IFMSA
International Federation of Medical Students' Associations

IFMSA Policy Document
Intercultural Learning and Competencies in Healthcare

Proposed by Team of Officials
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Policy Statement

Introduction:
Due to globalization, the increasing cultural diversity amongst nations has created more possibilities and challenges for health professionals, institutions, and policymakers to develop, provide and deliver quality healthcare services that are culturally competent and inclusive. An individual's values, beliefs, and conduct can be influenced by various factors, including gender, race, nationality, ethnicity, language, physical and mental ability, socioeconomic level, occupation, and sexual orientation. All of these are taken into account by cultural competence in healthcare, which helps organizations and healthcare professionals better understand the knowledge and skills required to incorporate these factors into the design of healthcare systems, choose the best method for interacting with patients, and deliver high-quality healthcare services that are tailored to each person's needs. The quality of healthcare delivery services and health outcomes can be enhanced by a culturally competent healthcare system devoid of all forms of bias affecting healthcare at the individual and community levels. This validates the need for the present and future health workforce to be well prepared with the needed intercultural learning and competency skills to become better healthcare providers in a culturally sensitive setting. Without cultural competencies, racial and ethnic minorities are disproportionately burdened by chronic illness, having higher morbidity and mortality from chronic diseases. The consequences can range from a more significant financial burden to higher activity limitations. This may hinder engagement with specific communities, such as minorities, and may lead health professionals to impose their beliefs, values, and behavior patterns upon those from other cultural backgrounds.

IFMSA position:
The International Federation of Medical Students' Associations (IFMSA) believes that developing and incorporating intercultural learning and competencies in health professions education (medical, dentistry, nursing, pharmaceutical, paramedics, veterinary & social sciences students) is the key to the development of a culturally competent health workforce, who will be able to adapt and deliver in a culturally diverse environment. This, in turn, is essential for ensuring the quality of the global health workforce, reducing health disparities, improving health outcomes of populations and achieving universal health coverage (UHC).

Call to Action:
Therefore, IFMSA calls on:

Governments to:
- Develop and ensure the implementation of evidence-based policies and guidelines that promote the longitudinal integration of intercultural learning in medical curricula by the demographic and cultural determinants of respective communities;
- Integrate cultural competence as a critical pillar in universal health coverage and equity;
- Support institutions in implementing intercultural learning of health workforce programs and research;
- Help the human resource department in the development of the task force, which will assist in designing programs built specifically around refugee/migrant, indigenous and first nation populations;
- Fund and engage in bilateral and/or multilateral partnerships through global health programs, health policy and research that work towards a culturally competent health workforce.

Universities, education providers and academic institutions to:

- Create curricula based on intercultural learning methodologies, which promote the development of cultural competence among health care students as well as participants in continuous learning programs, and implement it in education systems;
- Initiate research aimed at understanding best practices in integrating and implementing intercultural-based curricula in medical and workplace-based education, and encourage the exchange of knowledge and experiences between academic institutions and experts;
- Advocate for and ensure intercultural learning environment by including educators and students of different cultural backgrounds in the educational programs. This criteria will not be the main reason why they are included in these teams, as their competencies will be reviewed before;
- Ensure meaningful student engagement in the development, conceptualization and implementation of cultural competency-based education and training within curricula;
- Ensure the community is included as a key stakeholder in integrating cultural competence development in medical education and workplace practice.

Health care facilities and health care professionals to:

- Unite on the local, national, and international levels to promote inclusiveness and diversity in various healthcare facilities and amongst the global health workforce to promote cultural competence in healthcare.;
- Promote continuous professional development learning opportunities that will facilitate open discussions on cultural competence;
- Ensure that patients' psychological, social, spiritual, and physical needs and cultural beliefs and practices are met through assessment and promoting employee and medical staff sensitivity.

IFMSA National Member Organizations (NMOs) and medical students to:

- Advocate for the conceptualization and inclusion of intercultural learning and competencies in health care professions curricula;
- Develop, implement policies and advocate for a culturally sensitive healthcare education;
- Initiate, support and promote projects on intercultural learning and cultural competence;
- Collaborate with relevant stakeholders on initiatives that support developing and implementing intercultural learning and competencies in health care.

NGOs, including Patient Organizations, Human Rights Organizations and Professional Associations to:

- Develop an advocacy plan on the importance of cultural competence in the organizational, structural, and clinical settings for their organizations, healthcare institutions and relevant stakeholders;
- Implement the framework of intercultural learning in their organizations, including their working plans and the structure of the organization;
- Support youth-led organizations for intercultural learning or cultural competence-related initiatives through the utilization of available resources;
- Collaborate with other organizations, including governmental organizations, in founding a platform for discussion, dialogues, and initiatives on the health outcomes of cultural competence;
- Share the updates and progress on the latest articles, evidence, frameworks, or guidelines on intercultural learning and cultural competence to health communities at every level.

Position Paper

Background information:
Health has been recognized by the World Health Organization (WHO) as a fundamental human right since 1946. [1] This means that for less than 80 years, all health care has been focused on the person in need, thus giving Health its anthropocentric characteristics. [2]
However, this anthropocentric approach to Health is, by definition, a fluid state that must adhere to what people need to ensure their well-being. According to the WHO, "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity." [3] People's needs change with time as their surroundings, environment and lifestyle are altered.

In the past few decades, globalization has become a critical factor in the mobility of people worldwide. It is now common for people to reach out to so many different places across the globe looking for better pay, quality of life, education, new experiences and adventures, and so much more. [4] Moreover, the disheartening drivers of international mobility, such as war or poverty, are still in our reality forcing the increase in the number of refugees and migrants, [5] accounting for more than ten percent of the total population in Europe, Northern America and Oceania. [6]

As a result, populations are culturally diverse. [7] Cultural diversity relates to not only a person's country of birth but also their ancestry, the country of birth of their parents, languages spoken, Aboriginal descent, religious affiliation, ideas, belief systems, customs and social behavior. [8] Cultural diversity can create many challenges in the provision of health care. [9] Since the 1990s, global population and socioeconomic changes have resulted in an increased number of hospitalized patients from diverse backgrounds. [6] Clinicians must be cognisant of patients' individual healthcare preferences influenced by cultural diversity and the importance of communication to ensure safety and equity in healthcare provision. [10]

Cultural issues are central in delivering health care services, treatment and preventive interventions. As health care is a cultural construct that arises from beliefs about the nature of the disease and the human body, these elements influence beliefs surrounding Health, wellness, illness, disease, healing and delivery of health care services. [11] Cultural respect has a positive outcome on patient care delivery by enabling healthcare providers to deliver respectful and approachable services to patients' health practices, beliefs and cultural and linguistic needs. [12]

The process of cultural competence includes the social, cultural, and psychological needs of patients, which is effective for cross-cultural communication with health care providers. [13] The focus of cultural competence intervention has been on training and educating the health workforce regarding the necessary knowledge, attitudes and skills that effectively help in sociocultural issues arising in clinical settings. [14] Cultural competence has gained attention for providing equal and quality healthcare services for culturally differing patient groups. [15] Every job in the healthcare system requires a specific set of cultural competencies for healthcare professionals to tackle their tasks efficiently.

A variety of cultural competence interventions, including provider training and valuable tools, are based on various cultural competence models that have been established. While the phrase "cultural competency" has traditionally been used to describe the language and culture of racial and ethnic minorities, it is also used to refer to various groups, including persons with disabilities and members of the LGBTQ community. Studies on cultural competency treatments have mainly focused on these

populations. [16] As a recognition that mutual understanding between patients and clinicians necessitates the integration of culturally and linguistically competent and Health literate approaches, cultural competence has also come to be linked with health literacy. [17]

Cultural competence and Universal Health Coverage (UHC) go hand in hand, and together they make the model for health equity possible for everyone around the globe. "Universal health coverage signifies that all the people and community can use the promotive, preventive, curative, palliative and rehabilitative health services when needed." [18] UHC also ensures the use of services that are readily available, accessible, acceptable (which includes culturally competent healthcare) and of high quality without exposing the consumer to any financial problems. [19]

Discussion:

1. Definitions

Culture: The shared ideas, meanings and values acquired by individuals as members of society. [20]

Culturally Appropriate: Displaying sensitivity to cultural differences and similarities and showing effectiveness in translating that awareness to action through organizational mission statements, services and communication strategies to disparate cultures. . [22]

Cultural Competence in Health Care: The capability of systems to administer care to patients with diverse beliefs, values and behaviors, including tailoring delivery to meet patients' social, cultural, and linguistic needs. . [21]

Cultural Awareness: Recognition of the differences between one's own and other cultures. [22]

Cultural Diversity: Differences in gender, race, ethnicity, nationality, religion, sexual identity, language, behavior patterns, socioeconomic status, physical ability, beliefs, values, or customs among various groups within a community, organization, or nation. [22]

Cultural Sensitivity: Understanding the emotions and needs of your own culture and the culture of others.[22]

Cultural Humility: A dynamic and lifelong process of self-reflection and self-critique, acknowledging one's biases. [23]

2. The stand of culture in health systems

Back in 2001, the United Nations Education, Scientific and Cultural Organization (UNESCO) defined culture as "the set of distinctive spiritual, material, intellectual and emotional features of society or a social group … [which] encompasses, in addition to art and literature, lifestyles, ways of living together, value systems, traditions and beliefs". It is essential to recognize that here the culture is not only addressed just as a matter of nationality, race or ethnicity – it encompasses both explicit beliefs and practices, as well as subtle and taken-for-granted conventions that define what constitutes normal and abnormal, as well as provide us with a feeling of purpose and direction in life. [24]

Culture affects various aspects of society and life daily. Being one of the social determinants of Health, it influences health beliefs and behaviors, ideas about medication, responses to drugs, gender roles, medical education systems and work environments, all of which are the essential components of a health care system itself. [25]

It is common to refer to diversity in health care as including health care professionals, trainees, educators, researchers, and patients from diverse backgrounds, including race, ethnicity, gender, disability, social class, socioeconomic status, sexual orientation, gender identity, primary spoken language, and geographical region, and in this diversity, each individual requires a health care system capable of recognizing, identifying and meeting their needs. The inclusion of diversity in healthcare systems has become a necessary need that will only grow in the future, supported by statistics. The so-called "minority" populations in the US will take over as the majority in 2043. But only a small number of groups will constitute the majority. The majority group will continue to be non-Hispanic whites. It is anticipated that "minorities," or people who are not of white European heritage, will make up 57% of the population by 2060, an increase from the current 37%. Therefore, we must follow up on cultural impacts and societal changes to ensure an efficient healthcare system. [26]

3. Intercultural-based healthcare professions curricula

Competency-based medical education (CBME) aims to shift programs to an outcomes-based approach. Design a competency-based education is expected to take different steps, including: [27] ● Selecting needed competencies;

- Recognizing to what extent those competencies are required;
- Designing assessment framework;
- Long Term Evaluation of the developed program and its outcomes.

Six (6) core competencies: Interpersonal and communication skills, Patient care, Medical knowledge, Professionalism and Systems-based Practice, and Practice-based learning and improvement, were endorsed in 1999 by the American Board of Medical Specialties (ABMS) and the Accreditation Council for Graduate Medical Education (ACGME) to promote competency-based medical education for physicians in training. The CanMEDS framework, which also encourages competency-based medical education, describes several key competencies, including knowledge, skills and attitudes of healthcare professionals and are elaborated in detail by the enabling competencies. The main aim of CanMEDS is to improve patient care. [28] The CanMEDS model has been adapted worldwide, both within and outside the health professions. In both, intercultural learning falls under different vital competencies.
According to Leclercq (2002), "intercultural education is not so much a matter of teaching something different, but more of teaching differently within the existing curricula." [29] Intercultural education can not be discussed separately as it closely relates to societal changes, politics, economic development, justice, human rights, ecology, and globalization. Healthcare services also have been affected by different aspects of culture. As a result of globalization, preparing medical students for doctor-patient solid relationships with patients from other cultures or confronting culturally related conditions, including intercultural competencies and global Health within medical education, is a valid point to discuss. [30] According to the Lancet Commission on Culture and Health (2014), it is crucial to have a broad understanding of culture in medicine and develop cultural competencies during medical education. [31]

After a study about the role of Intercultural Education at Nelson Mandela University, people of different linguistic and cultural backgrounds now interact more than ever with one another in social and work situations. Student teachers are more prepared with intercultural education with the tools needed to

interact more efficiently in several intercultural problems with their principles, their colleagues, and their students. The role of the educator in facilitating academic inclusion, value and accepting the multicultural reality is critical to find the roads that will promote the advancement of an open mentality to create an actual intercultural dimension to welcome diversity [32]. Once intercultural education is concerned, the problem could be addressed by including a subject separately or extracurricular classes divided into methodological courses, lectures, and study visits to institutions specializing in intercultural education and holding achievements in this field. With the rapidly rising number of international programs worldwide and the research on diversity policies show the necessity for the consideration of intercultural education in higher education for the personal, social and professional challenges [33]

4. High-yield cultural competence strategies through assessment

As a result of teaching culturally appropriate measures at each level of service provision, we can ensure improved patient experiences from the onset of access to the healthcare system to the time after they have availed of desired services. Follow-up and support building is also a part of planning for cultural competence, as well as encouraging leadership roles of minorities and creating resources through training and outlining a plan of action toward achieving the said goals. Collecting and analyzing data on standards of education and the curriculum is required for expanding the educational content. This is an impactful manner of providing culturally specific care with solid implementation techniques. [34] Although several strategies for cultural competency have been implemented, it is still challenging to understand the positive or negative impact patterns. This calls for a thorough and meticulous assessment of previously implemented cultural competencies to understand the way of change and develop improved recommendations. [35] Moreover, to achieve quality patient care and satisfaction with constructive health results, it is necessary that the healthcare providers, organizations, health systems and every major stakeholder work together and in tandem.

5. Significance of interprofessional collaboration

The will of an individual and their actions toward building an understanding between people and encouraging them to adopt an open-minded approach to diverse cultural perspectives is the key to cultural competency. This will help welcome different cultural perspectives, strengthen cultural security and work towards healthcare equality. Cultural competency is essential in human services, particularly in high-degree professional contact with diverse cultures. Pursuing advanced degrees and training in cultural competency is pertinent, especially for those who plan to work in human services. It can be done through effective communication, active listening, identifying prejudice, investigating cultural biases, and involving communities like the refugees/migrants and indigenous and first nation populations actively working on cultural competence. [36] Spending time with the said communities in the academic setting, workshops and training centers will help in achieving the goals and understanding the concept of multiculturalism and cultural competence. [37]

Using a wide range of resources and community members, relationship building is crucial to cultural competence and is based on understanding expectations and attitudes and ultimately building on the strength of each other's knowledge. [38] The cultural competency framework may soon move from the realm of theory into active practice, showing an increasing degree of relevance, awareness and a rising need to eliminate learned biases that emanate from personal behavior. [39, 40] The world, condensing globally, will pave the way to more opportunities for realizing the need for and implementing the strategies to attain a culturally accepting and accommodating world of health care.

6. Cultural Competence and Global Health

6.1 Global mobility of the health workforce and its impact

The global health workforce plays a central role in the health system, as this is reflected in the COVID-19 pandemic, as 66% of the disruption in health care reported globally are from a lack of health workforce. [41] Furthermore, the health workforce is also part of the Sustainable Development Goal 3 (SDG 3) to progress towards sustainability. [42] However, some considerations need to be addressed before diving into the idea of health workforce mobility on an international scale. Inequity might be more transparent through the increased mobility in the health workforce. The study conducted in 2022, based on the data available from the WHO's National Health Workforce Account (NHWA), showed that by 2030, there would be a significant increase amount of the health workforce and a reduction in a health workforce shortage. However, the disparity remains between each region; the inequity is especially stressed in the African and Eastern Mediterranean areas. [42]

Moreover, although global mobility of the health workforce is a promising idea, the stakeholders might also need to consider an essential aspect of transmitting transmissible infectious diseases from the mobility of the global health workforce. As most of the transmission of emerging infectious diseases (EIDs) occurs from traveling, education on the importance of migration and travel issues should also be integrated into the core competencies of medical education and healthcare workers. [43]

6.2 Cultural competence in global Health

The definition of cultural competency is that it goes beyond cultural sensitivity or cultural awareness. Cultural competency displays the ability to not only respect the differences between cultures or to be able to acquire cultural knowledge but also to be able to use them effectively in cross-cultural situations. [44] Cultural competence also plays a significant role in integrating the global Health and health workforce. Cultural incompetence in healthcare can lead to health disparity through discriminatory treatment by healthcare practitioners. [45] Cultural competence has also been adopted as one of the strategies to prevent discrimination, racial and ethnic, in healthcare, by organizing the health system to meet clients' needs. The reason for this idea emerges from the sociocultural barriers identified in the health systems. A review article has identified these barriers at the organizational, structural, and clinical levels. The interventions, for example, the development of interpreter services or healthcare provider education on cross-cultural issues, are used to address the barriers. The disparities in Health are mainly attributed to the social determinants of Health that arise from the differences in cultural status that are external to the healthcare system, some of which are the lower level of opportunities for education or environmental hazard that emerges from the condition of living. All of these disparities will eventually lead to the uninsured status of minorities. [46]

An article in 1990 also stressed the importance of prolonged impacts on racism toward African Americans. The influential sources in American communities started using non-racial terms and methodology to downplay the disparities that arose from the long racism. The tours include "poor work habits," "noncompliance with medical advice," or "ignorance about health," and these are being used in various reports and analyses regardless of the structural inequities as well. [48]

To stress more on this in the clinical setting, the impact of being culturally competent on the level of provider-patient encounter, for example, the linguistic ability of the healthcare provider to converse in the same language with the patient, has proven to be directly linked with the health outcomes from the patient-doctor relationship. [45, 48] This evidence has led to the significant need for a "cultural competence" healthcare system to improve overall health outcomes.

7. Patient safety culture

It was in 2002 when the World Health Organization (WHO) brought the issue of patient safety and quality of care to the forefront of global concern and started an international patient safety movement. [49] In the same year, the organization passed resolution WHA55.18 [50], which urged policymakers of member states to prepare patient safety policies and practices to fight against adverse events in health care.
Among initiatives to advance patient safety, growing interest has been given to patient safety culture.
Research shows that patients from ethnic minority backgrounds are disproportionately at risk of experiencing disparity in the safety and quality of health care they receive compared to the mainstream group. [51]
Culture, as described by the Agency for Healthcare Research and Quality, is essential in assessing the quality and safety of patient-centered healthcare. [52] According to Sammer et al., patient safety culture refers to behavioral attitudes and actions related to patient safety that is expected and suitable to advance patient security. [53] Although the assessment of patient safety culture and the frequency of adverse events have been conducted for decades, according to worldwide literature, studies that correlate both evaluations of patient safety culture and the number of adverse events have yet to be concluded. [54, 55]
As such, patient safety programs have tended to underestimate and understate the critical relationship between language, culture, and the safety and quality of care of patients from minority racial, ethnocultural, and language backgrounds. [56]
Moreover, in keeping with what has been stated as a brand-new 'global agenda' for patient safety in health care [57], a plethora of literature has been published on patient safety. There is, however, an unrecognized and critical gap in the literature concerning patient safety processes pertinent to decreasing the vulnerabilities of patients from minority cultural and language backgrounds. A recent library search of diverse electronic databases (for all years) revealed that using the keywords 'clinical risk management,' patient safety, 'culture,' 'language,' 'health care (and variations thereof), 'ethnic minorities,' there is a lack of literature specifically addressing the vital relationship that exists between language, culture and patient safety, and the particular risks that patients from minority racial, ethnocultural, and language backgrounds face when being cared for by health care professionals who do not know about, share, or understand either their culture or language.

- Communication

According to studies, patient noncompliance, poor patient outcomes, and lawsuits are frequently caused by ineffective provider-patient communication. The behavioral, cognitive, language, environmental, and cultural hurdles that must be overcome may make communication factors in multicultural and minority communities even more important. Clinicians cannot offer the care they have been trained to provide when barriers caused by cultures and languages exist. The ability to provide culturally competent care depends on resolving the institutional and personal cultural disparities that might lead to disputes and misunderstandings. Adverse health consequences may occur if the provider cannot elicit patient information and negotiate appropriate care. [58]

- Bias and Ethnocentrism

Biases can be internalized stereotypes, attitudes or beliefs that can subconsciously or unintentionally shape how healthcare professionals perceive situations, behave and make decisions. These stereotypes or assumptions often result in the unfair treatment of some patients based on race, gender identity, sexual orientation, age, ethnicity, disabilities and other influencing characteristics. Lack of cultural competency, most often but not always brought on by bias, can be shown in the inability to take into

account the terminology, comfort care, and treatments used by people from cultures other than the one of the healthcare provider. [59, 60] Diagnostic mistakes, missed screenings, unexpected adverse medication reactions, harmful treatment interactions from concurrent use of traditional medicines, healthcare-associated infections, poor birth outcomes, and inappropriate care transitions are examples of patient safety adverse events that can occur if these factors are not addressed. [61]

In addition to affecting medical errors, cultural competence can have a powerful effect on another point of patient safety outcomes: patient engagement. Cultural and linguistic competence strategies, such as providing language assistance and using cultural brokers, can promote effective communication with diverse patients, which is vital to engage them as collective partners in their care. Other interferences, like cultural competence training, can increase understanding of what the patient is encountering, give providers skills to create cultural differences, and foster increased trust. [62]

Patient safety policy and program texts must contain explicit and substantive mention of the complexities and implications of culture and language mediating variables in the clinical encounter. Unless such explicit mention is made, the critical link between culture, language and patient safety may be overlooked or minimized as questionable assumptions are made about the capacity of mainstream patient safety programs to improve generally the safety and quality care of all patients regardless of their cultural and language backgrounds. The possible harmful outcomes of this oversight need to be anticipated and their risks reduced if not prevented. [56]

8. Challenges and conflicts

The factors that create gaps in communication between healthcare providers and patients keep growing despite their significance for a culturally competent setup. Some factors include ever-inflating medical technology, expanding sub-specializations, and cultural diversity. The cultural differences between physicians and patients become an issue when either party fails to live up to the cultural expectations of the other. [63] Among the strategies for different healthcare settings, the elimination of linguistic barriers can be done through increasing competency by providing healthcare professionals with linguistic aid at every point, such as medical billing, records and appointment desks as per requirement. [64]

Consequently, cultural competency still needs to be developed regardless of being a fundamental part of medical practice. The main reason behind it is diversity, which is a long and delicate path to navigate. Hence, the most crucial responsibility of current healthcare providers is to equip themselves with skill sets and resources and provide culturally specific and sensitive care to patients and their families. The efforts are ever-increasing with new strategies presented by stakeholders, healthcare professionals, and educators. However, a certain amount of time is needed to gauge the outcomes of the proposed approach and assess their results in building culturally competent setups.

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