Cultural Competence and HIV

(updated June 2023)

AETC AIDS Education & Training Center Program New England

Cultural Competence and HIV

This educational packet is a curated compilation of resources on Cultural Competence and HIV.

The contents of this packet are listed below:

- Health Equity Guiding Principles (CDC)
- Key Principles for Inclusive Communication (CDC)
- Health Equity Considerations for Developing Public Health Communications (CDC)
- Using a Health Equity Lens (CDC)
- CLAS, Cultural Competency, and Cultural Humility (Think Cultural Health, HHS Office of Minority Health)
- RESPECT Model (Think Cultural Health, HHS Office of Minority Health)
- Combating Implicit Bias and Stereotypes (Think Cultural Health, HHS Office of Minority Health)
- Communication Styles (Think Cultural Health, HHS Office of Minority Health)
- Effective Crosscultural Communication Skills (Think Cultural Health, HHS Office of Minority Health)
- How to Better Understand Different Social Identities (Think Cultural Health, HHS Office of Minority Health)

You may wish to customize this packet to meet the needs or interests of particular groups, such as event participants, providers, patients, clients, or the general public. So please feel free to distribute all or part of this document as either a printout or PDF.

CDC'S Health Equity Guiding Principles for Inclusive Communication

CDC's Health Equity Guiding Principles for Inclusive Communication are intended to help public health professionals ensure their communication work, including communication of public health science, meets the specific needs and priorities of the populations they serve and addresses all people inclusively, accurately, and respectfully. These principles are designed to adapt and change as both language and cultural norms change.

Why do words matter for health equity?

Language in communication products should reflect and speak to the needs of people in the audience of focus, using non-stigmatizing language. This means:

- Using a health equity lens when framing information about health disparities
- Using person-first language and avoiding unintentional blaming
- Using preferred terms for select population groups while recognizing that there isn't always agreement on these terms
- Considering how communications are developed and looking for ways to develop more inclusive health communications products
- Exploring other resources and references related to health equity communications.

How can I help?

CDC encourages all public health professionals at the federal, state, and local levels to look for opportunities to apply these ***Guiding Principles*** across their public health communication work, including when creating information resources such as scientific publications and public health recommendations, and when engaging with communities, partners, and staff.

Learn more: https://www.cdc.gov/healthcommunication/Health_Equity.html.

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention

CS 328419-A December 07, 2021

CDC's Health Equity Guiding Principles: Using a Health Equity Lens

Using a health equity lens in communication planning, development, and dissemination means intentionally looking at the potential positive and negative impacts of proposed messages on everyone with the goal to be inclusive, avoid bias and stigmatization, and effectively reach intended audiences, ideally with input from those intended audiences. Consider the following concepts:

Health equity concept…	This means…
Long-standing **systemic social and health inequities** have put some population groups at increased risk of getting sick, having overall poor health, and having worse outcomes when they do get sick.	• Avoiding perpetuating health inequities in communication by considering how racism and other forms of discrimination unfairly disadvantage people. • Avoiding implying that a person, community, or population is responsible for increased risk of adverse outcomes.
Community engagement should be a foundational part of the process to develop culturally relevant, unbiased communication for health promotion, research, or policy making.	• Remembering that successful community engagement is a continuous process that builds trust and relationships through a two-way communication process. • Starting with mindfulness and listening and continuing with joint decision making and shared responsibility for outcomes.
Health equity is **intersectional**; diversity exists within and across communities and can be defined by several factors.	• Remembering that people belong to more than one group and, therefore, may have overlapping health and social inequities, as well as overlapping strengths and assets. • Understanding that there is diversity within communities and members of population groups are not all the same in their health and living circumstances. • Acknowledging that communities can vary in history, culture, norms, attitudes, behaviors, lived experience, and many other factors.
Public health programs, policies, and practices are more likely to succeed when they **recognize and reflect the diversity of the community** they are trying to reach.	• Using language that is accessible and meaningful and tailoring interventions based on the unique circumstances of different populations. • Emphasizing positive actions and highlighting community strengths and solutions. • Recognizing that some members of your audience of focus may not be able to follow public health recommendations due to their cultural norms, beliefs, practices, or other reasons.
Not all members of your audience of focus may have the same level of **literacy** and, **specifically, health literacy**.	• Recognizing both the ability to read and the ability to understand the content in the language presented. • Using active verbs, plain language, and accessible channels and formats so that all members of your audience can access and understand the information.

Learn more: https://www.cdc.gov/healthcommunication/Health_Equity_Lens.html.

Key Principles for Inclusive Health Communication

Some overarching principles to consider, including written and oral dissemination of information:

Avoid use of adjectives such as vulnerable, marginalized, and high-risk.

These terms are vague and imply that the condition is inherent to the group rather than the actual causal factors. Consider using terms and language that focus on the systems in place and explain why and/or how some groups are more affected than others. Also try to use language that explains the effect (i.e., words such as impact and burden are also vague and should be explained).

Instead of this…

- Vulnerable groups
- Marginalized groups
- Hard-to-reach communities
- Underserved communities
- Underprivileged communities
- Disadvantaged groups
- High-risk groups
- At-risk groups
- High-burden groups

Try this…

- Groups that have been economically/socially marginalized
- Groups that have been marginalized
- Communities that are underserved by/with limited access to [specific service/resource]
- Under-resourced communities
- Groups experiencing disadvantage because of [reason]
- Groups placed at increased risk/put at increased risk of [outcome]
- Groups with higher risk of [outcome]

For scientific publications:

- Disproportionately affected groups
- Groups experiencing disproportionate prevalence/rates of [condition]

Avoid dehumanizing language. Use person-first language instead.

Describe **people** as having a condition or circumstance, not being a condition. A case is an instance of disease, not a person. Use patient to refer to someone receiving healthcare. **Humanize those** y**ou are referring to by using *people* or *persons*.**

Instead of this…

- Diabetics
- Diabetes patients
- The diabetes population
- The obese or the morbidly obese
- The homeless
- Disabled person
- Handicapped
- Inmates
- Victims of abuse
- Cases (when referring to affected persons)
- Individuals
-

Try this…

- People/persons with [disease]
- Patients with [disease] (if referring to people who are receiving healthcare)
- People experiencing [health outcome or life circumstance]
- People with HIV
- People with obesity; people with severe obesity
- Patients or persons with COVID-19
- People who are experiencing homelessness
- People who are experiencing [condition or disability type]
- Person with mobility disability
- Person with vision impairments
- People who are incarcerated
  Survivors [of abuse, cancer, violence]

Remember that there are many types of subpopulations.

Use of the term minority/minorities should be limited, in general, and should be defined when used. Be as specific as possible about the group you are referring to (e.g., be specific about the type of disability if you are not referring to people with any disability type).

Instead of this…

- Minorities
- Minority
- Ethnic groups

- Racial groups
- Disability Groups

Try this…

- Specify the type of subpopulation:
    - (People from) racial and ethnic groups
    - (People from) racial and ethnic minority groups
    - (People from) sexual/gender/linguistic/religious minority groups
    - (People with/living with) mobility/cognitive/vision/hearing/independent living/self-care disabilities

Avoid saying target, tackle, combat, or other terms with violent connotation when referring to people, groups, or communities.

Avoid saying target, tackle, combat, or other terms with violent connotation when referring to people, groups, or communities.

These terms should also be avoided, in general, when communicating about public health activities.

Instead of this…

- Target communities for interventions
- Target population
- Tackle issues within the community
- Aimed at communities
- Combat or fight against [disease]
- War against [disease]

Try this…

- Engage/prioritize/collaborate with/serve [population of focus]
- Consider the needs of/tailor to the needs of [population of focus]
- Communities/populations of focus
- Intended audience
- Eliminate [issue/disease]
  Prevent/control [disease]

Avoid unintentional blaming.

Consider the context and the audience to determine if language used could potentially lead to negative assumptions, stereotyping, stigmatization, or blame. However, these terms may be appropriate in some instances. Do not assume that people are refusing or choosing not to participate in a behavior or access a service – access, acceptability, or other structural issues may play a role.

Instead of this…

- People who refuse [vaccination/specific behavior]
- Workers who do not use PPE
- People who do not seek healthcare

Try this…

- People who have yet to receive/do [vaccination/specific behavior]
- People with limited access to [specific service/resource]
- Workers under-resourced with [specific service/resource]

Page last reviewed: May 23, 2023
Content source: Centers for Disease Control and Prevention

CLAS, cultural competency, and cultural humility

You can improve your quality of care by understanding, respecting, and responding to a patient's experiences, values, beliefs, and preferences. Several concepts can help us understand how to do this: CLAS, cultural competency, and cultural humility.

Culturally and linguistically appropriate services (CLAS) refers to services that are respectful of and responsive to individual cultural health beliefs and practices, preferred languages, health literacy levels, and communication needs. CLAS should be employed by all members of an organization (regardless of size) at every point of contact. CLAS helps you meet the six aims for improving health care quality: the delivery of care that is safe, effective, patient-centered, timely, efficient, and equitable.

At the provider level, providing CLAS means practicing cultural competency and cultural humility.

Cultural competency is a developmental process in which one achieves increasing levels of awareness, knowledge, and skills along a continuum, improving one's capacity to work and communicate effectively in cross-cultural situations. Strategies for practicing cultural competency include:

- ☐ Learning about your own and others' cultural identities
- ☐ Combating bias and stereotypes
- ☐ Respecting others' beliefs, values, and communication preferences
- ☐ Adapting your services to each patient's unique needs
- ☐ Gaining new cultural experiences

Cultural humility is a reflective process of understanding one's biases and privileges, managing power imbalances, and maintaining a stance that is open to others in relation to aspects of their cultural identity that are most important to them. Strategies for practicing cultural humility include:

- ☐ Practicing self-reflection, including awareness of your beliefs, values, and implicit biases
- ☐ Recognizing what you don't know and being open to learning as much as you can
- ☐ Being open to other people's identities and empathizing with their life experiences
- ☐ Acknowledging that the patient is their own best authority, not you
- ☐ Learning and growing from people whose beliefs, values, and worldviews differ from yours

Sources:

Cross, T. L., Bazron, B. J., Dennis, K. W., & Isaacs, M. R. (1989). *Towards a culturally competent system of care volume I: A monograph on effective services for minority children who are severely emotionally disturbed.* Washington, DC: Georgetown University Child Development Center, Child and Adolescent Service System Program Technical Assistance Center.

Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. American Psychological Association.

McGee-Avila, J. (2018, June 21). Practicing cultural humility to transform health care. *Robert Wood Johnson Foundation Culture of Health Blog.* https://www.rwjf.org/en/blog/2018/06/practicing-cultural-humility-to-transform-healthcare.html

Tervalon, M., & Murray-Garcia, J. (1998). Cultural humility vs cultural competence: A critical distinction in defining physician training outcomes in multicultural education. *Journal of Healthcare for the Poor and Underserved, (9)*2, 117-125.

RESPECT Model

What is most important when you engage with patients is that you remain open and maintain a sense of respect for your patients. The RESPECT model can help you remember what factors to consider to engage clients in a culturally and linguistically competent manner. These factors are important throughout assessment, diagnosis, and treatment.

R Respect	Understand how respect is shown within given cultural groups. Counselors demonstrate this attitude through verbal and nonverbal communications.
E Explanatory Model	Devote time in treatment to understanding how clients perceive their presenting problems. What are their views about their own substance abuse or mental symptoms? How do they explain the origin of current problems? How similar or different is the counselor's perspective?
S Sociocultural Context	Recognize how class, race, ethnicity, gender, education, socioeconomic status, sexual and gender orientation, immigrant status, community, family, gender roles, and so forth affect care.
P Power	Acknowledge the power differential between clients and counselors.
E Empathy	Express, verbally and nonverbally, the significance of each client's concerns so that he or she feels understood by the counselor.
C Concerns and Fears	Elicit clients' concerns and apprehensions regarding help-seeking behavior and initiation of treatment.
T Therapeutic alliance, Trust	Commit to behaviors that enhance the therapeutic relationship; recognize that trust is not inherent but must be earned by counselors. Recognize that self-disclosure may be difficult for some patients; consciously work to establish trust.

Source:

Mutha, S., Allen, C. & Welch, M. (2002). *Toward culturally competent care: A toolbox for teaching communication strategies*. San Francisco, CA: Center for Health Professions, University of California, San Francisco.

Combating implicit bias and stereotypes

Implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner. An implicit bias can make us susceptible to unintentionally acting in ways that are inconsistent with our values. Although you do not choose to have an implicit bias, you can choose to be aware of it and combat its effects.

Two important first steps are to:

- Recognize that we all have implicit biases and that implicit bias can negatively affect clinical interactions and outcomes
- Accept the responsibility to identify and understand your implicit biases

The table below presents the next steps you can take to confront your implicit biases and reduce stereotypic thinking. Consistent and conscious use of these strategies can help you create a habit of nonbiased thinking.

Stereotype replacement	Become aware of the stereotypes you hold and create non-stereotypical alternatives to them
Counter-stereotypic imaging	Remember or imagine someone from a stereotyped group who does not fit the stereotype
Individuating	See each person as an individual, not a group member; pay attention to things about them besides the stereotypes of their group
Perspective-taking	Imagine the perspective of someone from a group different than your own (“Put yourself in the other person’s shoes.”)
Contact	Seek ways to get to know people from different social groups. Build your confidence in interacting with people who are different from you. Seek opportunities to engage in discussions in safe environments, spend time with people outside your usual social groups, or volunteer in a community different than your own.
Emotional regulation	Reflect on your “gut feelings” and negative reactions to people from different social groups. Be aware that positive emotions during a clinical encounter make stereotyping less likely.
Mindfulness	Keep your attention on the present moment so you can recognize a stereotypic thought before you act on it

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
		some American Indian and Asian cultures.
Emotional expressiveness	Culture can influence how open people are in talking about their feelings. It's important to note that people from cultures that tend to be more emotionally expressive may still think that it is inappropriate to discuss emotions (particularly negative emotions) with people who are not close friends or family.	People from Western European cultures and white Americans are often relatively comfortable expressing that they "feel sad." In some other cultures, people may feel more comfortable showing different emotions, such as anger. In some cultures (for example, some East Asian cultures), expressing any strong emotions could be considered inappropriate. Gender, and how it intersects with cultural identity, can also play a big role in what emotions, if any, people are comfortable expressing.
Self-disclosure	Culture can influence whether talking to others about difficult personal situations is accepted or considered inappropriate. Individuals from cultures where self-disclosure is generally viewed negatively may disclose little about themselves and feel uncomfortable when asked to open up about personal problems.	Self-disclosure may be particularly low for people from highly collectivist cultures (such as many East Asian cultures), especially if they believe it can bring shame on the family to admit to having a mental illness or substance use disorder. However, it's important to note that level of trust with the officer also influences the degree of a community member's disclosure, meaning self-disclosure can be low for someone of any cultural group if there is not sufficient trust and rapport.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Formality	Culture can influence whether personal warmth or respect and formality are more valued.	Many Latinx, African American, and white American individuals prefer a personal and warm style. Community members from these cultures may expect to make small talk and ask questions to get to know those who are providing them with disaster or emergency assistance. Other cultural groups (for example, some East Asian cultures) may expect a relationship with a disaster or emergency responder to be formal, particularly at the beginning.
Directness	Culture can influence whether verbal directness is valued or considered rude.	The dominant cultural norm in the U.S. is to be relatively direct compared to many other cultures. In many cultures (for example, many Asian cultures and Latin American cultures), certain things, particularly those that are negative or embarrassing, should not be said directly but treated with subtlety.
Context	Culture can influence whether communication is high or low context. In low context cultures, words convey most of the meaning. In high context cultures, meaning is conveyed by more subtle verbal and non-verbal cues.	The dominant culture in the U.S. is mostly low context (i.e., words carry most of the meaning), whereas many other cultural groups are higher context. With community members from higher context cultures, it's important to pay attention to non-verbal and situational cues, not just the actual words said. Some messages may be "coded" and not intended to be taken at face value.

COMMUNICATION STYLE	CULTURAL DIFFERENCES	EXAMPLES
Orientation to self or others	Some cultures are much more oriented to the self, while others are more oriented to others. This shows in communication styles through the use of mostly "I" statements versus use of primarily third person and plural pronouns.	The dominant cultural norm in the U.S. is individualistic (self-oriented). Many other cultural groups are more collectivistic (i.e., other-oriented). Members of these groups may speak in third person and use plural pronouns rather than "I" statements. Community members who are more other-oriented may prefer to involve their families and communities in therapy. However, this is not always the case, as stigma and shame can also be particular issues for community members from collectivistic cultures.

Sources:

Galanti, G. (2008). *Caring for patients from different cultures* (4th ed.). Philadelphia, PA: University of Pennsylvania Press.
Purnell, L. D. (2009). *Guide to culturally competent health care* (2nd ed.). Philadelphia, PA: E.A. Davis Company.
U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration. Center for Substance Abuse Treatment. (2014.) *Tip 59: Improving cultural competence. A treatment improvement protocol* (HHS Publication No. (SMA) 14-4849). Retrieved from https://store.samhsa.gov/shin/content/SMA14-4849/SMA14-4849.pdf

Effective cross-cultural communication skills

Improve your cultural and linguistic appropriateness

- ☐ Understand that improving cultural and linguistic appropriateness is an ongoing journey!
- ☐ Understand the role that your culture plays in your interactions and delivery of care
- ☐ Understand the role culture plays in health beliefs and behaviors
- ☐ Become knowledgeable about the backgrounds of the individuals you serve
- ☐ Be aware of language differences, and offer language assistance services
- ☐ Build trust and rapport with the individuals you serve to facilitate learning about their needs, values, and preferences
- ☐ Be aware that some individuals may use various terms to describe medical issues (e.g., "sugar" for diabetes)
- ☐ Be aware of barriers that can arise when expressions, idioms, or multi-meaning words are used (even if you and your patient both speak the same language)
- ☐ Ask questions!

Do not make assumptions

- ☐ Use simple language. Avoid medical and healthcare jargon. Do not assume you know an individual's literacy and health literacy levels
- ☐ Check understanding and encourage questions. Do not assume an individual understood what you communicated
- ☐ Adopt a positive, curious, nonjudgmental approach toward all individuals. Do not assign meaning to an individual's nonverbal communication cues.

Understand and recognize differences in communication styles

- ☐ Appreciate how your communication preferences and style may differ from others'
- ☐ Understand how communication styles (e.g., nonverbal communication cues) and norms (e.g., the role of various family members) differ across cultures
- ☐ Tailor your communication so that your patients can better understand you

Sources:

Epstein, R. M., & Street, R. L. (2007). Effective communication in cancer care: Promoting healing and reducing suffering. [NIH Publication No. 07-6225 ed.]. Bethesda, MD: National Cancer Institute.
Hall, E.T. (1976). Beyond culture. New York: Doubleday.
Hall, E.T. (1990). Hidden differences. New York: Doubleday.
Teal, C.R. & Street, R.L. (2009). Critical elements of culturally competent communication in the medical encounter: A review and model. *Social Science & Medicine, 68*, 533-543.
Ting-Toomey, S. (1999). Communicating across cultures. New York, NY: Guilford Press. Title VI of the Civil Rights Act of 1964, 42 U.S.C. § 2000d-200d-7 (1964).

How to Better Understand Different Social Identities

Getting to know your client's social identities will help you understand the discrimination and oppression they have faced. It can also position you to help your client find ways to cultivate strengths and find inspiration. You can support your client in drawing strength from their intersecting social identities, finding a unique combination of qualities and capabilities that empower them.

When seeking to better understand a client's social identities, consider the following factors.

FACTOR TO CONSIDER	EXAMPLE
Key historical events	What lingering damage might American Indian communities face as a result of the history of compulsory boarding schools separating American Indian children from their families? How might a Hmong refugee be impacted by the long history of persecution and displacement faced by members of the Hmong ethnic group?
Sociopolitical issues	For a transgender client, what is the message sent with the passage of "Bathroom Bills"? How might a Latinx client be affected by current changes in immigration enforcement and plans to build a wall on the border with Mexico?
Basic values and beliefs	How might values of independence and individualism, common in dominant groups in the U.S., contrast with values of collectivism and family predominant in many Asian, African, and Latin American cultures? What misunderstandings could arise between groups that value straightforwardness, such as the dominant U.S. cultural group, and groups that value politeness, perhaps depending more on non-verbal cues to communicate?
Cultural practices	What cultural practices common among the dominant groups in the U.S. contrast with cultural practices of other groups? Take personal space, for example, which is important for many Americans. What impression would an insistence on personal space give a person from a Latin American or Mediterranean culture where people prefer to stand or sit very close to others while talking?

To explore cultural opportunities when engaging a client, try to link the conversation to what you know about the client's salient social identities. Even if your client does not say much in response, you have shown them that you are willing to explore cultural issues. As you build a strong therapeutic relationship, more discussions about cultural identity may take place.

Sources:

Mio, J. S., Barker, L. A., & Domenech Rodriguez, M. M. (2016). *Multicultural psychology: Understanding our diverse communities* (4th ed.). New York, NY: Oxford University Press.
Hook, J. N., Davis, D., Owen, J., & DeBlaere, C. (2017). *Cultural humility: Engaging diverse identities in therapy*. Washington, DC: American Psychological Association.