TEXTO & CONTEXTO ENFERMAGEM
TEXT & CONTEXT NURSING TEXTO & CONTEXTO ENFERMERÍA

CULTURAL COMPETENCE FOR WORKING WITH REFUGEE WOMEN IN SITUATIONS OF VIOLENCE: THEORETICAL REFLECTION FOR CARE

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ABSTRACT

Objective: to reflect on the contribution of using a Cultural Competence Framework by health professionals in providing care for refugee women in situations of violence.
Method: a reflective study which considered the theoretical model of the Conceptual Framework of Cultural Competence by Balcazar et al., which was developed to work with ethnic minorities with physical disabilities. We suggest the possibilities of incorporating this theoretical model into nursing and health in order to develop better care that respects and supports refugee women in situations of violence.
Results: regarding the existing model, it is understood that the construct of Cultural Awareness needs to be juxtaposed with the desire to engage by the professional to begin the process of becoming culturally competent in order to work with refugee women in situations of violence. The article reflects on the necessary adaptation of current healthcare models, and discusses dimensions that are considered necessary for Culturally Competent Care. These dimensions consist of Universal and Equitable Care, Cultural Care, Contextual Care and Single Care between the professional and the patient.
Conclusion: when cultural competence is understood in its entirety or achieved, it can be called Cultural Intelligence, since cultural thinking and acting will be aligned. These reflections theoretically contribute to the existing Cultural Competence model, and to future researchers who seek evidence of culturally competent procedures and practices to work with women in situations of refuge and violence, demonstrating understanding and respect for population diversity.

DESCRIPTORS: Cultural competence. Migration. Professional practice. Refuge. Violence against women. Nursing. Culturally competent healthcare.

HOW CITED: Gehlen RGS, Paula CC, Padoin SMM, Balcazar FE. Cultural competence for working with refugee women in situations of violence: theoretical reflection for care. Texto Contexto Enferm [Internet]. 2024 [cited YEAR MONTH DAY]; 33:e20240019. Available from: https://doi.org/10.1590/1980-265X-TCE-2024-0019en

COMPETÊNCIA CULTURAL PARA TRABALHAR COM MULHERES REFUGIADAS EM SITUAÇÃO DE VIOLÊNCIA: REFLEXÃO TEÓRICA PARA O CUIDADO

RESUMO

Objetivo: refletir sobre a contribuição do uso, por profissionais da saúde, de um Quadro de Competência Cultural no cuidado a mulheres refugiadas em situação de violência.
Método: estudo reflexivo, que considerou o modelo teórico do Quadro Conceitual de Competência Cultural de Balcazar e colaboradores, que foi desenvolvido para trabalhar com minorias étnicas com deficiência física. Sugerimos as possibilidades de incorporar esse modelo teórico na enfermagem e saúde a fim de desenvolver melhores cuidados que respeitem e apoiem as mulheres refugiadas em situações de violência.
Resultados: sobre o modelo existente, entende-se que, para trabalhar com mulheres refugiadas em situação de violência, o construto da Consciência Cultural precisa estar justaposto ao desejo de engajar-se pelo profissional, para dar início ao processo de tornar-se culturalmente competente. Reflete-se sobre a necessária adequação dos Modelos de Atenção em saúde vigentes, e tecem-se dimensões que se entende serem necessárias para um Cuidar com Competência Cultural, que componham as dimensões do Cuidado Universal e Equitativo, Cuidado Cultural, Cuidado Contextual e Cuidado Único entre o profissional e o paciente.
Conclusão: a competência cultural, quando compreendida na sua totalidade ou alcançada, pode ser chamada de Inteligência Cultural, visto que o pensar e o agir culturalmente estarão alinhados. Estas reflexões contribuem teoricamente ao modelo de Competência Cultural já existente, e para futuros pesquisadores, que buscam evidências de procedimentos e práticas culturalmente competentes para trabalhar com mulheres em situação de refúgio e violência entrecruzados, demonstrando compreensão e respeito à diversidade populacional.

DESCRITORES: Competência cultural. Migração. Prática profissional. Refúgio. Violência contra a mulher. Enfermagem. Assistência à saúde culturalmente competente.

COMPETENCIA CULTURAL PARA TRABAJAR CON MUJERES REFUGIADAS EN SITUACIONES DE VIOLENCIA: REFLEXIÓN TEÓRICA PARA EL CUIDADO

RESUMEN

Objetivo: reflexionar sobre la contribución del uso, por parte de los profesionales de la salud, de un Marco de Competencias Culturales en la atención a mujeres refugiadas en situación de violencia.
Método: estudio reflexivo, que consideró el modelo teórico del Marco Conceptual de Competencia Cultural de Balcazar y colaboradores, el cual fue desarrollado para trabajar con minorías étnicas con discapacidad física. Sugerimos las posibilidades de incorporar este modelo teórico a la enfermería y la salud para desarrollar una mejor atención que respete y apoye a las mujeres refugiadas en situaciones de violencia.
Resultados: respecto al modelo existente, se entiende que, para trabajar con mujeres refugiadas en situación de violencia, el constructo de Conciencia Cultural necesita yuxtaponerse con el deseo del profesional de involucrarse, de iniciar el proceso de volverse culturalmente competente. Se reflexiona sobre la necesaria adecuación de los Modelos de Atención en Salud actuales, y se crean dimensiones que se entienden necesarias para el Cuidado con Competencia Cultural, que conforman las dimensiones de Cuidado Universal y Equitativo, Cuidado Cultural, Cuidado Contextual y Cuidado Único entre los profesionales. y el paciente.
Conclusión: la competencia cultural, cuando se entiende en su totalidad o se logra, puede denominarse Inteligencia Cultural, ya que pensar y actuar culturalmente estarán alineados. Estas reflexiones contribuyen teóricamente al modelo de Competencia Cultural existente, y para futuros investigadores, que busquen evidencia de procedimientos y prácticas culturalmente competentes para trabajar con mujeres en situaciones de refugio y violencia entrelazadas, demostrando comprensión y respeto por la diversidad poblacional.

DESCRIPTORES: Competencia cultural. Migración. Práctica profesional. Refugio. Violencia contra las mujeres. Enfermería. Atención sanitaria culturalmente competente.

INTRODUCTION

Health professionals, including nurses, have the opportunity to assist individuals from diverse ethnic and cultural backgrounds in their daily practice. However, there is a global phenomenon related to the increasing migration flow in which people are forcibly displaced due to violence generated by conflicts and human rights violations[1]. Therefore, refugees demand health services to meet their needs which arise from experiences of violence[2–3].

Such violence permeates a historical process rooted in structural forces and interconnected systems of oppression, which are indicated as determinants of violence[4], and is convergent with the framework of intersectional violence[5]. From this perspective, the structures, the functioning of societies and social determinants generate violence, oppression, inequalities and vulnerabilities in people[6], with emphasis on women in this reflection.

In this context, a refugee woman is a person who has been forced to move due to a crisis in structural, economic and/or environmental conditions, or the political situation of her country of origin, in addition to gender-related violence. Every refugee woman has an experience of violence that needs to be considered when addressing healthcare for her[7,2].

There are problems in providing care to refugee women related to the perspective of the healthcare professional who provides care. Among them, a lack of information about cultural characteristics and the tendency to have an ethnocentric view of healthcare. This may affect the actions of these refugee women who often feel inhibited in seeking support, remain invisible and isolated, or are even discriminated against within healthcare settings[8].

It is important to highlight that these women present health complications and aggravations which require effective care that is consistent with their cultural needs, since such needs may not be addressed in the care practices to which they are subjected in the countries of asylum, generating discomfort and/or disrespect[9]. The cultural norms of their countries of origin, cultural and societal factors associated with social gender roles, customs, language and communication patterns are factors which can limit this population's access to health services[10–11]. Therefore, it will be necessary for health professionals to consider this context in their practice and give it due importance when implementing healthcare.

Prejudices and stereotypes are also frequently present elements, and health professionals are no less susceptible to prejudice than other service providers[12]. This is in line with intersectional violence, in which discriminatory attitudes based on race or ethnicity occur in a structural context. Although the effect of prejudice on patient care may not be immediately apparent, there is sufficient evidence to conclude that the negative impact of explicit and implicit prejudice on marginalized populations in healthcare deserves special attention and urgent interventions[13]. Thus, thinking about a care model for refugee women in situations of violence based on cultural competence first of all requires breaking down the internal (pre)conceptions of the health professionals who care for them.

Therefore, there is an urgent need for health professionals to develop Cultural Competence that is anchored in the holistic paradigm which considers all dimensions of the biological, cultural, social and spiritual person, family and community[14] from the time they are trained. The care model and healthcare based on Cultural Competence can strengthen the Unified Health System (*Sistema* Único *de Saúde – SUS*), which meets the needs of refugees and migrants. It is necessary to overcome the predominant care model marked by the hospital-centric and individualizing conception[11].

The concept of Cultural Competence should be understood as an ongoing process in which the health professional strives to develop their ability to work respectfully considering the patient's cultural context[15]. This occurs when the professional understands, appreciates, recognizes and respects the differences in health beliefs and behaviors that occur within cultural groups and is able

to intervene by adapting their actions to people of different ethnicities[16]. We also believe that when working with multicultural populations in which there are standardized behaviors in different cultures, singularity and individuality need to be the center of care, since there is no universal identity that is often imposed on specific groups[5,17] such as refugees.

In view of the above, the theoretical reflections are based on the results of a Qualitative Systematic Review study, presented in the doctoral thesis18, in which the experiences of health professionals in the care of refugee women in situations of violence were summarized. These reflections are aimed at theoretical contributions to the cultural competence model, so that health professionals, including nurses, can incorporate it into their care practices.

WHERE WE ARE: CULTURAL COMPETENCE CONCEPTUAL FRAMEWORK

The theoretical model that permeates this study is the Conceptual Framework of Cultural Competence developed and validated by Balcazar et al.[18,19], based on studies with ethnic minorities with disabilities (Figure 1). Cultural competence is then presented as a set of constructs consensually aggregated into three dimensions: cognitive, in which attitudes, beliefs and cultural knowledge are considered; behavioral, in which the development of practice in a competent manner is relevant; and organizational support[19].

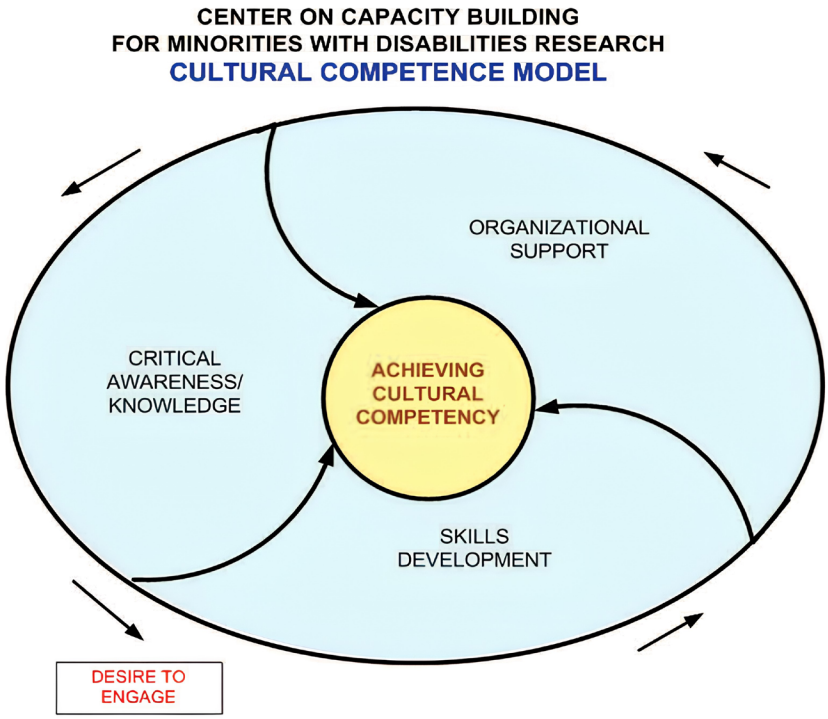

Figure 1 – Cultural Competence Model.
Source: Cultural Competence: Development of a conceptual framework[18].

Cultural awareness refers to the understanding and opinion about culture, recognizing one's prejudices in relation to other cultures; Cultural knowledge refers to the closeness that the professional develops with the stories of other cultures, as well as with characteristics, values, beliefs and behaviors; Competence corresponds to the skills and abilities necessary to adjust the care practice in order to meet the needs of multicultural populations; and Organizational support refers to the need to promote

the capacity of professionals to intervene in a culturally appropriate manner anchored in implementing individual and organizational practices.

The work practice in this proposal[18] begins with the personal desire to engage other cultures, enabling knowledge of different cultures, critical understanding of personal prejudices and the development of skills. This would enable the effective inclusion of people from different cultures and increase the level of organizational support for involvement in culturally competent practices[18,19]. After the model process is initiated by the desire to become engaged, the professional goes through the constructs in a cyclical manner, which should be a continuous and interactive movement in their experience, like a lifelong journey.

WHERE WE ARE GOING: FROM CULTURAL COMPETENCE TO WORKING WITH CULTURAL INTELLIGENCE

Our reflection on the conceptual model is about the possibility of confronting the initial point of the process, such as engagement, when applied to professionals who provide care to refugee women who experience situations of violence. There is also the entire cultural and knowledge burden which involves issues of violence intertwined with the elements of culture. There are beliefs and worldviews of professionals regarding these two elements, which are often limiting in meeting the needs of this population[20,21]. Thus, in view of the theoretical contribution of this article, we present a redesign of the cultural competence model (Figure 2) which emerged from reflections anchored in the results of the initial study.

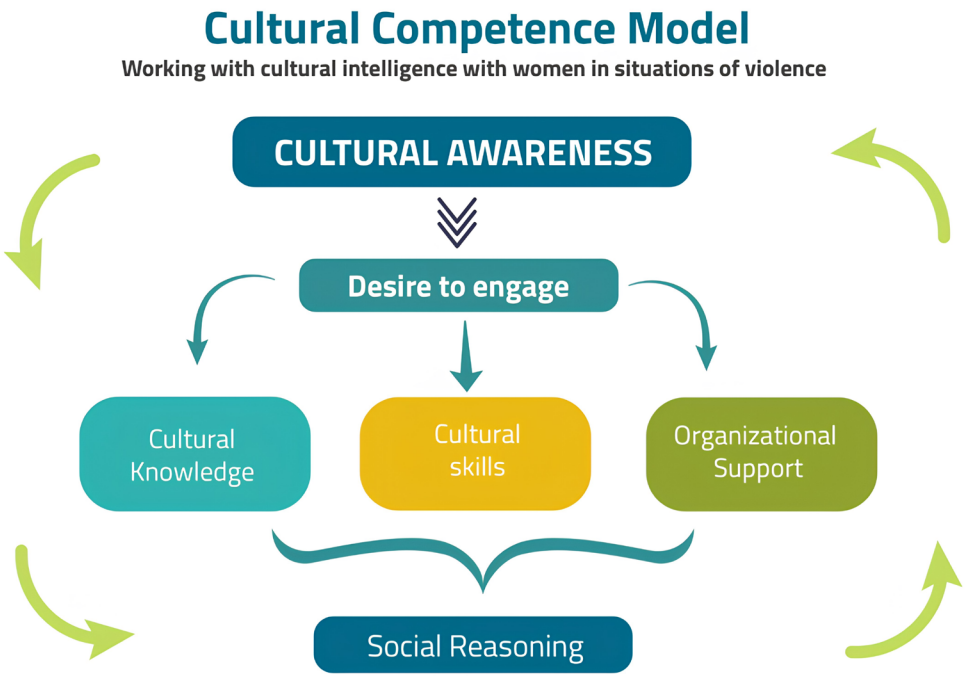

Figure 2 – Redesigning the Cultural Competence Model.
Source: adapted[18].

Thus, we believe that the Cultural Awareness construct needs to be juxtaposed with the desire to engage in order to begin the process of becoming culturally competent. Without a critical understanding and awareness that there are other cultures besides one's own, that social markers – such as culture – build privileged positions in society, including class differences and experiences of

oppression and violence, and without a critical reflection of our preconceptions regarding people who are in contexts different from ours, the probability of engaging in cultural competence will be very low.

The development of a reflective cultural awareness therefore allows the professional to become aware of care engagement within a cultural framework, permeating the other three constructs. When this occurs, we understand that this professional is able to perform care based on dynamic cultural reasoning, or beyond that, with Cultural Intelligence, since thinking and acting culturally will be aligned. Then, cultural intelligence will consequently enable developing social reasoning to work with multicultural and multiethnic populations.

In the course of providing care to people, nursing (along with other health areas) focus on care based on clinical reasoning, with the ability to develop social reasoning generally being neglected. Thus, regardless of the context in which they work, professionals need to consider: Who is the population under my care? What are the cultural, contextual aspects and intersecting social markers that involve their care? The ability to exercise social reasoning is a skill that needs to be practiced and applied, and it needs to go beyond a broad understanding of the social markers of differences[22–23] that intersect, exacerbating already aggravated situations, especially when there are intersecting social markers that cause stereotypical identities – as is the case with refugee women[17].

In the wake of social markers, it is important to clarify that these are determining components in our society that, in a certain way, sustain prejudices, stigmas and discriminatory behaviors in social relationships, both in the public and private spheres[22–23]. Violence against women in refugee situations and health disparities cannot be fully understood without examining how they intersect with social markers of difference. We agree that difference markers generate oppression and are socially constructed, being related to issues of gender and culture, in addition to race, ethnicity, nationality and socioeconomic status. Thus, examining an issue without considering oppression patterns results in an incomplete analysis.

In turn, consciousness gives rise to cultural competence, as it is not enough to appropriate cultural competence concepts only at the theoretical and discursive level. When applied in the field of health and nursing, it is essential that this construct critically and consciously integrates and operationalizes the action of caring for people, which implies understanding the human essence and the meaning of caring for oneself and others, in order to proceed with the most appropriate conduct[24].

In this context, the relevance of this redesign of the cultural competence model aimed at professionals who work with refugee women lies in the fact that appreciating and understanding a culture firstly involves an analysis of one's own prejudices in relation to the Other[25], recognition of the otherness present in each subject and the recognition that there are privileged positions in society, and that culture, as a social marker, intersected with other markers, has a determining action in society regarding its positioning on the social map[26].

In this sense, the presence of cultural awareness is also reflected (among other things) in the construction of empathy for the Other[25] and in their acceptance. Care must reside in respect and consideration for the patient in the sphere of the subject-citizen[27] and respecting their existence and otherness. Thus, care needs to be individualized, affectionate and humanized, regardless of whether we recognize ourselves in the other, under the risk of committing injustices and lacking care. Thus, empathy is built by the genuine desire to care and accept based on the recognition that the Other carries within themselves the singular need for health, which is legitimate. And therefore, we understand that cultural awareness has the potential to spread constructions of empathy and acceptance.

WHAT WE WANT: TO PROVIDE CARE WITH CULTURAL COMPETENCE

Caring is essential for life, well-being and dignity in the face of violence. It is argued in a fine line that culture is the essential basis for care and care encounters. The four constructs of cultural

competence enable the health professional to develop the ability to provide Cultural Care, which is understood as “caring in a given culture”, and must be dynamic, even if there are common characteristics.

It is reflected that cultural care varies over time (i.e. it changes across generations and changes in encounters with other cultures), undergoing acculturation processes. External circumstances, such as education and the economy, can also influence care. Therefore, it is important that health professionals, including nurses, be cautious when applying care theories, avoiding cultural generalizations, and considering the individual needs and circumstances of each patient. Care varies in different cultures and contexts. There are different traditions and care practices expected in providing assistance and healthcare to women in situations of violence in different cultures.

When the health professional respects the woman and has some knowledge of her culture, she dares to ask sensitive and difficult questions. When genuine interest is demonstrated, along with specialized knowledge and empathy, trust and bonding are formed and the chances of the woman talking about her real experience and needs increase[28]. In view of this, especially considering how Cultural Intelligence is fundamental to developing a healthcare model, a Cultural Care approach was developed for refugee women in situations of violence with the purpose of providing guidance and reflections for a care model with cultural competence. Intercultural care does not occur automatically in the relationship between professional and patient; it requires knowledge and prior planning.

Therefore, in order to adapt the current Healthcare Models – which correspond to the way in which the institution and professionals organize themselves and consider the care itself, the way in which care encounters occur and the technology offered for this sector – it is necessary to reflect that a care model that contemplates a Cultural Framework needs to encompass some care dimensions. In turn, this study presents four dimensions that are understood to be necessary for care that respects and is guided by a cultural framework, which comprises the dimensions of Universal and Equitable Care, Cultural Care, Contextual Care and Single Care between the professional and the patient.

Universal care is independent of time and place, and contemplates dignity, respect and cultural safety. It must focus on approaching human rights, in which the dignity of the human being is respected regardless of origin, since the country of birth – which is an involuntary act of the person – cannot be decisive in guaranteeing healthcare, or access to any of their human rights. In fact, there can be no single determinant; access must be full and absolute. Likewise, equitable care must guide care, taking into account the particularities and individual needs of each woman, even if they belong to the same ethnic group. It is important that the professional understands the distinction between an “equitable care” and an “equal care” approach, prioritizing equity over equality with multicultural populations.

Cultural care means that cultural capital, cultural factors and other basic factors (i.e. social, economic, educational, etc.) are taken into account, as well as the woman’s personal desire to acculturate or not, and access to care and the violence-fighting network. From the professional’s perspective, it means that care is provided with Cultural Intelligence and management of one’s own cultural context so that it does not influence the care provided, developing skills to work with multicultural populations, gender equality and acculturation, and changing the care standard for women in situations of violence, adapting healthcare and the culture of care according to the woman’s needs. Contextual care means recognizing the contexts in which these women are inserted, and outlining analyses to assess whether this context behaves as a support network or as a context of violence. Furthermore, from the professional’s perspective, changes are needed in the work process and in the spaces where care is provided, so that they are welcoming and offer privacy. Single care means that communication works, the woman is respected and her needs are met, and then trust can be built. The single care perspective is highlighted in caring activities such as listening to the woman’s story, being flexible, empathetic, being willing to understand the life situation and help her, being non-judgmental, resolving conflicts, maintaining continuity and the relationship.

It can be inferred that if these four dimensions are considered, there is the possibility of promoting health and well-being, alleviating suffering, and establishing networks to combat violence, even if it is a slow journey through work and the established bond. There may be fewer misunderstandings and conflicts, fewer negative experiences, and the care relationship will be maintained, even if the professional does not agree with the woman on all issues.

The professional's ethical conflicts in relation to the patient's culture need to be managed and discussed in multidisciplinary teams to reach a resolution and not leave the woman without care. Cultural shock and awareness of the life stories told by women cannot be factors which prevent care provision to them. If this is too difficult for the professional, multidisciplinary work is highly valued. Thus, the ethical commitment of the health professional to work independently of cultural shock and external circumstances is reaffirmed.

Three contexts of external circumstances that can influence care practice by the professional are also mentioned. Thus, care is influenced by society in general, by the woman's ethnic community and by the woman's immediate environment. In the context of society, political and economic circumstances, acts, decrees and recommendations that affect the ability to care for her stand out. For example, there may be political acts and decisions (local or national) that make it difficult to assist refugee women.

There may be ethnic figures in the community context, such as community and religious leaders or counselors influencing women and their families on issues of violence. The ethnic community plays a fundamental role in the decision to initiate the Critical Route[29] and break violence cycles. The stigma and ostracism that many communities impose on women when they decide to report violence is still a major obstacle to caring for them. Family members are key elements in the context of the woman's environment, both her own family and that of her husband/partner, who are often also perpetrators of violence.

The experience of caring expresses the relationship between the health professional and the woman, and conflicts and negative experiences in intercultural care encounters can lead to changes in the care culture in which the woman is cared for, or in the unique care that the woman receives, when the professional understands the meaning of caring or the woman's life situation. It may also happen that the woman begins to trust the professional and changes her attitude towards him/her in care encounters. Finally, it is reflected that cultural competence comes from a continuum of personal experiences, in-depth knowledge and acquired professional skills. The professional develops cultural intelligence permanently in practice and in reflection on this practice.

CONCLUSION

The four constructs of the conceptual model form a necessary set to achieve cultural competence; therefore, they are inseparable and complementary. Thus, when cultural competence is understood in its entirety (with regard to the four interconnected constructs) and achieved, it can be called Cultural Intelligence, since cultural thinking and acting will be aligned. In this context, cultural intelligence refers to the ability of professionals to become culturally competent to promote Cultural Care based on social reasoning and understanding.

Developing cultural intelligence in the work practice of health and nursing enables guiding professional to conduct and assist in developing care strategies which are compatible with the worldviews of the people receiving care, which in turn implies in ethical commitment of the health professional to develop care regardless of the person's culture or external circumstances.

Therefore, it is necessary to recognize that respecting culture during care can be a complex and challenging issue, because if this culture is permeated by violence, machismo, and sexism, it can be considered that there is a violation of human rights, and then there will be conceptual conflicts. It is in this sense that this article contributes to health, because cultural intelligence should permeate care for multicultural populations, and the skills to work with social reasoning and cultural intelligence need to be permanent professional objectives for qualifying and improving practical skills.

The care delivery models and the attitudes and behavior of health professionals are an important target area for researchers. In this line of thought, implementing this framework needs to be tested and evaluated in order to advance the frontier of knowledge and also eradicate unfair healthcare. This affects the contribution to society, since redesigning Cultural Competence can be the basis for guiding people's healthcare processes, promoting an awakening of cultural awareness and engaging health professionals in a professional and personal stance of culturally competent care as a lifelong journey.

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NOTES

ORIGIN OF THE ARTICLE

Article extracted from the thesis – *Experiências de competência cultural de profissionais de saúde na atenção às mulheres refugiadas em situação de violência: Revisão Sistemática Qualitativa*, presented to the Postgraduate Program in Nursing, *Universidade Federal de Santa Maria*, Brazil, in 2023.

CONTRIBUTION OF AUTHORITY

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CONFLICT OF INTEREST

There is no conflict of interest.

TRANSLATED BY

Christopher J. Quinn.

HISTORICAL

Received: January 16, 2024.
Approved: July 31, 2024.

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