in focus
fact sheet

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Leading knowledge exchange on home and community care

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Diversity: Ethnoracial Issues in Home and Community Care

What is diversity?

Diversity has many dimensions. A broad and comprehensive understanding includes religious beliefs, cultural traditions, mental and physical ability, sexual orientation and class, as well as differences in race, language and ethnicity (Elliot, 1999; Fried & Mehrotra, 1998). This In Focus looks at the provision of home and community care for ethnoracially diverse communities.

Why focus on diversity issues in home and community care?

Illness and disease are socially constructed experiences. The meanings and experiences of illness and disease may vary from group to group. As such, providers and users may approach health, wellness and community care in a variety of ways depending on ethnoracial and cultural differences.

Canada's changing population. The importance of diversity has become increasingly relevant to health and social care providers as changes in immigrant source countries to Canada is altering the ethnoracial composition of communities.

- The Canadian population, including our senior population, is becoming more diverse (National Advisory Council on Aging, 2005). Between 1979 and 2000, 3.7 million immigrants arrived in Canada and over 50% of them were from Asia.
- Canada has over 200 different ethnic groups (Statistics Canada, 2003).
- Visible minorities make up 13% of Canada's population and 7% of the senior population (Statistics Canada, 2007). As our population ages, seniors will become more diverse.
- 19.4% of new immigrants were 65 years of age and over at the time they arrived in Canada (National Advisory Council on Aging, 2001).

Access to home and community care. A growing body of Canadian and international evidence suggests that ethnoracial and cultural differences can hinder or facilitate access to health and social care and affect health status (Bowen, 2001). For example:

- In Ontario, immigrant seniors from Asia, Central America, South America and Africa were less likely to use home care services than Canadian-born and immigrant seniors from America, Europe and Australia (Maurier & Northcott, 2000).
- A study examining patterns of Type 2 diabetes management among 267 adults found that English-speakers as compared to Cantonese- and Portuguese-speakers were more likely to be better informed about how to manage their disease because they were more likely to use a variety of information sources (family doctors, endocrinologists, diabetes educators, publications and media, and relatives or friends) (Ryerson University, 2007).
- A 1999 report from the Olson Center for Women's Health at the University of Nebraska Medical Center noted that the mortality rate from breast cancer for women of colour is 31.2 deaths per 200,000 people compared with 26 per 200,000 for white women. This may be because examining one's breast is not considered appropriate behaviour for Muslim women (Farooqui, 2005).

- Because of the culturally accepted custom of arranged marriages in South Asian communities, doctors may mistakenly assume that premarital sex is not practised. For this reason, they may overlook or neglect to order tests for sexually transmitted diseases (STD). Furthermore, women may be reluctant to discuss matters about sexual health with care providers, particularly when they are accompanied by their husbands or mothers (Alliance for South Asian AIDS Prevention, 1999; British Broadcasting Corporation, 2004). As a result, reported incidences of HIV/AIDS and other STDs have increased among women in South Asian communities. To provide better services around sexual health to women from South Asian communities, health practitioners need to be aware of such cultural assumptions (Canadian Broadcasting Corporation, 2009).

- There is increasing recognition that health and community care often involve multiple factors including ongoing communication with client's family and the broader social support network. Thus, effective support and care require clear communication between providers and clients which in turn require understanding the ethnoracial context of care. When providers and clients do not speak the same language, or, if providers are unaware of the client's cultural context, support and care may be compromised (Saldov, 1991; Lum et al., 2003).

- A comparison of home health care recipients from different ethnic and racial groups found a disparity in IADL and ADL outcomes: white clients experienced substantially better functional outcomes than did home health care recipients of other racial and ethnic backgrounds (Brega, et al., 2005).

What is ethnoracially appropriate care?

- Ethnoracially appropriate care is sensitive to the varying cultural, social, emotional, spiritual and linguistic care needs of diverse populations. Ethnoracially appropriate care competence is the ability of providers to deliver effective services to diverse populations.

- There is no widely accepted framework for providing ethnoracially appropriate care. While there is a recognized need for "inclusiveness and equity" for clinical and home and community care, there is no single validated checklist for ethnoracial and cultural competency.

- Organizations are often left to improvise ethno-specific programs to meet emerging needs in their communities often with few resources for a long-term strategic plan.

How do organizations provide ethnoracially appropriate care?

Cultivate effective communication skills. Effective communication skills are essential to engage clients, learn about them, identify issues and provide appropriate care. For example, Bigby (2003) provides a model to help achieve effective, culturally competent communications, denoted by the acronym **LEARN.**

Listen to the client's perspective. For example, among some cultures, "empowerment" and self managed care may not be valued and can be taken to mean "less care" and "leaving me to myself so bad things can happen."

Explain and share your perspective;

Acknowledge differences and similarities between two perspectives. For instance, while client autonomy and agency is often assumed, in some Asian and African cultures, decisions over health may be family-centred (Hawker, 2004).

Recommend a course of care;

Negotiate a mutually agreed upon plan.

Information from individuals and families or other community agencies and organizations may mean that service provision needs to be adapted to respond to the needs and preferences of ethnoracially and culturally diverse clients.

Care providers cannot assume that one size fits all. Nor can they assume to know an individual's

cultural beliefs based on outward appearances, language or geographical area of origin.

Identify and address barriers to access through effective outreach strategies.

- Expand outreach strategies utilizing both formal and informal networks (e.g., faith groups, social clubs) particularly if your client population does not reflect the broader population.
- Conduct a twice a year "knock on doors" in the community to identify at risk clients.
- Use the grapevine or word of mouth within ethnoracial groups as an outreach tool.
- Recognize that seniors from ethnoracial communities may be unable to participate in programs because of care giving responsibilities for children. One solution may be to offer intergenerational programs.
- Ensure that your diverse client populations feel welcomed by the outward appearance of your organization with appropriate signage, printed materials, symbols and visual images.
- Try innovative methods. An agency that wanted to reach women experiencing domestic violence in particular communities distributed emery board nail-files with the name and phone number of the agency in different languages. The nail files were widely distributed in places such as washrooms and hair salons.
- Broaden the focus of health concerns and issues to include those that affect diverse client populations because of genetic, social and/or cultural factors (Waterloo Wellington Local Health Integration Network, 2006). Doing so leads to recognizing that some health concerns are more prevalent in some ethnoracial populations than in others (e.g., bacterial meningitis, Sickle Cell Disease, Fetal Alcohol Syndrome, HIV/AIDS, Tuberculosis, and Tay-Sachs disease). Broadening the focus of health concerns will increase early detection of culturally-specific diseases, improve access to health and community care and health outcomes (Central East Local Health Integration Network, 2006).

Use appropriate translators. Engaging specially trained volunteers can be a cost-efficient means for organizations to bridge communication gaps when hiring multi-cultural and multi-lingual staff is not economically feasible.

Friends, family members/children are often used as translators. This may be convenient but is not recommended because it may:

- breach confidentiality;
- discourage clients from disclosing critical information on private matters, especially on sensitive issues where individuals may fear isolation or stigma (e.g., HIV status, or sexuality issues) particularly in small, tight-knit communities;
- result in misleading translations as inexperienced translators may inadvertently substitute some words for others that have a different meaning, add editorial comments, or omit important information.
- place children in stressful situations of having to convey information that a parent may not want to hear. As well, some topics may be too complex for children to fully grasp and children may lack sufficient command of language to communicate information correctly (Early, 2003; Lum et al., 2003).

Some facilities in Canada and the U.S. are currently experimenting with telephone translation services. As yet, there are few studies assessing the availability, quality, effectiveness and standards of these services, particularly in home care settings.

Leverage community resources. There are many untapped resources within ethnoracial communities that can be used to enhance culturally sensitive care.

- For example, a community service agency in Toronto linked with field placement offices of local universities to recruit social work placement students with specific language, religious and cultural skills. This strategy allowed the agency to enhance its cultural competency in delivering services in a cost

effective way. Some students continued on as permanent staff upon graduation.

- A Community Care Access Centre linked professional health providers with specific language, religious and cultural skills in one area to clients in another area to ensure culturally competent care.
- A municipal housing provider partnered with a community service agency and ethno-specific senior citizen centre. As a result, 10 seniors from that racial community were able to gain access into supportive housing (Meade, 2007). Ongoing partnerships with diverse communities may also help defray the cost of ethnoculturally-specific social programming in supportive housing.
- Research comparing the aging experience of Cantonese-speaking Chinese and Caribbean seniors found that Chinese seniors were more likely to access community support services despite poorer English language proficiency than Caribbean seniors (Lum & Springer, 2004). Community Service Agencies successfully reached into the well-established network of Chinese communities and leveraged their strong social infrastructure. As a result, individuals obtained support services that they would not otherwise access.

Maximize the use of care management / community intervention and assistance. Research comparing seniors in social and supportive housing suggests that care managers were effective in mediating cultural or linguistic barriers to facilitate the provision of culturally and linguistically appropriate support service packages, especially for seniors from small emergent ethnoracial communities with relatively weak infrastructures. Without care management, individuals and their families had to navigate programs and services for themselves (Lum, Ruff, & Williams, 2005).

Recognize the importance of multiple entry points to service. A number of reports emphasize that a single point of entry (e.g., one central information referral centre/ telephone number) is optimal for clients to access integrated health and community care services. People of diverse backgrounds may feel more comfortable accessing services through agencies that provide culturally and linguistically appropriate services. The key is that both single and multiple points of entry should lead to integrated health and community care services.

Anticipate diversity within ethnoracial communities. Ethnoracial communities are rarely homogeneous. To avoid aligning with one particular part of the ethnoracial community and alienating another, care providers may wish to find formal or informal community leaders or academics that can help identify any internal political, religious, class, clan or regional cleavages and how different communities resolve internal conflicts.

How can I learn more?

All the references are available in our knowledge bank. As well, watch for our next diversity In Focus where we will be looking at sexual orientation issues and home and community care.

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