Barriguda Project: Incorporating Cultural Competence into Education of Health Professions

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"I had no idea what I could learn here."

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Summary:

The need to address issues of cultural and ethnic diversity in health professions' education has been suggested as a means to improve the quality of care and reduce disparities in health care.

“Quilombolas” are the descendants of enslaved Africans that maintain their ancestors culture, livelihood, and religious traditions. They commonly live in rural areas with low availability of basic infrastructure and limited access to health care.

The elective module for undergraduate health courses

with the subject "Cultural

Competence in Health Care for Quilombola Women" was implemented and the first discipline in Brazil to address the study of cultural competence with quilombo remnant populations. The program inserts the students in the process of a collective prenatal care service involving health profession students from Federal University of Rio Grande do Norte (UFRN), and a multidisciplinary team with anthropological and educational resources on history and culture of African-Brazilian communities. The community where these studies take place, Capoeiras dos Negros, in Macaíba-RN/ Brazil, includes approximately 300 families with limited access to adequate health care.

Research with a qualitative approach was carried out, and an exploratory case study was developed. Data were collected through participant observation and focus groups, with 24 students who completed the course between 2016 and 2017, with categorical thematic content analysis.

The students' self-perception about the development of cultural competences at the end of the intervention revealed that knowing the health situation of the Quilombola population, interacting with the community, and experiencing inter-professional work, demonstrated to be effective strategies to enhance the development of cultural competences.

In 2017, the project was one of six winners of the competition, "Innovation Laboratory on Social Participation in Integral Care to Women's Health," being a successful case in the area of vulnerability and equity in women's lives and health. The project was validated by the Brazilian Ministry of Health for replication in other neglected communities.

Background: Brazilian Scenery

The history of Brazil, built on the foundations of inequality, reserved for the black population the place of the poorest social classes and the most precarious conditions. Despite the official abolition of the enslavement of African peoples and their descendants, there is no denying that there is still a silent and undeclared racism in our society today. The persistence of this situation throughout these years is easily observed in the precocity of deaths, the high rates of maternal and infant mortality, the higher prevalence of chronic and infectious diseases, as well as in the high rates of urban violence that affect the black population.

The National Curricular Guidelines for undergraduate medical schools establish that the fundamental contents must be related to the whole health-disease process of the citizen, the family, and the community, and inserted in the epidemiological and professional reality, providing the integrality of the actions of the taking care of health, contemplating the approach of transversal themes in the

curriculum that involve knowledge, experiences, and systematized reflections on human rights, social responsibility, education of ethnic-racial relations, and history of Afro-Brazilian and indigenous culture (Ministério da Educação 2014).

Within the context of the traditional populations in Brazil there is the Quilombola ethnic minority group within the Brazilian black population who are still fighting for equal rights, for the ownership and land regularization of their lands, for the expansion of full citizenship, and for equity in health care (Ministério da Educação 2014). Because it is a historically persecuted and/or excluded group, it faces greater difficulties in accessing public health, both due to the deep social inequalities to which it is exposed, as well as the geographical location of communities, predominantly rural and remote.

In the current scenario of Health Education, Afro-descendant populations are still neglected, despite the undeniable advances related to teaching-service-community integration in several higher education institutions. Part of this difficulty stems from the relative invisibility of these population groups to health schools, whose conservative curricula disregard their specific health needs, resulting in the poor ability of teachers and students to cope with the multicultural context.

Institutional racism diffuses in the daily functioning of institutions and organizations, causing inequality in the

distribution of services, benefits, and opportunities to the different segments of the population from a racial point of view, and, for this deconstruction, it is necessary to implement public policies that provoke a process of de-racialization, as well as generate academic reflections on how these mechanisms operate (Lopez 2012).

Cultural Competence in the Training of the Health Professions

In societies that are rapidly becoming multicultural, health professionals are increasingly facing the challenge of promoting comprehensive health care for people within the context of ethnic and cultural diversity. Literature has increasingly outlined the various impacts of the socio-cultural factors of race and ethnicity on health and clinical care, indicating that the lack of culturally competent care directly contributes to negative outcomes in the care experienced by users, as well as the reduction of patient confidence and increased inequities in health, regardless of the quality of services and health systems available (Betancourt 2003).

Culture can also have important consequences for the formation of bonds in the interpersonal relationship that is established between health professionals and their patients. Failure to consider the cultural and linguistic diversity of a patient may result in imprecise clinical histories, decreased satisfaction with the attention received, poor adherence to treatment, discontinuation of

care, less preventive screening, communication failures, difficulties with informed consent, inadequate analgesia, unlikely to have a primary care provider, less access to care, harmful drug use, and delayed immunizations (Flores 2000).

Health care is a complex social construction that makes context, geographical location, and culturally important considerations important in any discussion about the behavior of health professionals. Students, educators, and health professionals are now much more in a global movement, being exposed to cultural and social attitudes, values, and beliefs that may differ from their own traditional perceptions of professionalism (Jha et al. 2015).

Thus, health professionals are not protected from diversity, since patients have varied perspectives, values, beliefs, and behaviors regarding health and well-being, which include variations in the recognition of symptoms, thresholds for care, capacity to communicate complaints to a provider who understand them, ability to understand the prescription, expectations of care (including preferences for or against diagnostic and therapeutic procedures), and adherence to preventive and treatment options (Flores 2000).

It is in this context that the development of "cultural competence" presents itself as a strategy for health education, capable of helping these professionals with

issues related to ethnic and cultural diversity, as well as a means for improving the quality of care for the reduction of ethnic and racial disparities (Seeleman et al 2009).

Various definitions of cultural competence are found in literature, but as a simple concept, a health professional who possesses cultural competencies would have behaviors that fit individual, group, or institutional values, beliefs, and ways of life, in order to provide quality health care (Fenza et al 2010).

A conceptual framework on cultural competence was proposed based on the skills of physicians in general, and the difficulties experienced by doctors in different cultural settings. The conceptual framework encompasses knowledge (epidemiology and manifestation of diseases in various ethnic groups and differential treatment effects in these groups), attitudes (awareness of how culture shapes individual behavior and thinking), and knowledge of the social context in which specific ethnic groups live (ability to transfer information in a way that the patient can understand, to know when to seek outside help with communication, and ability to adapt to new situations in a flexible and creative way) (Seeleman et al. 2009).

Therefore, it is of utmost importance to develop curricula for training the health professions that enable students to assess and appreciate the cultural sources of each patient's health beliefs. Failure to develop these skills and attitudes can limit access to health care resources for

some users, pose risks to patient safety, and contribute to the persistence of health care disparities (Crosson et al. 2004).

Providing health students with culturally immersive opportunities to promote a multicultural health concept can be an important component in the training of professionals who demonstrate cultural competence. (Zanetti et al. 2011) Despite some conceptual limitations, most research has suggested that cultural competency training can effectively sensitize health professionals to cultural differences and increase the quality of care. (Kelly 2011) In Brazil, with continental dimensions, regional differences, and social situations so disparate, the insertion of this theme into the curricula of health professions is a necessity, and the lack of published reports of experiences in this sense, a reality.

It is in this context that there is a need to include in the curriculum strategies capable of fostering the development of cultural competences in health education that is part of this initiative, in order to contribute to overcoming the challenges inherent to curriculum development, teaching and learning methodologies, practice scenarios, and to teaching-service-community integration.

The Barriguda Project

The Barriguda project was developed by the Center for

Education and Research in Health Anita Garibaldi (Santos Dumont Institute) in 2015 in the rural community of Capoeira dos Negros. The community of Capoeiras, as it is better known, within the municipality of Macaíba, is the largest Quilombola community in the state of Rio Grande do Norte, with approximately 300 families with limited access to adequate health care. The community is located in a rural area and has no primary care team.

The pilot project was developed through action research intervention that aimed to identify the maternal health needs of Capoeiras' population and establish a care strategy for this specific population. After this stage, an inter-professional prenatal care service was implemented, which included student participation as members of the team (physician, nurse, physiotherapist, psychologist, social worker, and residents of Obstetrics/Gynecology). The preparation of the professionals included discussions and studies on the anthropology of the community in question, public policies for the health of the black population, and cultural competence.

The care provided to the pregnant women in the community began to be carried out by the team at the family medicine clinic of the community on a weekly basis. This included health education actions using soft technologies, group dynamics, relaxation techniques, artistic activities, and cultural activities.

Participating pregnant women and medical students during an educational art therapy session.
Credit: General Archives, Instituto Santos Dumont

In 2017, the Barriguda Project was awarded by the Pan American Health Organization and the National Health Council at the competition “Innovation Laboratory,” for the National Health System (SUS) in the Social Participation category, in recognition of the relevant results obtained in promoting access to health for women in situations of vulnerability.

What Was Done

The methodological course adopted was a research with a qualitative approach, and an exploratory case study was

developed. The epistemological framework used was that of social phenomenology, which seeks to understand and interpret reality, relationships, values, attitudes, beliefs, habits, and representations, from a set of socially generated phenomena.

The curricular component, "Cultural Competence in Health Care for Quilombola Women," was proposed with the goal of providing students with the development of cultural competences in the context of health care and education of culturally and ethnically diverse populations. It was implemented in March 2016 and inserted as an optional curricular module for undergraduate courses in the health area of the Federal University of Rio Grande do Norte, accounting for 60 class hours. In the development of the course plan, results were considered about the perceptions of 37 medical students, who participated in the activities of the Barriguda project in 2015. Based on these observations and the bibliographical survey on the subject, the contents and teaching strategies were defined, in order to promote the development of cultural competences. Some general principles were guiding the pedagogical planning of the discipline, such as interprofessional education, the use of soft technologies, the possibility of insertion of students from the beginning of their undergraduate courses (and not only in the final years), and the need for time of coexistence between the students and the people of the community, including more opportunities of "immersion in the life of Capoeiras,"

besides the specific actions of health care and education (Freitas Junior et al. 2017).

With regard to the cognitive dimension, the main idea of the discipline is to approach the knowledge of the processes that influences the health and health care of the Quilombola population. The skills element focuses on the communication and understanding skills of social, cultural, behavioral, psychological, ecological, ethical, and legal determinants, at the individual and collective levels, of the health-disease process of Quilombola women. Regarding the attitudinal component, it is proposed to stimulate the students' reflective capacity regarding the diverse values, beliefs, and behaviors related to health. Additionally, it seeks to promote reflections on the racist formation of Brazilian society, the marginalization of Afro-descendant communities, and the relative invisibility of their contributions and needs.

The discipline provides a preparatory phase for the insertion of students in the community, with an interdisciplinary approach of the interfaces of health with anthropology, sociology, geography, and history, in relation to subjects ranging from the diaspora of the black people, Afro- Brazil, through the public policies for the health of the black population in Brazil, to the understanding of cultural competence as a strategy to reduce inequities in the care of people's health. The students then move on to the entrance phase in the field, which begins with the presentation and interaction with

local leaders and knowledge about the territory and its social facilities. The discipline culminates in the accomplishment of activities in the community, which are developed in an integrated way with the Barriguda project and culminate in the development and execution of a collective intervention project.

As a strategy to expand students' knowledge horizons, teachers from different disciplines participate in the course, including professors from various health areas, anthropologists, social scientists, geographers, historians, journalists, pedagogues, and community leaders from Capoeiras.

The present article includes the analysis of the results related to the development of the discipline in the 2016.1, 2016.2, 2017.1, and 2017.2 semesters, with participation of 24 students from the following courses: Medicine (n = 8), Physiotherapy (n = 11), Dentistry = 2), Nutrition (n = 1), Psychology (n = 1), and Social Communication (n = 1).

For the data collection, the participant observation procedure and the focus groups were used. In total, four focal groups were conducted with an average duration of 120 minutes, one for each class being offered. Focus groups were guided by a semi structured road map, including students' perceptions of the discipline, how the bond with the community was established, and what competencies they recognized as necessary to work with the Quilombola community. The information was recorded

in audio, being transcribed, analyzed, and codified. The information obtained through participant observation was recorded in the field diary and later integrated into the analysis process.

The analysis of the data was performed using the categorical thematic content analysis technique. The categories related to the development of cultural competence were based on the concept proposed by Campinha-Bacote (Campinha-Bacote 2009) which identifies five constructs of cultural competence for health professionals: cultural awareness (self-reflection of one's own prejudices), cultural knowledge (obtaining information about different cultures), cultural skills (ability to obtain relevant cultural data of the patient's problem), cultural encounters (personal experiences with patients from different backgrounds), and cultural desire (the desire to be culturally competent).

Professor and medical student interacting with community members during a student led session. Credit: General Archives, Instituto Santos Dumont

Students' Perceptions

Cultural Awareness

Cultural consciousness encompasses the capacity for self-reflection about one's own prejudices and stereotypes, and any other presuppositions that can be made of individuals different from ourselves. The students at various moments made reflections on their prejudices and reinforced the importance of the discipline and the experience in the community as a way to promote these

reflexes.

"I had never stopped to read anything about it. I think that because of prejudice...I had no idea." (Medical student)

"I never thought it existed so close to us." (Medical student)

"I think every meeting had something that stuck somewhere. None of the classes I left quietly...All the meetings I left with something in the head to think, to transform, to talk with the boys at various other times. And it was like that, from the first to the last encounter..." (Physiotherapy student)

Ly e Crowshoe (Ly and Crowshoe 2015) propose that students need to develop a critical understanding of the racial and ethnic disparities that permeate health care, and that opportunities should be offered to deconstruct racism and its effects on health interactions.

A survey carried out in Brazil with the objective of identifying institutional racism with managers and public sector workers in several cities of the country, evidenced the differential and unequal treatment between whites and blacks in labor relations; the difficulty of recognizing the competence of black people in technical and managerial positions; discrimination of users on the basis of their racial belonging; and the lack of knowledge about the diversity, cultural, and religious practices of professionals (Lopez 2012).

Another Brazilian study of national scope sought to analyze the differences between prenatal and childbirth care according to race and color, finding that black women had a higher risk of having inadequate prenatal care, a lack of attachment to maternity for childbirth, absence of companion, pilgrimage for childbirth, and less local anesthesia for episiotomy (Leal et al. 2017), explaining in the maternal health field the racial disparities existing in our health system.

"I had not participated in any discussion of cultural competence in college, and we do not always know how to respect the culture and thoughts of the individual. It opened my head to many things, and touched me on how I want to be for life, and how to be a professional..." (Student of social communication)

Promoting opportunities to reflect on the racism that permeates Brazilian society in health education, starting with their own prejudices and stereotypes and raising awareness that we are not immune to them, is extremely important to train professionals who are skilled in the care of the ethnic minorities and population of our country.

Cultural Knowledge

Cultural knowledge as a dimension of cultural competence consists of obtaining solid information on specific populations, including health-related beliefs, cultural practices and values, incidence and prevalence of

diseases, and particularities in treatment (Campinha-Bacote 2009). This category was widely present in the students' reports, but with the particularity of highlighting the previous ignorance of the subject and lack of approach of the subject in the curricula of the health professions.

"...a black population, it has several dimensions, and I think the health area needs to be more worked within the own academy, such as specific diseases, particularities of a treatment for the black population such as falciforme anemia, in short, other peculiarities that we do not have access to in the construction of the courses, we do not study it with a directed look, we only see punctually..." (Physiotherapy student)

"...I found out that it is very difficult to know the particularities of black people's health, because I do not see it in college. And I heard from a woman in the community that some hypertension medicines were not good for blacks and I was shocked because I did not know that and I heard it from her..." (Physiotherapy student)

"...and it is important not to have a module for this, but to have this in all modules, because we see in college how to provide health care for white people, and I did not feel competent in theory to give care for a black person..." (Dentistry student)

These findings highlight how racism continues to shape

the way we perceive and treat blacks and racial disparities in health care, possibly contributing to the worst indicators in this group. Closing the eyes on the problem, including the training of professionals, would perpetuate the existing vulnerability conditions. At various moments in the development of practical activities with the community, students were able to hear testimonials from users about the assistance they received in various health sectors throughout.

To understand the health issues, it is necessary to understand the disqualified, devalued social insertion, the invisibility of the real needs in the actions and programs of assistance, health promotion, and disease prevention. Black women and men live in a constant defensive state, which can lead to inappropriate behaviors, psychosocial and physical illness, and the understanding of this context is a key point in the understanding of the problems with care providers. (Brasil, Minitério da Saúde, 2013).

During the chats on the module, it was notable the lack of knowledge of the students about the inequalities in health indicators based on the race and other aspects related to the assistance of the black population, evident in the speech that names the article: "When I arrived here I thought it was only a very poor rural community...I had no idea what I could learn here..." (Medical student). From an educational perspective, this discourse is extremely important and reveals the invisibility of issues related to social vulnerability to which the black population is

exposed in educational institutions.

Cultural Skill

The professional should be able to obtain relevant data from the patient's complaint with cultural sensitivity, appropriate language, and with the patient's participation in building their therapeutic plan. In the interviews, reports on cultural skills also included the difficulties that students encountered in clinical practice, especially with the ability to communicate with pregnant women:

"There were times there that I thought I had unlearned to speak. How come?! No one understood me..." (Medical student)

"Neither she looked at me nor answered me. The teacher next to me...I thought: what now? What do I do? I had to do something..." (Medical student)

Developing evolutionary attitudes such as curiosity, empathy, respect, and humility are central to communicate in a physician-patient relationship, whether the patient is in a cultural context similar to or different from the caregiver. (Betancourt 2003)

In some reports, the speeches suggest ways to improve interaction with patients, and overcome barriers in the clinical encounter. Also, the importance of joint construction of the therapeutic plan is recognized, with the patient at the center of care and relationship:

"...in the consultation you can perceive other problems that you cannot perceive at other times and it is necessary to build care along with them, we have a different perspective from theirs ..." (Physiotherapy student)

"It is necessary to be together, to listen, not just to do the medication part, that guideline of care that everyone does that is already normal, but to do something more unique for patients ..." (Dentistry student)

"... I think having empathy is very important, try being in the patient's place, and not only see them as a patient, but as a human being, they have a way of thinking, they have a culture, a life ..." (Physiotherapy student)

Developing cultural insight and awareness has been described as a journey, not something that happens overnight, and thus the early exposure in training to cultural diversity with patients and families can establish a framework for further development (Crosson et al. 2004).

Cultural Encounters

Having personal experiences with patients from different backgrounds is the definition for cultural encounters (Campinha-Bacote 2009). The importance of the meetings with the Quilombola population was reported in several moments in the interviews, and emphasizes the need of the practical experience in the development of

competences:

"We arrive there and there is still this process of feeling the community, of people opening the space, trusting you, because like it or not we have different realities from them ..." (Dentistry student)

"...what attracted our attention was that we had very practical experiences, the experience of living the environment and, most of the time, learning lessons from it, from ourselves, from our experiences ..." (Dentistry student)

Cultural Desire

The desire to be culturally competent is the basis of building cultural competence, as it provides the foundation for this journey. Humility is a key factor in addressing cultural challenges as humble professionals have a genuine desire to discover how their patients think and feel (Campinha-Bacote 2009). The students expressed in their speeches the interest in knowing more about the subject, and the need for more curricular opportunities on the matter:

"We have a very high deficit in these issues, in basic education, in interacting, in going to the community, because teachers are not interested, and are not able to talk about it, about population minorities. We need to be open in class to talk about it. Sometimes we try to talk and

most of the time it's not taken into consideration. You need to put that in the evaluation, instigate the student to think about it, bring people who have the knowledge to talk about it ..." (Physiotherapy student)

The reports expose the curricular gaps in health graduations in Brazil, in which the teaching of cultural competence has not been systematically contemplated in our universities. One must think of the impossibility of building culturally competent care provider systems in the face of the lack of culturally competent health professionals. Competence cannot be expected to come simply from the determining characteristics of the personality, character, and availability of the student who is interested in the subject.

The understanding of cultural competence for health professions includes, but is not limited to: knowledge about customs, religion, eating habits, and diseases prevalent in a particular population or community. It gathers from effective communication skills, regardless of linguistic diversity, accessing and understanding the belief system and practices of the people to whom health care is intended. It also understands the effectiveness to interact and care for people with different perspectives for the interpretation of the reality in which they are inserted. The development of cultural competence is indissociable from the assumption of social responsibility in the context of education for the health professions. In this sense, worrying about the training of professionals capable of

interacting effectively with individuals and culturally different populations transcends the curricular dimension of the egress profile desired by the health schools to reach the dimension of the effectiveness of health systems and the need for them to be inclusive, democratic, and equitable. (Freitas Junior et al.2018).

Thus, the need to promote such discussions in the context of curriculum development is increasing, with emphasis on teaching-service-community integration and strategies to develop cultural competence in undergraduate courses. The literature reviews explain the lack of uniformity in the definitions and matrices of cultural competencies in the different areas of health care. This lack of consensus in the definition and evaluation of cultural competence can contribute to the heterogeneity of the interventions and the limitations on the evaluation process of competences.

Conclusion

Culturally competent care demands knowledge, skills, and attitudes whose development requires specifically designed educational strategies, impregnated with intentionality in their activities and in the settings in which teachers, students, and community interact. When educational objectives and the structuring of services are integrated to the needs of the community, everyone will benefit.

There are limitations for the findings of this study to be broadly extended to other populations, however, our results can be used as a model for the development of training strategies in the graduation of the health professions in order to develop cultural competence.

To create opportunities for the students to know the health situation of neglected populations, to interact with the community, and to experience inter-professional work in the care of this population can be strategies capable of developing cultural competences in health education.

Group photo of community members, teachers, and students inside the community center.
Credit: Ariane Mondo

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