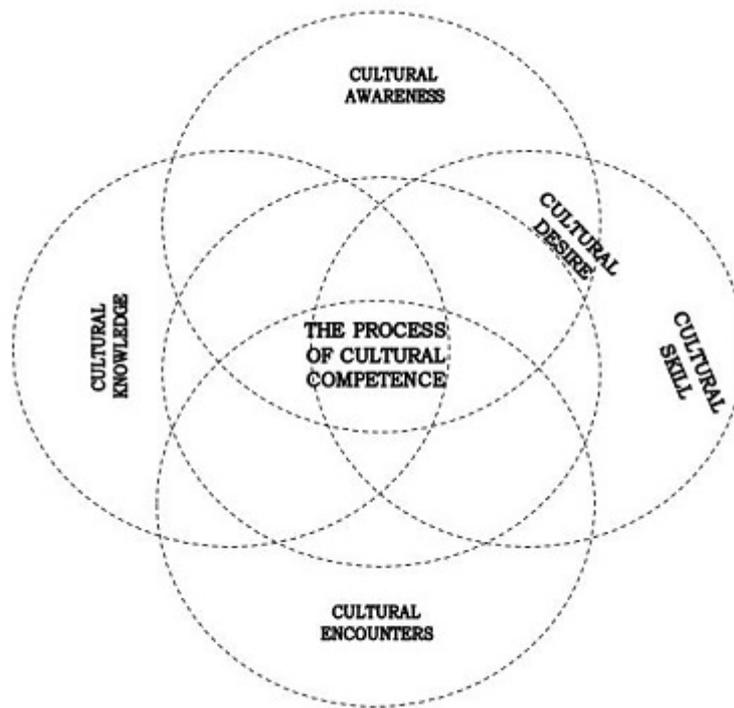
In doing so, the study draws on Campinha-Bacote's (2002) Model of Cultural Competence. Campinha-Bacote's model of cultural competence in health care delivery is a model that health care providers can use as a framework for developing and implementing culturally responsive health care services. The model views cultural competence as the ongoing process in which the health care provider continuously strives to achieve the ability to effectively work within the cultural context of the client. This ongoing process involves the integration of cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire (Campinha-Bacote, 2002:181).

Methods and Settings

Description of the Study Area

Jimma is one of the largest towns in Ethiopia located at the Southwestern part of the country. The town is located 356 km Southwest from Addis Ababa. Jimma town has a total population of 184,925, of which 92,938 are men and 91,987 women. The three largest ethnic groups reported in Jimma town are Oromo (46.71%), Amhara (17.14%) and Dawuro (10.05%); other ethnic groups make up 26.1% of the town's population (Jimma City Administration, 2015).

The study was conducted in Jimma University teaching and specialized referral hospital. The hospital is located in Jimma town. It is currently the only teaching and referral hospital in the Southwestern part of the country. Its recurrent annual budget increased progressively from 4.25 million Birr in 1992 E.C (2000 G.C) to 105 million Birr in 2006 E.C (2014 /2015 G.C). It provides specialized health services for approximately 15,000 inpatients³ and 160,000 outpatients⁴, 4,435 delivery and 11,855 emergency services per year with a bed capacity of 523 and a total of more than 1369 (650 supportive and 719 technical) staff members (Annual report of the Jimma University Specialized Hospital, 2015).



Source: Campinha-Bacote (2002). The Process of Cultural Competence in the Delivery of Healthcare Services: A Model of Care, *Journal of Transcultural Nursing*, 13(3), 181-184.

Study Design

An ethnographic design was used to understand the interaction of patients, health care professionals and administrative staff at Jimma University Specialized Hospital in light of cultural competence. We deployed purposive sampling to identify informants, including healthcare providers, patients, and administrative staff of the hospital. We then administered key informant interviews with 5 key informants (health care professionals) and three different focus group discussions with physicians, nurses and patients. The focus group discussions were held between April 20, 2015 and April 29, 2015. The first focus group discussion was organized with 6 purposively selected medical doctors who provide healthcare services in Jimma University Specialized Hospital. Medical doctors were selected based on their educational level and their work experience. The second focus group discussion was conducted with 9 purposively selected patients (inpatients and outpatients) who were directly served in the hospital during study time. The third focus group discussion conducted with 7 purposively selected nurses (B.Sc. and diploma graduates) who provide health care services in Jimma University Specialized Hospital.

On top of this, we observed the health care services taking place at the study site. We observed different conditions of patients and the services given by the healthcare providers at different wards observing and taking notes about the general activities at natural setting. We made informal conversation with patients and healthcare providers about cultural competence and how the healthcare providers and patients conceptualize culture and cultural competence at healthcare service organizations.

Based on selected sample wards we observed the conversation and communication styles of different health care providers and patients at the Hospital during clinical diagnosis of three wards: maternity, surgical, and medical from February 15, 2015 to February 23, 2015 and ophthalmology and gynecology wards from February 24, 2015 March 15, 2015. At each ward there were three actors: doctors, nurses, and patients. These actors each had their own roles and status in health care services.

Ethical Clearance

We consulted beforehand with the chief executive officer, clinical director and administrative staff of the hospital. They assessed the intent of the research and gave us a written letter of ethical clearance that permits the study in the hospital. The health care professionals and administrative staff had participated in the research cognizant of the research objectives as well as the permission given by the hospital officials. Moreover, patient informants participated in the study voluntarily. They were informed not only about the study and asked for their consent but also about their right to withdraw at any time during the study. We also used pseudo names in order to protect the informants.

Results and Discussion

This study was inspired by the interest to understand the status of cultural competence at Jimma University Specialized Hospital and the barriers to culturally competent health care services. Culturally competent health care service have become a concern for providers because studies have shown its influence on patients' compliance to their treatment plan, satisfaction with the health care services and health care disparities (Betancourt et al, 2003:297; Grice-Dyer, 2010; Campinha-Bacote, 2002:180).

Data obtained from Jimma University Specialized Hospital showed that patients come mainly from two zones of Oromia National Regional state, three zones of Southern Nation, Nationalities and Peoples Regional State and Gambella National Regional State. This implies that patients were diversified in terms of language, worldviews and religion. Patients from different areas were treated in 11 wards in Jimma University Specialized Hospital according to their specific need of medication. These patients reflect their cultural norms, values and beliefs through their language, clothing and communication styles with assigned physicians at each ward. Therefore, the status of cultural competence and barriers to culturally competent health care at Jimma University Specialized Hospital are presented below.

Culture Conceptualized by Health Care Professionals

Culture is an influential concept in anthropological discourse because it touches every aspect of human life. The scope of the concept could be noted from Guest (2014: 35-36):

Culture is a system of knowledge, beliefs, and patterns of behavior, artifacts, and institutions that are created, learned, and shared by a group of people. Culture includes shared norms, values, and symbols, mental maps of reality, and material objects as well as structures of power – including the media, education, religion, and politics – in which our understanding of the world is shaped, reinforced, and challenged.

Ultimately, the culture that we learn shapes our ideas of what is normal and natural, what we can say and do, and even what we can think.

In order to move on to discussions about cultural competence, we inquired about the health care professionals' understanding of the concept of culture. These key informants defined culture in closely related but different ways. Dr. X for instance defined culture as "the way we eat, clothe, and celebrate holiday" (In-depth interview one, April 2015). Dr. Y, another physician key informant said: "culture is the living condition of human being. The way of interaction, the way of solving problems in the community" (In-depth interview two, April 2015).. Dr. Z also added: "culture in health related situations is mostly seen as the interaction of physicians and patients at health care service organizations" (In-depth interview three, April 2015). From the definitions offered by the health care professionals, it appears that they lack a complete understanding of the concept. What they have raised are just a few strings or fragments about culture. Moreover, it was evident that all key informants did not have equal or similar understanding of the concept.

In addition to the above question, we asked the key informants if culture is related to health and health care services. One of them stated "culture is related to health mostly on the interaction of physicians and patients at health care service organizations" (In-depth interview three, April 2015). According to this key informant, culture is composed of day to day interactions of different communities at their local environment. And the communities express the health-related problems at health care organizations based on their cultural view. So, awareness about a community's cultural values, norms, taboos and beliefs is beneficial for effective medical practice.

Culture Conceptualized by Patients

Data obtained through focus group discussions and in-depth interviews with patients revealed that their explanations of culture are largely in line with the worldviews of their community. Mr H who came from Jimma zone, Dedo woreda for medical surgery for instance defines culture as "celebrating holidays, participating during mourning and happiness in the community". (In-depth interview four, April 2015). From our interaction with patient informants, we understood that they come to the health care setting with limited awareness about how the hospital as an institution works. Both during and after clinical diagnosis, there were serious problems of non-congruent behavior between the health care providers and patients that interferes with the provision of culturally competent health care services.

Provision of Culturally Competent Care

By extending our questions from health care professionals' understanding of culture as related to health, the next point of discussion was the concept of cultural competence and how it is practiced in the hospital. The results from focus group discussions, key informant interviews, and our observation revealed that there is a very limited understanding of cultural competency in the hospital. On one extreme, a nurse key informant for example reported: "I do not know what cultural competence means and how it is related to health care services. Instead, I learned about medical ethics. Its focus is on the general ethics to be considered during treatment of patients at health care services. But cultural competence is a new concept to me." (In-depth interview five, April 2015)

On the other end of the spectrum, there were physicians with fuzzy ideas of cultural competence. A physician key informant reported: "cultural competency refers to the relationship between physicians and patients at health care service organizations during clinical diagnosis."

He explained that cultural competence in a health care setting is related to the communication between physicians and patients that should take into account the religious background of patients, the language ability of patients, and their level of understanding about health. Moreover, our discussion with patients shows the health care service at the hospital falls short of being culturally competent. Patients reported a gap in communication and decision making process during treatment. In general, data obtained from key informants and from focus group discussions showed that the level of understanding in provisions of culturally competent health care was limited.

Barriers to the Provision of Culturally Competent Health Care

It is obvious that cultural competence in health care settings is influenced by a range of barriers. Some of these barriers are related to individual health care professionals while others are linked to institutional policies. However, both are not separate entities but work together against the provision of culturally competent health care services. The study also categorizes the barriers identified during fieldwork in this line. These barriers could broadly be categorized as the nature of biomedicine, organizational imperatives, and health care professionals' heavy workload.

The Nature of Biomedicine

Biomedicine is a little more than a century old in Ethiopia. The medical school largely imported its curriculum in order to standardize the education as well as to produce globally competent professionals. But the focus on its expansion both in terms of medical schools and health care facilities over the last twenty years are unprecedented in order to ensure the health care coverage of the population. The medical school in Jimma University and the professionals working in the Specialized Hospital are part and parcel of this national effort. However, it was evident during fieldwork that the quest to globalize biomedicine has been put in place at the expense of local realities.

More than eighty linguistic groups live in Ethiopia, with the South and Southwest of the country being especially diverse. These groups of people have world views that rarely fit to the biomedical understanding of human life experiences including life and death. Since the medical school is primarily concerned with the "scientific" approaches to health problems and the appropriate intervention procedures, the graduates will apply their lessons at medical school to assist their patients. Nonetheless, it was evident that what they acquired at medical school is deficient in terms of equipping the graduates with the knowledge and skill necessary to provide culturally competent health care. The health care professionals had been enculturated to think "scientifically". Their patients on the other hand are coming from areas where about 80-90 % of the population utilize traditional medicine (WHO, 2003:5). Since the use of traditional medicine is not encouraged by the physicians, patients often hide their previous consultation with traditional healer which in turn complicates the treatment process at the hospital. The responses during in depth interviews with doctor key informants showed that this has become a serious challenge. Moreover, the emphasis on the scientific nature of biomedicine with negligence to local realities at times made physicians confused about how to deal with unusual expectations by patients or their relatives. The experience of a nurse informant is a case in point:

Sister A was helping her patient under emergency condition. The patient came from one of the National Regional States. She tried her best to diagnose and help the patient as per the professional ethics. Unfortunately, the patient passed away despite her effort. Following the death of the patient, she wanted to perform the "death care" (preparing the body for funeral). On the process, the relative of the patient came up

with the idea which she called shocking. While she tried to perform the “death care”, a relative of the dead patient told her that the dead person is prepared for funeral after wearing clothes in his culture. Hence, she conducted the “death care” according to request of the relative of the dead patient though with some degree of shock since she did not know the case like this before (In-depth interview six, April, 2015).

The nature of training in biomedicine exposes health care professionals to shocking experiences not only in cases like the above during performing “death care” but also while saving patients from death. For instance, a doctor key informant reported that he faced resistance while trying to help a female patient with serious pregnancy complications. Based on the level of complications, he decided to conduct surgery. He then asked for the consent of the patient and the patient’s relatives. They consented to the operation but declined the transfusion of blood in the process. This was “bizarre” to the mind of the doctor because it is a conventional practice to transfuse blood to patients in need during the operation. But it was found that the patient declined the proposal due to her religious teachings.

Lately, limited effort was made to recognize the importance of culture in health care service about four years back when medical anthropology was included as a course in the nationally harmonized curriculum. However, it seems that the attempt was made with less understanding about the importance of culture in medical school because the course was assigned the least credit hours.

Organizational Imperatives

While the formal establishment of “modern” health care service is a century old, the country began to formulate substantive health care policies since the 1950s (Massow, 2001). These policies focus primarily on the prevention of disease. The treatment is second in priority targeting those which surpass the prevention and non-preventable health problems. In the process, the policies do not clearly stipulate the importance of cultural competence. The construction of health care facilities is dictated by geographic accessibility to the target population. The staffing is usually made on a national level through the lottery method. Health care professionals are then assigned to the health care facilities in line with the lottery they drew at national level. Although the process minimizes the room for nepotism, it endangers one of the ingredients for cultural competence: language. By extension, the health care settings in which these professional provide health services do not have an organizational policy that guide how to make their service culturally competent. What we observed at Jimma University Specialized Hospital is not far from these complications. The hospital does not consider cultural competence among its core areas of concern. It provides health care services to people from wide geographic coverage and linguistic backgrounds without formal organizational policy framework in relation diverse patient population.

For instance, Geiger and Davidhizar (2002:185) believe that communication is the means through which humans interact and share information and that it is very important in the healing process. When nurses or other healthcare providers and their clients are from different cultures, communication may be impeded and this can result in many barriers to the healing process. These communication problems may not only be caused by the lack of common language between the nurse and client, but also by the difference in communication styles and patterns. Thus, in addition to understanding the actual words used to communicate, health care providers must also be aware of the meaning of facial expressions, gestures and intonations used.

In settings that health care professionals encounter communication problems with their patients during clinical diagnosis, the only solution is using an interpreter. But when someone interprets without the knowledge and skill of interpretation, the result may be disastrous. The following case is a good example:

Ms B, a 27 years old patient from Jimma zone, Mana woreda, reported that she communicated with her doctor through interpreter because the doctor was unable to conduct effective conversation about diagnosis at Jimma University Specialized Hospital due to the language barrier. She said that the doctor speaks Amharic and she speaks only Afan Oromo. Then, both agreed to use one of the patients from the compound as an interpreter. The diagnosis was conducted with the help of this interpreter. Unfortunately, the interpreter failed to convey the message of the patient correctly that result of the diagnosis did not represent what the patient told him (In-depth interview seven, April, 2015).

Heavy Work Load on Physicians / Limit to Patience With Patients' Demands

Improving the patient to physician ratio is among the areas of concern for the Ministry of Health. Health care professionals, especially Physicians are working under stress due to large patient population compared to limited number of physicians on job market. The reality at Jimma University Specialized Hospital is the extension of this national condition. It seems this workload has affected the common sense respect for someone older observed in various linguistic groups in the country. Young physicians rarely care about the cultural expectations on how to communicate with older patients as well as patients in general. Perhaps, what soothes their long hours of continuous services is the involvement of medical interns in the provisions of health care services. Yet, their involvement at times harms the expectations of patients given these interns are left with some more trainings to qualify as physicians.

Conclusion

While the importance of cultural competence as an integral component of contemporary health care services has been demonstrated by research findings (for instance, Grice-Dyer, 2010; Campinha-Bacote, 2002; Sobo and Loustaunau, 2010), the situation at Jimma University Specialized Teaching Hospital is different. The health care services in the hospital are less in touch with cultural competence. Despite large patient population coming from diverse backgrounds, the effort of the teaching Specialized Hospital seems to excel in the provision of health care service without consideration to cultural competence. In fact, there is visible chain of barrier to the provision of culturally competent health care services. The national medical school curriculum rarely incorporates courses from social sciences. Prospective graduates rarely understand the link between culture and health. Moreover, the hospital lacks an organizational policy that could accommodate patients from diverse backgrounds. Even when health care professionals try to seemingly make their services culturally competent using common sense, the heavy workload (high patient to doctor ratio) interferes with their effort.

Therefore, it is vital for the hospital to work on the missing aspects from its ever expanding service – the provision of culturally competent health care. This could be implemented through on-job training to health care professionals as well as revising organizational policy. On a national level, the medical schools in the country need to reconsider their syllabus in line with the production of trained professionals that could effectively serve patients from diverse backgrounds.

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Notes

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³This refers to a patient who is admitted to hospital and stays overnight or for an indeterminate time, usually several days.

⁴This refers to a patient who is not hospitalized for 24 hours or more but visits a hospital, clinic, or associated facility for diagnosis or treatment.