Health literacy, culture and language

Never Stand Still | Medicine | Centre for Primary Health Care and Equity

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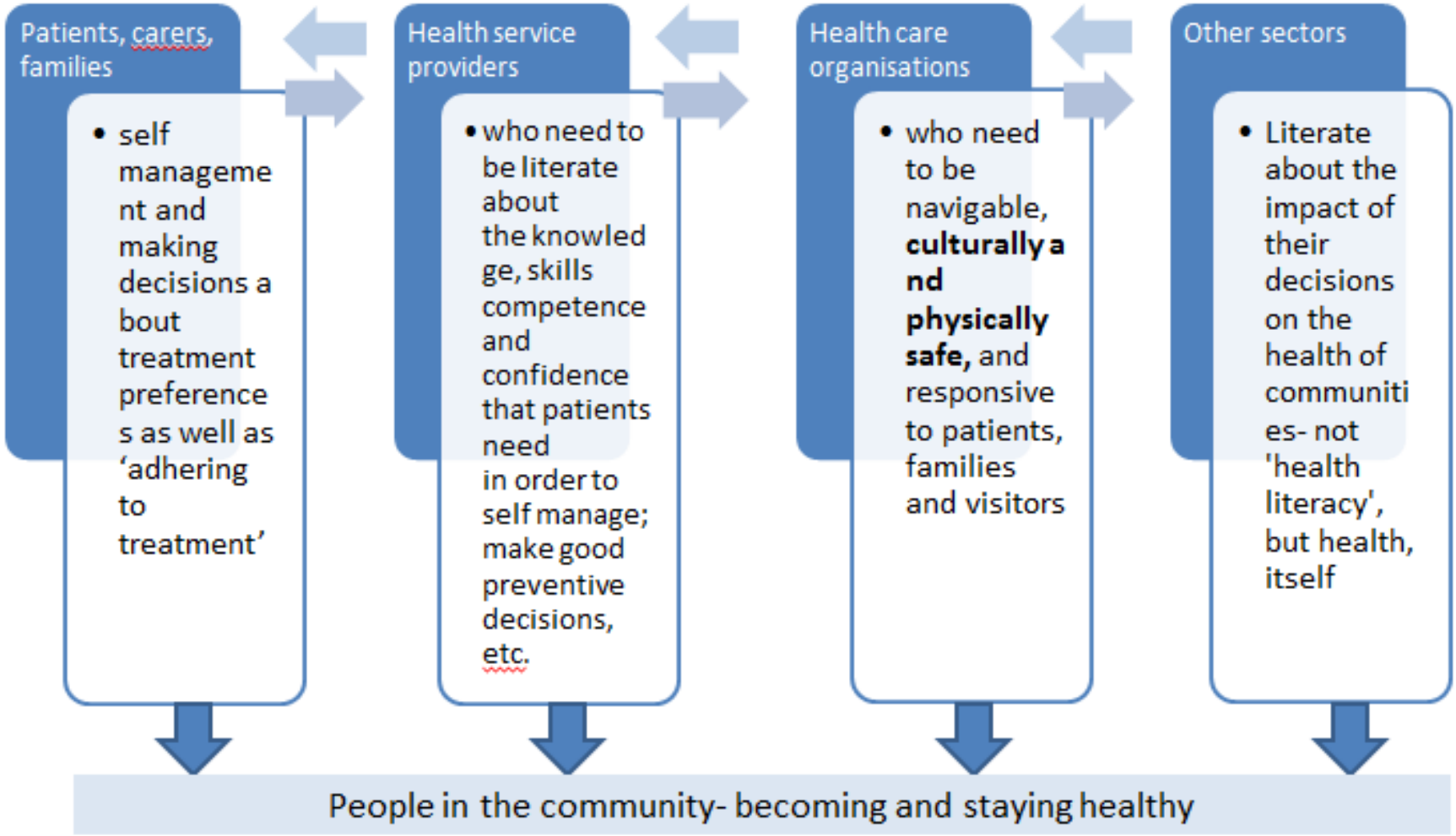
Outline

1. **Health literacy and related concepts**
   a) Organisational health literacy
   b) Cultural competence vs humility
2. **Organisational responsiveness**
3. **Putting it into practice**
   a) Health literature environments – Walking Interviews and Cultural Support Workers
   b) Health literature populations- Can Get Health in Canterbury

Health literacy requires action by…



People need to engage with complex organisations and systems

- Health system:
  - who to see for what problem
  - how to navigate among many potential care providers
- Health services:
  - how to find your way in a hospital
  - what to do before / during / after a visit to a GP or specialist
- Patient/provider interactions:
  - asking questions
  - sharing decision-making
- Information:
  - medicines information, informed consent, discharge instructions
  - many sources of information – what can be trusted?

Organisational health literacy

- A health literate organisation reduces the health literacy demands placed on patients to access health care.
- System-level changes are needed to align health care demands better with the public's skills and abilities.
- While frameworks exist, there are few examples of organisational health literacy interventions being demonstrated to improve and sustain access to high quality health care.

Related concepts

- Culturally competent communication - emphasises that individuals' concept of health may differ, affecting the way individuals receive, process and accept information.
- Linguistic competence – patients who don't speak English are offered bilingual clinicians or interpreters.

Related concepts - cultural humility

‘incorporates a lifelong commitment to self-evaluation and self-critique, to redressing the power imbalances in the patient-physician dynamic and to developing mutually-beneficial and non-paternalistic clinical and advocacy partnerships with communities on behalf of individuals and defined population’.

Tervalon M, Murray-Garcia J. Cultural humility versus cultural competence: a critical distinction in defining physician training outcomes in multicultural education. Journal of Health Care for the Poor and Underserved. 1998;9(2):117-1258

Pathway for responsiveness

Health literacy + Cultural humility + Language access services = **RESPONSIVENESS**

But what does this pathway involve?

Organisational responsiveness….

	Professional	Organisational
Health literacy	• Literate about the knowledge, skills, competence and confidence that patients need in order to self-manage and make good preventive decisions	• Navigable and responsive to patients, families and visitors
Cultural humility	• Contribute to a workplace that is culturally and physically safe • Access education/ workforce training • Participate in a diverse workforce • **Recognise one's own culture and bias**	• Signs • Artworks • Providing facilities to allow people to prepare or store their own food (e.g. fridges) • Providing space for families to visit • Policy on employing a diverse workforce
Language	• Book an interpreter • Use simple language	• Have interpreters available and a policy around interpreter use • Provide resources in other languages

Why are biases important to recognise?

Source: https://apasseducation.com

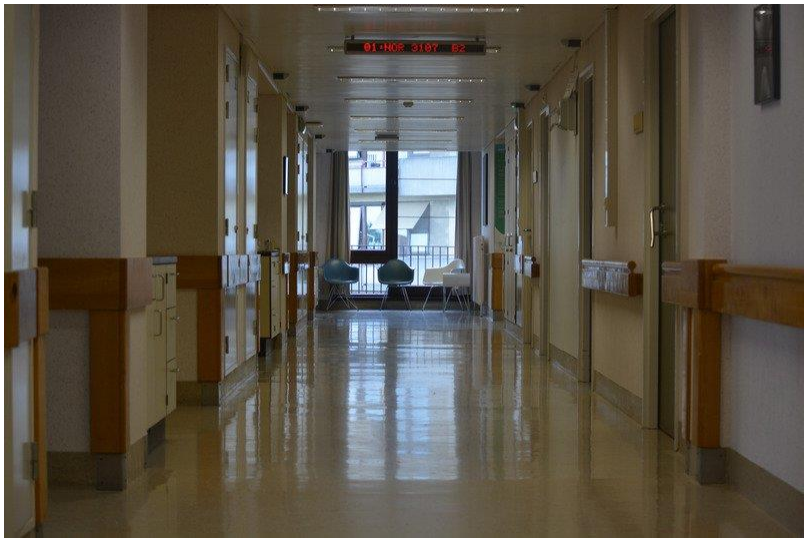
- To shed light on hidden assumptions
- Because how we think influences how we behave

Putting it into practice….

- How do we structure healthcare organisations to become health literate environments accessible to all?
- How do we increase health literacy and health equity in the population?

Putting it into practice- health literate environments

We conducted a pilot study in Canterbury Hospital which aimed to identify strengths and weaknesses in responsiveness to health literacy, cultural humility and language within Canterbury Hospital.



Walking interviews

Bilingual Community Educators (BCEs) engaged community members from the Rohingyan, Bengali and Arabic language groups in a feedback process on their experiences of navigating within Canterbury Hospital, using a walking interview tool.

The tool assesses:

- level of ease navigating in hospital
- comfort and effectiveness of patient/health professional communications

Findings

First impressions

	Positive overall atmosphere at entrance to hospital
	Previous experiences with hospitals shapes experience of future visits

Navigation and wayfinding

	Preference to ask staff rather than use sign or map
	Asking a staff member for help was generally a positive experience
	Signs in English only- difficult for patients who did not read English

Communication

	Previous interactions with health professionals and health services generally positive
	Health professionals checked for understanding
	Some participants couldn't access an interpreter service in their preferred language

Limitations

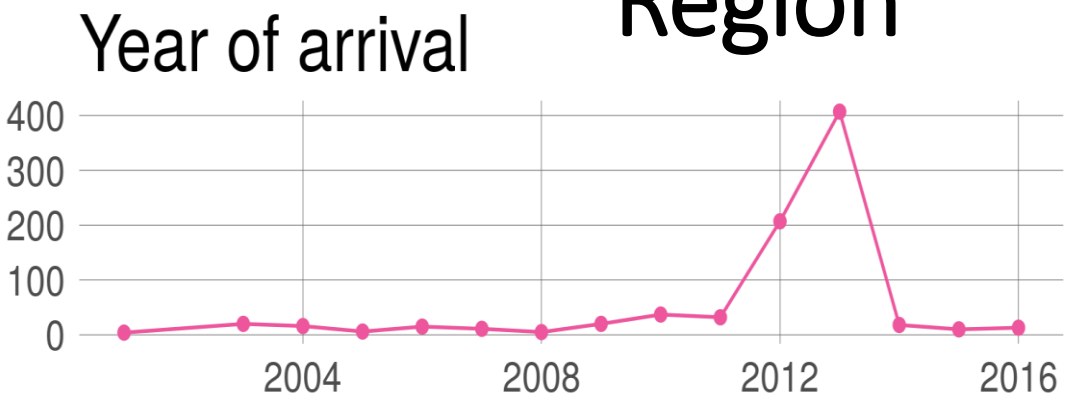
- Time intensive process
- Expensive
- Narrow in focus (small number of language groups)
- It is an audit rather than an intervention, although the findings can be used to generate change

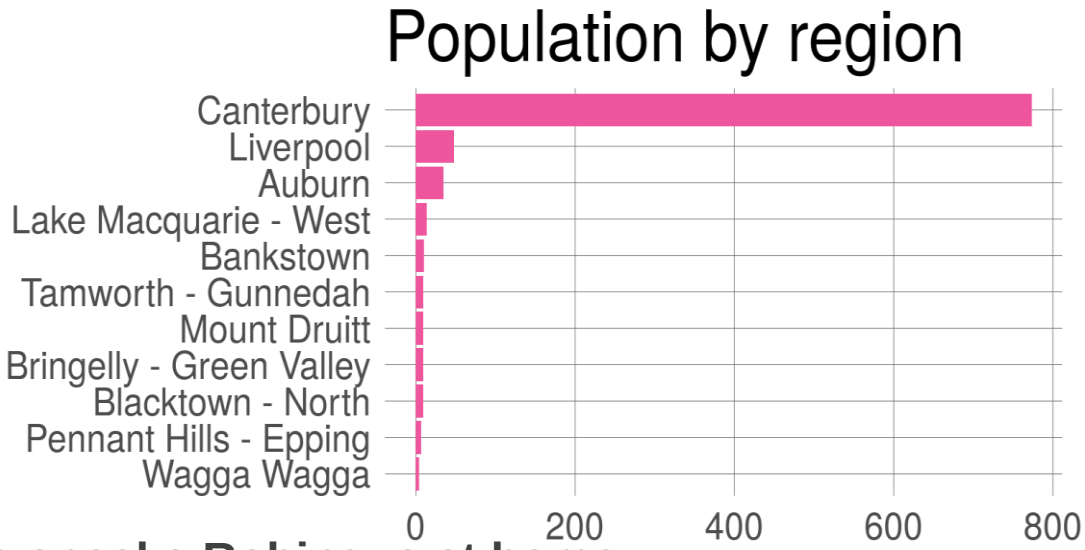
Putting it into practice- health literature populations

Can Get Health in Canterbury (CGHIC)

- Partnership between Sydney Local Health District, Central and Eastern Sydney PHN (CESPHN) and the University of New South Wales, Centre for Primary Health Care and Equity (CPHCE).
- A place-based intervention that aims to improve health and reduce inequities for marginalised culturally and linguistically diverse (CALD) populations in the Canterbury region.
- The project objectives include:
  - Improving access to comprehensive primary health care services
  - Increasing individual and community health literacy
  - Identifying and working with relevant stakeholders to address at least one the social determinant of health.

Rohingya community in the Canterbury Region





Source: Census 2016 who speaks Rohingya at home

The Big Local

Why community empowerment matters for health inequalities

- A lack of control over decisions that shape people's lives may contribute to poorer health outcomes.
- The Communities in Control study is researching a Lottery funded initiative called Big Local, which puts decision making into the hands of residents across 150 areas in England.
- NIHR SPHR researchers are producing learning about how groups of residents work together to take action and influence change locally and the effects of this on their health and wellbeing.

www.sphr.nihr.ac.uk @NIHRSPHR

Rohingya Little Local

- From activities and community engagement to community led
- Allocate $10,000 (once)

Considerations

- Community creates decision making group- includes women, living in Lakemba, acting as individuals
- Community determines the priorities
- Training to strengthen skills and capacity - governance, project management, dealing with organisations - training
- Ongoing support by CGHIC – attend occasional meetings, help with documentation etc.

Rohingya Little Local – deliberations

- Who are the community/communities?
- Balance between support and relinquishing control
  - How much support do we provide and how do we leave it to them?
- Who provides the backbone?
- Opportunity to create community infrastructure and process so that the community can apply for local government grants
- Foresee negative issues - what can be done?
- Interpreting readiness and co-design

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Questions/thoughts for the future

Don't revert to what we always do:

- Translate pamphlets into language
- Cultural competency course
- Increase the number of interpreters.

<u>While these are important, they are insufficient to reach the goal of responsiveness.</u>

Co-design is a way forward – community engaged in own definition of access and health literacy priorities and own solutions

CHWs – cultural brokers, educators, researchers, community development – provide an additional workforce to enable this.

Redesign services to be responsive i.e. review appointment booking system, health service tours, provide outreach clinics

Acknowledgements

Walking interviews:

- Dr Genevieve Wallace, Former General Manager of Canterbury Hospital
- Bilingual Community Educators
- Community members who volunteered
- Research team: Jane Lloyd, Louise Thomas, Sarah Dennis, Heather Attenbrow, Elizabeth Harris, Marilyn Wise, Mark Harris.

Can Get Health in Canterbury:

- Gisselle Gallego, Barbara Hawkshaw, Elizabeth Harris
- Members of the Management Committee and the Advisory Committee

Thank you!

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'The single biggest problem in communication is the illusion that it has taken place'

George Bernard Shaw Nobel Prize in Literature 1925