A MODEL FOR CULTURAL COMPETENCY IN THE HIV MANAGEMENT OF AFRICAN AMERICAN PATIENTS

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Cultural competency is an area in which physicians of all races must work to insure they are giving their patients the best possible care. Perhaps nowhere is this better demonstrated than in the struggle to provide culturally appropriate care to black patients who are infected with HIV. The BESAFE model for cultural competency suggested by the National Minority AIDS Education and Training Center will assist healthcare providers in fostering a relationship of mutuality and health promotion.

Key words: HIV/AIDS ♦ BESAFE model ♦ cultural competency

INTRODUCTION

The provision of culturally appropriate healthcare to African Americans who are infected with Human Immunodeficiency Virus (HIV) is an important step to eliminating the disparities in care in this population.

Barriers to health care such as cultural stereotyping of minority patients infected with HIV and distrust of the medical community can be reduced by a commitment to improving cultural competency by providers who take care of African American patients infected with HIV.

Culture includes an integrated combination of constructs that go beyond ethnicity and race. It can be referred to as an integrated pattern of human behaviors that includes thoughts, communications, actions, customs, beliefs, values and institutions of racial, ethnic, religious or social groups (HRSA 2000). Culture is a way of life that is shared between groups of people, but it also includes components that are unique to the individual.

Health is viewed as one of these components of an individual's culture. Therefore, HIV specifically contributes significantly to one's cultural makeup. The cultural shaping that a disease such as HIV makes on an individual is associated with the emotional distress present, societal discrimination and the economic hardship it creates on the individual.

The National Minority AIDS Education and Training Center (NMAETC) pursued the development of a model for Cultural Competency in HIV with the intent of integrating its features with issues that uniquely affect the lives of individuals infected with HIV. In order to develop this model the NMAETC addressed the following questions:

- What is the available literature on cultural competency?
- What are comprehensive models of cultural competency?
- How does HIV affect the culture of an individual?
- Who should receive cultural competency training?

METHODS

Overview of the Model Development

The National Minority AIDS Education and Training Center convened a panel of healthcare providers with the intent of developing a model for cultural competency in dealing with African Americans infected with HIV. The panel consisted of twenty five members, including physicians, advanced practice nurses, dentists, physician assistants, clinical pharmacists, and HIV educators. The panel also represented different African Diasporas seen in the United States. These included American born, Caribbean born, Africa born, Latin American and Cape Verdean.

BESAFE

Barriers to health care
Ethics in cultural competency
Sensitivity of the provider
Assessment appropriate to a cultural determination
Facts related to ethnocentric physiologic differences
Encounters

Members of the model development group attended workshops conducted by Dr. Campina-Bacote, an international expert in the field of healthcare cultural competency, where several cultural competency models were presented. Included in these was her model, which included the constructs of cultural competency, including cultural awareness, cultural knowledge, cultural skill, cultural encounters and cultural desire. Members of the group selected, reviewed, and interpreted the data. The panel also reviewed the literature on cultural competency.

The NMAETC's model was finally developed by a method of consensus. Following its development, the model was presented to groups of healthcare providers for discussion and feedback. Responses were used to guide the final development of the constructs of the model. The final version of the model was then used for the development of a book on the topic of cultural competency for providers who take care of African-American patients infected with HIV.

RESULTS: THE BESAFE MODEL

BESAFE is a framework that uses culturally pluralistic content and perspectives based on the six core elements: Barriers to health care, Ethics in cultural competency, Sensitivity of the Provider, Assessment appropriate to a cultural determination, Facts related to ethnocentric physiologic differences, and Encounters. The following is a summary of these elements, and how they give healthcare professional a framework to provide culturally appropriate primary healthcare services to African American individuals infected with HIV.

Barriers to Care

Barriers to care is defined as gaps to providing quality care that may be real or perceived and are compounded by the relationship HIV has to ethnicity. These barriers include African American mistrust of the medical community, access to care issues, stigmas surrounding HIV,

support systems, and bias in medical decision-making.

The disparities seen in HIV research between the participation of African American patients and white patients reflect the mistrust African Americans have for the health professional community. More widespread negative attitudes may explain why half as many African American patients as white patients attempt to obtain experimental HIV medications[1]. Although specific examples are often given for the mistrust seen in the black community, there is evidence that the mistrust stems from centuries of medical mistreatment and abuse[2].

A review of survey data produced by the Kaiser Family Foundation in October 2000 shows that African Americans' access to health care services is compromised by an uninsured rate that is one and a half times that of whites. African Americans also seek HIV testing later than whites. Forty-three percent of African Americans had two months or less between testing positive for HIV and an AIDS diagnosis compared to 31 percent of whites. When African Americans do get access to care, it is often substandard. Data from the HIV Cost Services Utilization (HCSUS) a national probability sample of persons with HIV receiving medical care in early 1996, showed that African Americans were 1.5 times less likely to receive prophylaxis for Pneumocystis carinii pneumonia than whites.

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Ethics

Ethics is defined as a science of the human condition as it applies to the morality of beliefs, values, and behavior. The sources of ethics include reason, individual experiences and society's experiences. A large portion of these experiences may include those factors that make up one's culture. Hence, having ethics as a component of a cultural competency model is not only important as a guide of the principals of the model, but also it is a natural extension of cultural definition.

It is the duty of the healthcare worker to do no harm and to do their best for their patients. These are the principals of beneficence and benevolence. They can be looked upon as components of natural law-the ethical principal emphasizing the desire of all humans to doing what is morally good. These principals support the valuing of different cultures.

Other issues that are important in the care of individuals infected with HIV include truth telling, confidentiality, HIV research, dealing with dying patients, and the responsibility of the HIV healthcare provider. These issues often create dilemmas between the different ethical layers. These layers include the ethics of the individual, ethics of the institution, and the ethics of society.

In summary, the importance of ethics in determining the morally good practice of a healthcare provider in acknowledging and learning about their client's culture is included as a construct of the cultural competency model.

Sensitivity of the Provider

The panel utilized Campina-Bacote's construct of cultural awareness under the heading of cultural sensitivity. The Sensitivity of the health care professional involved the process of examining one's prejudices and biases toward other cultures as well as an in-depth exploration of one's own cultural background[3]. The construct of cultural sensitivity was included to aid the health care professional in reducing the phenomena of cultural imposition-the tendency to impose their values on another culture[4].

Before one can begin to understand another's

culture it is important to identify one's biases and to determine where they are along a continuum that ranges from unconscious competence to unconscious competence.

Campina-Bacote describes this continuum beginning with unconscious incompetence, where the health care professional is not aware that cultural differences exist. Further along the continuum is conscious incompetence, remaining without an understanding of another's culture but aware of what one do not know. Next, is the consciously competent, the provider now becomes knowledgeable of the cultural differences, but is still in the process of learning about another's culture. Finally, the provider may become unconsciously competent where the knowledge of the differences between another's cultures is now appropriately incorporated in one's behavior and interaction with a person of a different culture.

Assessment

Another construct incorporated from Campina-Bacote is the assessment. She defines this as the ability of the healthcare professional to collect relevant data regarding the patient's health history and present problem in the context of the patient's cultural background[3]. The ethics section stated that health care professionals are obligated to respect the rights of the patients.

As stated by Leininger, one of the rights of the patients is to have specific cultural beliefs, values, and practices. The cultural assessment includes tools that promote a mutually beneficial interaction between the provider and the client. The provider utilizes the cultural assessment to illicit cultural knowledge from the client as a component of their medical history.

Facts

The full assessment of a patient requires the understanding of physiology, behavior, and the patient's perception of their illness. In order to adequately design an appropriate treatment plan, the provider needs to individualize these characteristics to their patients. Therefore, an understanding from the perspective of the individual's culture including biologic variations based on ethnicity, worldviews, and culturally specific behavioral patterns are important.

Biologic variations can be misleading when treating an African Americans individual infected with HIV and basing it on experiences solely from a Caucasian model. Variations seen in clade HIV infectivity between different ethnic groups often show differences in the virologic and immunologic interpretations. There are different levels of risk associated with hypercholesterolemia, hyperglycemia, and other complications of highly active antiretroviral therapy between different ethnic groups. It is important for the health care practitioner to become knowledgeable of these differences if they are to effectively treat African American patients for HIV.

Worldviews are defined as a set of metaphorical explanations used by a group of people to explain life's events[5]. Geri-Ann Galanti states that people's worldview consists of their basic assumptions about the nature of reality[6]. Individuals often have differing ideas on how they perceive the causes of their health based on their differing worldviews.

For example, there are differing reasons why an individual may believe that they become infected with HIV based on their worldviews. Some individuals may believe that another person may have placed a curse on them; others may believe that it occurred because of their prior misdeeds or the misdeeds of their family. As a provider, although it is important for you to discuss the physiologic mechanisms of the disease transfer, it may negatively impact the relationship if you disqualify the client's beliefs.

Encounters

Cultural encounter is defined as the process that allows the healthcare provider to directly engage in cross-cultural interactions with clients from culturally diverse backgrounds[3].

The effectiveness of a cross-cultural encounter is dependant on prior knowledge and experiences of the patient's culture as well as the ability to be open to verbal and non-verbal messages transferred during the interaction. Although an individual can never be fully knowledgeable of another's culture, an atmosphere of respect and desire to learn from the patient can facilitate the encounter.

The goals of the cultural encounter include effective communication, the transfer of information and knowledge including medical and cultural information, and the creation of an atmosphere of mutual respect between the healthcare provider and the patient that incorporates cultural components into the therapeutic plan for the patient. The cultural encounter should occur throughout the relationship between the provider and the client. Cultural competence is a continual process that develops as more encounters occur.

CONCLUSIONS

Cultural competency is an integral part of taking a medical history. However, it goes beyond information gathering and also includes the building of a provider-client relationship that fosters mutuality and health promotion.

Health promotion in HIV management has several components, including the treatment and prevention of HIV related complications, adherence to complicated medicine regimens, reducing emotional distress, educating family and loved ones affected by the disease, and assisting the patient to navigate the complex path of the HIV health system. The model for cultural competency introduced above will assist healthcare providers in fostering a relationship of mutuality and health promotion.

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