Review the following terms to develop a more detailed and functional understanding of culture that can be applied to work with any population.

**Culture Is Interrelated Systems**
- Personal and social behavior, roles
- **Beliefs**, world view (e.g., morality, health)
- Social organization—family, institutions
- Ways of making a living, economy
- Psychological orientations, emotions
- Knowledge needed to function effectively
- Group identity and language
- Meaning, values, goals, expectations

Culture shapes the world in ways that seem “natural”—such as the economy and skills for making a living. Each culture has characteristic patterns that can be seen in many areas of life.

**Characteristics of Culture**
- **Shared** by a group of people
- **Learned** (not genetic)
- **Changes** over time
- **Seems natural and morally correct** to group members
- Provides a *repertoire* of values and possibilities for behavior and understanding
- People *draw on their cultural repertoires* in different ways, in different situations

**Shared**—need to define what is shared by which members
**Learned**—no matter how much it seems a part of people’s basic nature
**Changes over time**—not just when people immigrate, but naturally in one place
**Seems Natural And Morally Correct**—all cultures are ethnocentric, and make judgments about others. Not every culture has the ideal of valuing other cultures, but that is the value that promotes cultural humility and curiosity for cross-cultural learning.

**The Culture of U.S. Health Care**
- Based on biomedicine
- Requires professional training
- Involves a systematic socialization process
- Reflects specific values and practices of larger culture
  - Presumes “good will” and “acting for the good of all” are universal values, that are understood and shared by everyone—and that this value is a motivating factor for cooperating with the Health Department and for acting altruistically by naming partners
  - Appointments, punctuality
  - Patient is actively involved in decision making and prevention activities
- Shaped by national and local economic and political forces—access, insurance
- Prioritization for programmatic focus based on epidemiologic research
- Uses standards and protocols—systematized
CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 1: DEFINITIONS TO BUILD A FRAMEWORK FOR CULTURAL COMPETENCE

A CULTURAL GROUP / SUBGROUP / SUBCULTURE—PEOPLE WHO

- Share common experiences
- Express a shared identity
- Speak the same language
- Have a shared history
- Draw from same cultural “repertoire”
- May occupy same socioeconomic and political place in society
- Not every member has identical beliefs, behavior, experience, and knowledge
- Every culture has subcultures which share specific experience, knowledge, expectations, beliefs, skills, etc.

EXAMPLES OF CULTURAL GROUPS—WE ARE MEMBERS OF MANY AT ONCE

- “Mainstream” U.S. culture
- Ethnic groups—share history, and identity
- Subgroups of “mainstream” U.S. culture
  - age groups / generations
  - gender identities
  - sexual / affectional orientations
  - socioeconomic differences
  - rural / urban
- People born outside the U.S. and 2nd generation immigrants
- Racial groups—because race is part of identity and a source of inequalities
- Regional groups within a country
- Occupational/professional groups—health care staff
- Experiential subcultures (corrections, substance use, homeless)

THE LIMITS OF DEMOGRAPHIC CATEGORIES

Race and ethnicity are socio-political terms used by US government for census and epidemiologic data. Race is a concept based on faulty definitions of human diversity (i.e., not scientifically defined categories of physiology). Race confuses observed physical differences with differences in behavior, but has important social effects that structure health access.

Culture is not the same as race / Race is not the same as ethnicity

Europeans, North & South Americans, Australians
African-Americans, Afro-Caribbeans (Haiti, Cuba, Jamaica), Afro-Latinos (Brazil), Africans
Hispanic culture includes European, African descent (and indigenous—what race?)

Ethnicity is only part of Culture

Hispanic ethnicity includes all cultures of Mexico, Central & South America, Spain
Subcultures within ethnic groups share heritage and language—differ by gender, age, religion

Language is only part of Culture

Arabic language is spoken in countries from Saudi Arabia to Iraq to Sudan
Malay (Malaysian/Indonesian) is spoken in Malaysia & Indonesia, often as a second language
English is spoken in England, U.S., Australia, New Zealand, Canada, Ghana, Nigeria, Kenya
This is an example of a small population which an HIV/AIDS (or STD) program would not have had to work with before. However, these immigrants are part of a high priority, high risk population that needs some very specific interventions.

Case Study

African immigrants & refugees are 1% of population in Minnesota, but:
- 21% of new HIV infections, many identified at AIDS diagnosis
- 53% of new infections in women
- Countries of origin—Ethiopia, Liberia, Kenya, Cameroon, Somalia, Uganda
- Ethnic groups—Oromo, Somali, Ethiopian, Sudanese, Tigrinya
- Languages—Oromo, Somali, Tigrinya, Swahili, Arabic
- Religions—Christian (Coptic & Protestant), Muslim, Waaqqeta (traditional Oromo)
- Cultural Challenges: language barrier, distrust of providers/interpreter to keep confidentiality, unfamiliar with health care system, gender roles, religious judgments

Interviews with community leaders, focus groups, and individuals living with HIV/AIDS revealed:
- people respect their religious leaders and
- religious leaders reinforce community members’ prejudices and misinformation about HIV/AIDS
- However, any successful interventions will need to work with the religious leaders, and will probably have to start with them to be effective in changing people’s attitudes and health-seeking behavior.

Disparities Analysis

Structural factors—new immigrants, unfamiliar with health care system, unaware of treatments, very dependent on their community and members of same ethnic group for social & personal support, and for economic support in adjusting to new living situation. Most have no health insurance.

Patient-level factors—men and women had different understanding of their risk factors, different roles in seeking care, different meanings of HIV to each

Provider-level factors—no providers from ethnic group; existing providers didn’t know how to do outreach

Cultural barriers—gender roles of women tied to childbearing, focused on home, so HIV prevention that was also contraception was not effective; gender roles of men emphasized public roles, stigma of HIV/AIDS, belief that there was no treatment, worry about being ostracized if HIV/AIDS status known

Possible Strategies for Attitude and Behavior Change

It is important to see cultural “barriers” as possible keys to behavior change. It is rarely possible to change a core element of culture, but sometimes community leaders can help to reframe a message and lend their moral authority, to motivate people to change their views and behavior.

An example of what initially was a cultural barrier becoming a key to behavior change and program success is family planning in Indonesia, which has one of the world’s most effective family planning program. However, there initially was resistance from Muslim individuals and religious leaders. Discussions with Muslim leaders led to them coming to consider family planning as consistent with Islam and they then supported the national family planning program.

http://www.guttmacher.org/pubs/journals/3002704.pdf

CULTURAL COMPETENCE IN STD PROGRAMS
HANDOUT 3: ETHNOMEDICINE AND THE CULTURAL CONTEXT OF ILLNESS

Etiquette: Introductions and rapport

- Biomedical doctors & patients discuss symptoms;
- Shamans may consult family members for details of patients’ lives;
- Herbalists may know patient, focus on symptoms

Etiquette: How an interview begins is important, so learning and following some basic etiquette helps to establish trust. What name one uses to talk to patients is very important—find out whether to use first or last name, or not to address the person by name. Find out what is respectful. Find out what kinds of questions are expected when people meet—in Indonesia, “Are you married?” “How many children do you have?”. In some cultures, you may need to talk about something besides personal questions, or illness for a while until people are comfortable, and then start the “actual interview.” Most of us do these things, but biomedical culture in the U.S. is very direct and frank, so we may need to spend more time on preliminaries than we are used to. Not seeming rushed can be very important.

Roles and relationships of healers and patients

- Doctors impart bio-medical knowledge
- Shamans perform ceremonies at patients’ homes
- Herbalists prepare plant recipes
- Massage therapists make home visits.
- Patients could be active, assertive and advocate for themselves
- Patients could rely on family members to understand information about illness and make decisions,
- Patients could rely on shamans to find out things from spirits
- Patients could rely on herbalists for medicine and/or making treatments oneself

Roles: Medical sociologists and anthropologists also describe the behavior expected of patients, family members, and healers as their roles. Understanding something about what motivates patients’ and their families’ behavior, and what they expect from a healer helps to tailor our behavior so that it makes sense to the patient, or to realize what the patient may not understand about our behavior.

Beliefs about the cause of illness/disease vary across cultures and subcultures

- illness caused by germs
- supernatural (ancestors)
- witchcraft (evil eye)
- environment (wind)
- patient’s emotions (shock, fright)
Illness also could be a punishment from God. Or people may have a sense that illness is caused by eating bad food, or the wrong food—sometimes there is an understanding of illness as an imbalance of eating the too much of a “hot” or “cold” food.

Many times not one-to-one word or concept corresponds to disease terms. Because language describes how we understand the world, our word for Syphilis, which is a specific set of symptoms over a particular period of time, may not match how a patient understands what is wrong with him or her. In an interview, it can be helpful to explain germ theory, and why certain tests are done, but also to acknowledge that the patient has other explanations. Patients don't have to accept the biomedical explanation, or to accept it exclusively, in order to agree to take medication.

Treatment practices across cultures

- Exam/diagnosis by bacterial culture
- Shamanic ceremony
- Figuring out who has a grudge
- Treatment by medication
- Prayer or sacrifice
- Making amends to someone

Biomedicine looks for the bacteria or viruses. Shamanic ceremonies contact spirits and ask them what or who is causing the illness, and what should be done to treat it. Someone who understands witchcraft may be able to figure out who has caused someone to become sick, and why. Treatment follows from the cause of illness in each of these cases. For example:

- Medication to kill bacteria.
- Offerings to spirits to tying a string to the body to keep the soul
- Making amends to someone who is jealous, or casting a spell back on them
Questions to ask patients

These questions can help gather information to understand the patient’s perspective, to figure out how to best share information, and demonstrate that you want the best outcome for the patient and you are willing to work with them to achieve that.

- What do you feel is the most pressing problem?
- What does the medical diagnosis/treatment/prevention recommendation mean to you (cognitively, emotionally, socially, economically)?
- What special requirements and limitations do you anticipate?
- What are your goals for treatment/prevention? What do you want to gain? to avoid?
- What range of healing/health maintenance resources are you familiar with, and which do you feel are applicable to this situation?
- What level of priority do you assign to the medically indicated course of action when weighed against other personally important life goals and constraints?
- What is important to your sense of self or identity?
- What are your expectations of sick people and their caregivers?
- Who do you feel should be in charge of decisions and actions that affect the patient?
- Who is considered family and how is kinship defined?
- What do you feel is the proper (or essential) role of family members and significant others? Of health professionals?
- What do you define as an appropriate decision making process? Who needs to be involved?
- What sources of authority do you recognize and respond to? Where do health professionals fit in your authority hierarchy?

Source: O'Connor, Promoting Cultural Competence in HIV/AIDS Care
**Cultural Competence in STD Programs**  
**Handout 5: Patient Centered Care and Culturally Competent Care: Two Complementary Approaches**

Patient-centeredness and cultural competency share the overarching goal of improving the quality of health care by integrating the patient’s perspective. Both approaches include criteria for patient-provider interactions as well as service delivery. Many insights and principles that are central to the concept of patient centeredness are also essential elements of cultural competency. In essence, patient-centeredness involves viewing health care from the patient’s perspective and then adapting care to more closely meet the needs and expectations of patients. Patient centered care focuses on individualized care personal relationships. Like cultural competency, patient centeredness refers to aspects of provider-patient interaction as well as to characteristics of health care systems.

### Patient-Centered Approach

<table>
<thead>
<tr>
<th></th>
<th>Culturally-Competent Approach</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Sees the patient as a unique person</td>
<td>✓ Uses interpreters effectively to improve communication and gain an understanding of the patient as a unique individual</td>
</tr>
<tr>
<td>✓ Views the diagnosis and treatment from the patient’s perspective</td>
<td>✓ Recognizes the role that culture plays in health and illness, and values diversity in culture</td>
</tr>
<tr>
<td>✓ Builds a trusting relationship between provider and patient</td>
<td>✓ Seeks out information or resources about other cultures in order to establish common ground with patients</td>
</tr>
<tr>
<td>✓ Incorporates patient needs, preferences, and patient values into treatment plans</td>
<td>✓ Develops treatment plans that are congruent with explanations of diagnosis, appropriate treatment, and desired outcomes</td>
</tr>
</tbody>
</table>

### Patient-Centered Health Care System

<table>
<thead>
<tr>
<th></th>
<th>Culturally-Competent Health Care System</th>
</tr>
</thead>
<tbody>
<tr>
<td>✓ Offers patient education materials appropriate to patient populations</td>
<td>✓ Provides interpreter services and patient materials in appropriate languages and literacy levels</td>
</tr>
<tr>
<td>✓ Allows for the coordination of diverse services into a continuum of care</td>
<td>✓ Provides on-going staff training issues related to cultural competence</td>
</tr>
<tr>
<td>✓ Promotes overall well-being as well as treats specific conditions</td>
<td>✓ Develops its work force to reflect major patient groups served</td>
</tr>
<tr>
<td>✓ Provides services that are easily accessible and convenient for patients</td>
<td>✓ Partners with community groups to offer services that meet population priorities, needs, and preferences</td>
</tr>
</tbody>
</table>

Providing interpreters for limited English proficient clients whenever needed and at the client's request, free of charge, not only improves clinical outcomes and patient satisfaction, it is the law.¹

Who Must Comply and Who Can be Found in Violation?

All programs and operations of entities that receive assistance from the federal government, including:
- State agencies
- Local agencies
- Private and nonprofit entities Subrecipients (entities that receive federal funding from one of the recipients listed above) also must comply.

Title VI of the 1964 Civil Rights Act

"No person in the United States shall, on the ground of race, color or national origin, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under any program or activity receiving federal financial assistance." 42 U.S.C. § 2000d.

The United States Supreme Court in *Lau v. Nichols* (1974) stated that one type of national origin discrimination is discrimination is based on a person's inability to speak, read, write, or understand English.

Federal Legal Mandates—The Americans With Disabilities Act of 1990 (ADA)

- Improves on Rehabilitation Act of 1973
- Requires ALL public & private buildings, programs, services & employment, be equally accessible.

Federal Standards for Culturally and Linguistically Appropriate Services (CLAS)
http://www.omhrc.gov/assets/pdf/checked/finalreport.pdf

- 14 standards are organized by themes
  - Culturally Competent Care (Standards 1-3)
  - Language Access Services (Standards 4-7)
  - Organizational Supports for Cultural Competence (Standards 8-14).

- Within this framework, there are three types of standards of varying stringency
  - mandates
  - guidelines
  - recommendations