Cultural Humility & Reducing Stigma and Discrimination

Provider Handbook

Updated 4/6/2018
What is Cultural Competence & Humility?

Every human being is a member of many cultures. Culture influences an individual’s health beliefs, practices, behaviors and even the outcome of medical treatments. **Cultural competence** in health care is defined in this report as the ability of individuals and systems to respond respectfully and effectively to people of all cultures, in a manner that affirms the worth and preserves the dignity of individuals, families and communities. **Cultural humility** refers to the ongoing commitment to self-reflection and cultivation of beneficial, non-paternalistic relationships. These are not final destinations, but instead a continuous process.¹

For example some norms that may be determined by cultural beliefs are:

- Clothing
- Beliefs about causes of illness and effects of treatment
- Eye contact
- Decision making
- Touching
- Being alone
- Food and diet
- Religious customs
- Respect for personal space

Basic Terminology

- **Ageism**: the stereotyping or discrimination of a person or group due to their age, particularly experienced by seniors.
- **Allostasis**: refers to the process of achieving homeostasis (or stability) in the body through physiological or behavioral change.
- **Classism**: differential treatment based on social class or perceived social class; the systematic oppression of subordinated class groups to the advantage of dominant class groups.
- **Competence**: The capacity to function effectively as an individual and an organization within the context of the cultural beliefs, behaviors, and needs presented by consumers and their communities.
- **Culture**: The thoughts, communications, actions, customs, beliefs, values, and institutions of racial, ethnic, religious, or social groups. Cultural issues are central in the delivery of health services treatment and prevention interventions. By understanding, valuing, and incorporating the cultural differences of America’s diverse population and examining one’s own health-related values and beliefs, health care organizations, practitioners, and others can support a health care system that responds appropriately to, and directly serves the unique needs of populations whose cultures may be different from the prevailing culture.
- **Cultural Blindness**: Differences are ignored and one proceeds as though differences do not exist. ("There’s no need to worry about a person’s culture; if you’re sensitive, you’ll do OK.")
- **Cultural Health**: A set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals that enables effective work in cross-cultural situations.
- **Cultural Humility**: lifelong commitment to self-evaluation and self-critique and developing beneficial and non-paternalistic relationships.
- **Cultural Imposition**: Belief that everyone should conform to the majority. ("We know what’s best for you. If you don’t like it you can go elsewhere.")
- **Culturally and Linguistically Appropriate Services**: Health care services that are respectful of and responsive to cultural and linguistic needs.
- **Discrimination**: Differential treatment of an individual due to minority status, both actual and perceived. ("We just aren’t equipped to serve people like that.")
- **Ethnocentrism**: Inability to accept another culture’s world view. ("My way is best.")
- **Health Disparities**: a particular type of health difference closely linked with social, economic or environmental disadvantage. Adversely affects groups of people who have systematically experienced greater obstacles to health based on race, ethnicity, gender, sexual orientation, geography, immigrant status, disability, income or other characteristics historically linked to discrimination.

- **Heterosexism**: the societal and institutional reinforcement of heterosexuality as the privileged and the norm; and the assumption that everyone does or should identify as heterosexual.

- **Homeostasis**: the body’s ongoing defense and maintenance of vital physiological systems.

- **Intersectionality**: the complex, cumulative way that the effects of different forms of discrimination combine, overlap or intersect.²

- **Racism**: the belief that a particular race is superior or inferior to another and that a person’s character or ability is predetermined by their race.

- **Sexism**: prejudice or discrimination based on sex or gender, especially against women and girls.

- **Stereotyping**: generalizing about a person while ignoring the presence of individual differences. ("She’s like that because she’s Asian; all Asians are nonverbal.")

- **Stigma**: negative attitudes and beliefs that lead people to reject, avoid, or fear what is perceived as different or disgraced.
  - **enacted stigma**: experiencing discrimination because of HIV status
  - **anticipated stigma**: anticipated or perceived prejudice or discrimination in the community
  - **internalized stigma**: feeling shame or blame because of HIV status

- **Structural violence**: refers to systematic ways in which social structures harm or otherwise disadvantage individuals.³

### LBGTQI Terminology

- **Agender** (adj.) – Describes a person who identifies as having no gender.

- **Ally** (noun) – A person who supports and stands up for the rights of LGBT people.

- **Asexual** (adj.) – Describes a person who experiences little or no sexual attraction to others. Asexuality is not the same as celibacy.

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² Word We’re Watching: Intersectionality. Merriam-Webster, April 2017 Web. 5 Feb. 2018
- **Binding** – a process used by some transgender people to flatten one’s breast tissue in order to create the appearance of a flat chest.
- **Biphobia** (noun) – The fear of, discrimination against, or hatred of bisexual people or those who are perceived as such.
- **Bisexual** (adj.) – A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender and people of other genders.
- **Cisgender** (adj.) – A person whose gender identity and assigned sex at birth correspond (i.e., a person who is not transgender).
- **Gay** (adj.) – A sexual orientation that describes a person who is emotionally and sexually attracted to people of their own gender. It can be used regardless of gender identity, but is more commonly used to describe men.
- **Gender dysphoria** (noun) – Distress experienced by some individuals whose gender identity does not correspond with their assigned sex at birth. Manifests itself as clinically significant distress or impairment in social, occupational, or other important areas of functioning. The Diagnostic and Statistical Manual of Mental Disorders (DSM-5) includes gender dysphoria as a diagnosis.
- **Gender fluid** (adj.) – Describes a person whose gender identity is not fixed. A person who is gender fluid may always feel like a mix of the two traditional genders, but may feel more one gender some days, and another gender other days.
- **Genderqueer** (adj.) – Describes a person whose gender identity falls outside the traditional gender binary. Other terms for people whose gender identity falls outside the traditional gender binary include gender variant, gender expansive, etc.
- **Heteronormativity** (noun) – The assumption that everyone is heterosexual, and that heterosexuality is superior to all other sexualities.
- **Heterosexual** (straight) (adj.) – A sexual orientation that describes women who are emotionally and sexually attracted to men, and men who are emotionally and sexually attracted to women.
- **Homophobia** (noun) – The fear of, discrimination against, or hatred of lesbian or gay people or those who are perceived as such.
- **Intersex** (noun) – a general term used for a variety of conditions in which a person is born with a reproductive or sexual anatomy that doesn't seem to fit the typical definitions of female or male. Some intersex individuals may be raised as a girl or boy but then identify with another gender identity later in life.
- **Lesbian** (adj., noun) – A sexual orientation that describes a woman who is emotionally and sexually attracted to other women.

- **Men who have sex with men/Women who have sex with women (MSM/WSW)** (noun) – Categories that are often used in research and public health settings to collectively describe those who engage in same-sex sexual behavior, regardless of their sexual orientation. However, people rarely use the terms MSM or WSW to describe themselves.

- **Pangender** (adj.) – Describes a person whose gender identity is comprised of many genders.

- **Pansexual** (adj.) – A sexual orientation that describes a person who is emotionally and sexually attracted to people regardless of gender.

- **Polyamorous** (adj.) – Describes a person who has or is open to having more than one romantic or sexual relationship at a time, with the knowledge and consent of all their partners. Sometimes abbreviated as poly.

- **Queer** (adj.) – An umbrella term used by some to describe people who think of their sexual orientation or gender identity as outside of societal norms. Some people view the term queer as more fluid and inclusive than traditional categories for sexual orientation and gender identity. Due to its history as a derogatory term, the term queer is not embraced or used by all members of the LGBT community.

- **Questioning** (adj.) – Describes an individual who is unsure about or is exploring their own sexual orientation and/or gender identity.

- **Sexual orientation** (noun) – How a person characterizes their emotional and sexual attraction to others.

- **Trans man/transgender man/female-to-male (FTM)** (noun) – A transgender person whose gender identity is male, but was assigned female at birth, may use these terms to describe themselves. Some will just use the term man.

- **Trans woman/transgender woman/male-to-female (MTF)** (noun) – A transgender person whose gender identity is female, but was assigned male at birth, may use these terms to describe themselves. Some will just use the term woman.

- **Transgender** (adj.) – Describes a person whose gender identity and assigned sex at birth do not correspond. Also used as an umbrella term to include gender identities outside of male and female. Sometimes abbreviated as trans.

- **Transphobia** (noun) – The fear of, discrimination against, or hatred of transgender or gender non-conforming people or those who are perceived as such.
- **Transsexual** (adj.) – Sometimes used in medical literature or by some transgender people to describe those who have transitioned through medical interventions.
- **Two-Spirit** (adj.) – A contemporary term that connects today's experiences of LGBT Native American and American Indian people with the traditions from their cultures.  

## “People First” Language

People-first describes a way of speaking that tries to avoid perceived and subconscious dehumanization when discussing other people. This can be applied to any group that is defined by a trait or condition rather than being defined first and foremost as a human being.

When it comes to illnesses and health issues, putting the person before the diagnosis describes what the person has rather than what they are. Using a sentence structure where the person comes first allows for this. For example saying “people with disabilities” is more humanizing than saying “disabled people” or “the disabled.”

## HIV & AIDS: Say This, Not That

<table>
<thead>
<tr>
<th>Stigmatizing</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIV infected person, HIV/AIDS patient or carrier, Positives, Hivers</td>
<td>Person living with HIV (PLHIV). Do not use “infected” when referencing a person.</td>
</tr>
<tr>
<td>To die of AIDS</td>
<td>Died of AIDS-related illness, died of AIDS-related complications or end stage HIV</td>
</tr>
<tr>
<td>HIV infection, became infected</td>
<td>HIV transmissions, diagnosed with HIV, acquired HIV</td>
</tr>
<tr>
<td>Victim, innocent victim, sufferer, contaminated</td>
<td>Person living with HIV, survivor, warrior (Don’t use “contaminated” in reference to a person)</td>
</tr>
<tr>
<td>To catch, contract, or transmit AIDS; to catch HIV</td>
<td>An AIDS diagnosis, developed AIDS, contract HIV (AIDS is a diagnosis and HIV is the virus)</td>
</tr>
<tr>
<td>Compliant</td>
<td>Adherent</td>
</tr>
<tr>
<td>Prostitutes/Prostitution</td>
<td>Sex worker, transactional sex, selling sexual services</td>
</tr>
<tr>
<td>Promiscuous</td>
<td>Use “having multiple partners” instead of this</td>
</tr>
</tbody>
</table>

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<table>
<thead>
<tr>
<th>Value Judgement</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Tainted” blood, “dirty” needles</td>
<td>Shared needles, blood containing HIV</td>
</tr>
<tr>
<td>Clean, as in “I’m clean, are you?”</td>
<td>Avoid! Never suggest those living with HIV are dirty.</td>
</tr>
</tbody>
</table>

**LGBTQI: Say This, Not That**

<table>
<thead>
<tr>
<th>Stigmatizing</th>
<th>Preferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>&quot;homosexual&quot; (n. or adj.)</td>
<td>&quot;gay&quot; (adj.); &quot;gay man&quot; or &quot;lesbian&quot; (n.); &quot;gay person/people&quot;</td>
</tr>
<tr>
<td>Because of the clinical history of the word “homosexual,” it is aggressively used by anti-LGBTQ extremists to suggest that people attracted to the same sex are somehow diseased or psychologically/emotionally disordered – notions discredited by the American Psychological Association and the American Psychiatric Association in the 1970s. Please avoid using &quot;homosexual&quot; except in direct quotes. Please also avoid using &quot;homosexual&quot; as a style variation simply to avoid repeated use of the word “gay.”</td>
<td>Please use gay, lesbian, or when appropriate bisexual or queer to describe people attracted to members of the same sex.</td>
</tr>
<tr>
<td>&quot;homosexual relations/relationship,&quot; &quot;homosexual couple,&quot; &quot;homosexual sex,&quot; etc.</td>
<td>&quot;relationship,&quot; &quot;couple&quot; (or, if necessary, &quot;gay/lesbian/same-sex couple&quot;). &quot;sex,&quot; etc.</td>
</tr>
<tr>
<td>Identifying a same-sex couple as &quot;a homosexual couple,&quot; characterizing their relationship as &quot;a homosexual relationship,&quot; or identifying their intimacy as &quot;homosexual sex&quot; is extremely offensive and should be avoided. These constructions are frequently used by anti-LGBTQ extremists to denigrate LGBTQ people, couples, and relationships.</td>
<td>As a rule, try to avoid labeling an activity, emotion, or relationship as gay, lesbian, bisexual, or queer unless you would call the same activity, emotion, or relationship &quot;straight&quot; if engaged in by a heterosexual. In most cases people will be able to discern people's sexes and/or orientations through the names of the parties involved, depictions of their...</td>
</tr>
</tbody>
</table>
| "gay lifestyle," "homosexual lifestyle," or "transgender lifestyle" | "LGBTQ people and their lives"
---|---
There is no single LGBTQ lifestyle. LGBTQ people are diverse in the ways they lead their lives. The phrases "gay lifestyle," "homosexual lifestyle," and "transgender lifestyle" are used to denigrate LGBTQ people suggesting that their sexual orientation and/or gender identity is a choice and therefore can and should be "cured."

| "gay agenda" or "homosexual agenda" | "Accurate descriptions of the issues (e.g., "inclusion in existing nondiscrimination laws," "securing equal employment protections")"
---|---
Notions of a so-called "homosexual agenda" are rhetorical inventions of anti-LGBTQ extremists seeking to create a climate of fear by portraying the pursuit of equal opportunity for LGBTQ people as sinister.

| "special rights" | "equal rights" or "equal protection"
---|---
Anti-LGBTQ extremists frequently characterize equal protection of the law for LGBTQ people as "special rights" to incite opposition to such things as relationship recognition and inclusive nondiscrimination laws. Avoid term.

LGBTQ people are motivated by the same hopes, concerns, and desires as other everyday Americans. They seek to be able to earn a living, be safe in their communities, serve their country, and take care of the ones they love. Their commitment to equality and acceptance is one they share with many allies and advocates who are not LGBTQ.
LGBTQI: Provider Basics

**Dimensions of Sexual Orientation**

- Listen to how patients refer to themselves or loved ones (names, pronouns) and use the same language they use; ask if unsure.
- Display in common areas policies indicating non-discrimination for sexual orientation/identity and display LGBT-friendly symbols such as rainbow flag, pink triangle etc.
- Include verbiage on signage or intake forms that is safe, judgement free and non-discriminatory, including gender neutral language.
- Waiting rooms or common areas should reflect reading materials relevant to LGBT patients; include local resources for LGBT resources.
- Remember that not all patients are heterosexual or monogamous; use “partner” instead of “spouse” or “boy/girlfriend,” and replace marital

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status with relationship status on forms to allow patients to indicate non-traditional relationship status outside of monogamy.

- Demonstrate openness and avoid assumptions.
- Create and designate unisex or single stall restrooms.
- Refrain from making assumptions about a person’s sexual orientation or gender identity based on their appearance or voice (even via phone).
- Recognize that self-identification may not align with behavior: a man may identify as heterosexual but engages in sex with other men.
- Ask the patient if you are uncertain about the terminology they use to describe sexual behavior – but only ask when there is a need to know; it is not the patient’s job to educate you.
- Always affirm gender identity by using preferred name and pronouns, even when they are not in the room.⁶
- Check in with patients periodically – identities and behaviors can change just as relationship status and living arrangements may vary.
- Be consistent with language to and about the patient, especially among colleagues.

Taking a Sexual History: Basic Steps

Remember the 5 P’s when taking a sexual history:

1. Partners
2. Practices
3. Past History of STDs
4. Protection from STDs
5. Pregnancy

Resources

- PDF – A Guide to Taking a Sexual History (Centers for Disease Control, 2014)
  https://www.cdc.gov/std/treatment/sexualhistory.pdf

Figure 2: Algorithm for Taking Sexual Histories

Set the Stage
- Bring up the sexual history as part of the overall history
- Explain that you ask these questions of all patients
- Ensure confidentiality

Begin with Three Screening Questions
1. Have you been sexually active in the past year?
2. Do you have sex with men, women, or both?
3. How many people have you had sex with in the past year?

New or Multiple Partners
Ask about:
- STD/HIV protection
- Partners
- Substance use
- History of STDs
- Trauma/violence
- Pregnancy plans/protection
- Sexual function and satisfaction
- Other concerns

Long-term Monogamous Partner
Ask about:
- Pregnancy plans/protection
- Trauma/violence
- Sexual function and satisfaction
- Other concerns

Not Sexually Active
Ask about:
- Past partners (if patient is new)
- Any questions or concerns

Follow up as appropriate
(e.g., STD and HIV testing, counseling and education, referrals)

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Structural Violence and Health Disparities

In the words of Paul Farmer structural violence is the “physical or psychological harm resulting from exploitative and unjust political, social and economic systems.” This type of violence occurs on a large scale via cultural institutions and systematic practices that perpetuate inequity and result in health disparities. Health disparities are differences in health outcomes closely linked to social, economic or environmental disadvantages that create barriers to health based on race, ethnicity, gender, sexual orientation, geography, immigrant status, disability, income or other characteristics.

Examples of structural violence include:

- Decades of an inequitable distribution of wealth (rooted in slavery)
- Lack of political power, such as gerrymandering
- Stigma rooted in particular forms of religiosity
- Lack of transportation and infrastructure
- Poorly funded education systems
- Lack of comprehensive sexual health and relationship education
- Mass incarceration and criminalization of black men
- High rate of uninsured individuals
- Health Provider Shortage Areas and closing rural hospitals
- Lack of substance use prevention and treatment services

Farmer describes these types of overlapping hardships as a “synergy of plagues” among marginalized groups that results in higher rates of HIV.

For instance, despite having only 37% of the overall population, the South accounts for about 44% of all HIV diagnosis in the country and experiences more HIV related illnesses and deaths than any other region.8

This disproportionate burden of HIV in the South most adversely affects the African American community.9 In particular, black men who have sex with men currently face the poorest HIV health outcomes due to this very intersection of discrimination, stigma, poverty and other social/political disadvantages.

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8 HIV in the Southern United States Fact Sheet, Centers for Disease Control and Prevention, May 2016, Pdf. 5 Dec 2017.
Remembering the past...

It is important to recognize the historically traumatic relationship between medical institutions and the African American community. Justifiably there is a lack of trust in research, public health, and other health professionals among some community members.

Perhaps one of the most notorious cases of this is the 1932 United States Public Health Service Syphilis Study at Tuskegee Institute. The study recruited 600 Black men in the local Macon County area of Alabama. 399 diagnosed with syphilis and 201 without. Participants were misled about what the study entailed, its intended purpose and were not given Penicillin to cure their syphilis even after it was accepted as the ideal treatment in the late 1940’s. As the study continued it gained official support from both the Centers for Disease Control and local medical societies. In 1972 the study was finally terminated after news articles led to public condemnation.

Resources


Cultural Humility & Reducing Stigma and Discrimination

HOW STIGMA LEADS TO SICKNESS

Many of the people most vulnerable to HIV face stigma, prejudice and discrimination in their daily lives. This pushes them to the margins of society, where poverty and fear make accessing healthcare and HIV services difficult.

![Diagram: How HIV stigma leads to sickness](image_url)

Adapted from UNDP stigma-sickness slope 
AVERT.ORG

Figure 3: How HIV stigma leads to sickness\(^\text{11}\)
Cultural Humility: Provider Basics

Self-Awareness

- Do I offer all patients the same information, tests, and treatments?
- What assumptions do I make about patients based on appearance?
- What are my personal cultural values or beliefs and how do these influence my practice?
- In what ways have fear, ignorance, and systemic oppression (including, but not limited to, ageism, classism, ethnocentrism, heterosexism, racism, and sexism) influenced my own attitudes and actions?
- What are steps I can take to minimize the effects of this personal bias?
- Use self-awareness to appreciate the multicultural identities of clients/patients and colleagues.

How to challenge implicit bias...

- Stereotype replacement — recognizing that a response is based on stereotype and consciously adjusting the response

- Counter-stereotypic imaging — Imagining the individual as the opposite of the stereotype

- Individuation — Seeing the person as an individual rather than a stereotype (e.g., learning about their personal history and the context that brought them to the doctor's office or health center)

- Perspective taking — “Putting yourself in the other person’s shoes”

- Increasing opportunities for contact with individuals from different groups — Expanding one’s network of friends and colleagues or attending events where people of other racial and ethnic groups, gender identities, sexual orientation, and other groups may be present

- Partnership building — Reframing the interaction with the patient as one between collaborating equals, rather than between a high-status person and a low-status person

Resources

- Reducing Implicit Bias
  http://www.ihi.org/communities/blogs/how-to-reduce-implicit-bias
- Implicit Association Tests (Bias)
  https://implicit.harvard.edu/implicit/selectastest.html
- PDF – Privilege: Unpacking the Invisible Backpack (Peggy McIntosh, 1989)
  http://code.ucsd.edu/pcosman/Backpack.pdf
- Video - How I Got Over: The Journey to Cultural Competence (California Prevention & Training Center, 2013)
  https://www.youtube.com/watch?v=fqB3bpC4czs
- Unconscious Bias online course (Microsoft eLesson, 2015)
  https://www.mslearning.microsoft.com/course/72169/launch
- Breaking the Prejudice Habit (AHAA, 2016)
  http://breakingprejudice.org/teaching/group-activities/

Interpersonal

- What are the history, traditions, values, family systems, and communication patterns of major client/patient groups served?
- How might these influence help-seeking behaviors and perceptions of health, illness, health care treatments, disability, caregiving roles, and death/dying among client or patient groups served?
- Demonstrate genuineness, empathy, warmth, openness, and flexibility to facilitate client/patient engagement throughout service delivery.
- Approach information about cultural groups or characteristics in a strengths-based manner.

Resources

- Video - Vanessa Goes to the Doctor (National LGBT Cancer Network, 2015)
  https://www.hrc.org/blog/new-video-emphasizes-need-for-lgbt-cultural-competency-trainings-for-health
- TED Talk: How To Talk & Listen To Transgender People (Jackson Bird, 2017)
  https://www.ted.com/talks/jackson_bird_how_to_talk_and_listen_to_transgender_people/discussion#t-88337
- Video - Welcoming LGBTQ Patients (NYC Health and Hospitals, 2017)
  https://www.youtube.com/watch?v=1E0OmhxexlU
- Empowering Queer Youth In Healthcare - Q Cards (Q Card Project)
  http://www.qcardproject.com/
- PDF – LGBT Non-Discrimination Policy Sign (American Medical Association)
- Toolkit to Give Your Own Unbias-ing Workshop (reWork Google, 2015)
  https://rework.withgoogle.com/guides/unbiasing-hold-everyone-accountable/steps/give-your-own-unbiasing-workshop/
- Physician’s Practical Guide to Culturally Competent Care Online Course
  https://cccm.thinkculturalhealth.hhs.gov/
- Culture Clues Tip Sheets for Providers
  http://depts.washington.edu/pfes/CultureClues.htm
- Cultural Competency – Migrant Clinicians Network
  https://www.migrantclinician.org/services/education/training/cultural-competency.html
Institutional

- Create a mission statement articulating the principals, rationale and values for cultural and linguistic competence at all organizational levels.
- Develop strategies to engage patients or community members from various cultural groups in the development and evaluation of your organization’s core functions.¹²
- Ensure the non-discrimination policy includes race, religion, gender identity and sexual orientation.
- Provide fiscal support, professional development and incentives for improvement among all levels of the organization.
- Conduct an individual and organizational assessment, on an ongoing basis, of cultural and linguistic competence in order to identify areas for growth.¹³

Resources

  http://www.ihi.org/resources/Pages/IHIWhitePapers/Achieving-Health-Equity.aspx
- Be More America – Training on Biases
  http://www.bemoreamerica.org/services.html
- Cultural Competence Organizational Self-Assessment & other Tools – National Center for Cultural Competence https://nccc.georgetown.edu/assessments/
- PDF – Key Ingredients for Successful Trauma-Informed Care Implementation (Center for Health Care Strategies, 2016)
  http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Using Client-level Data to Measure Outcomes

*RWHAP client-level data, along with other epidemiologic and qualitative data, can be used for...*

- **Planning** - Prioritizing, targeting, and monitoring available resources in response to needs

- **Addressing gaps** - Identifying gaps in and barriers to care for PLWH

- **Improving services** - Identifying issues and opportunities to improve delivery of services to PLWH as well as high-risk, uninfected individuals (e.g., HIV testing; linkage to prevention services, behavioral health, social services)

- **Improving outcomes** - Improving engagement and outcomes at each stage of the care continuum

**Other Initiatives to address disparities**

- Secretary’s Minority AIDS Initiative Fund – Innovative Projects

- Minority AIDS Initiative – addresses gaps in care

- Special Projects of National Significance/Ryan White HIV AIDS Program Part F – Demonstration Projects designed focused on implementation of service delivery reforms to create efficiencies, improve effectiveness and improve health outcomes

- Learning Collaboratives – Southern Initiatives to address geographic disparities based on Institute for Health care Improvement

- Increased Collaborations and Partnerships with HUD, SAMSHA and DOL to address the intersectionality of illness, mental and behavioral health, poverty, employment and housing status
How does religion affect patient care?

Clinicians who understand their patient’s cultural values, beliefs and practices are more likely to have positive interactions and provide culturally acceptable care.

Norms that may be determined by patients’ religious backgrounds are:

- Involvement of family in medical decision making
- Preference for traditional healing practices over or alongside Western medicine
- Refusal of treatments requiring hair removal (i.e. Sikhism)
- Preference for a provider of the same sex
- Discomfort discussing sexual history or behavior
- Beliefs on condom use or birth control practices
- Willingness to accept psychiatric diagnosis
- Fasting practices (Ramadan, Ash Wednesday, etc.)
- Vegetarian or kosher diet
- Opposition to medical intervention or medication (i.e. Christian science)
- Time and privacy needed for daily prayers

Religion: Provider Basics

- Obtain a “spiritual history.”
- Abide by patient requests to decline some aspects of medical care.
- Acknowledge and respect your patients’ interpretations of their illnesses.
- Use open-ended questions (instead of yes/no questions) to make sure you and your patients share a common meaning.
- Tell your patients what you are writing as you take notes. After you are done taking their medical history, give your patients another opportunity to bring up something they may have omitted or did not feel comfortable talking about at first (especially if this is their first visit with you). They may feel more comfortable discussing something further into the visit.

➢ Tell your patients what you are doing and what they will feel if you are doing an exam, procedure, or other care that involves physically touching them.\(^\text{15}\)

**Resources**

- How Can Patients and Providers See Eye to Eye?  
  [http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/TrevorTorres-TruePartners.aspx](http://www.ihi.org/education/IHIOpenSchool/resources/Pages/Activities/TrevorTorres-TruePartners.aspx)

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**Helpful Questions on Patient Beliefs**

**Provider:** So that I might be aware of and respect your beliefs...

1. What cultural, religious, spiritual or lifestyle beliefs may impact the kind of health care you want to receive?
2. Would you like to receive your test results and diagnosis information, or do you prefer this information be given to someone else?
3. Would you like the information written, in pictures, or both? – Remember to ask the patient to “teach back” the information you give them and then document their understanding.
4. How does the care plan I’m recommending fit with your lifestyle and beliefs? Will you be able to follow this plan?
5. Can a family member, friend, or someone else help you follow your plan of care?
6. Do you use any traditional health remedies such as herbal treatments, homeopathy, Ayurveda, etc.?
7. Is there someone, in addition to yourself, with whom you want us to consult in making medical decisions about your care?

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8. Are there certain health care procedures and tests that your culture prohibits?
9. Do you change your diet in celebration of religious or other holidays that you feel I should know?
10. Is there anything else you would like to know? Do you have any questions for me? (Encourage two-way communication).

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### Maslow’s Hierarchy of Needs

Maslow proposed that motivation is the result of a person’s attempt at fulfilling five basic needs: physiological, safety, social, esteem and self-actualization. Physiological needs are those needs required for human survival such as air, food, water, shelter, clothing and sleep.

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Characteristics of self-actualizers:
1. They perceive reality efficiently and can tolerate uncertainty;
2. Accept themselves and others for what they are;
3. Spontaneous in thought and action;
4. Problem-centered (not self-centered);
5. Unusual sense of humor;
6. Able to look at life objectively;
7. Highly creative;
8. Resistant to enculturation, but not purposely unconventional;
9. Concerned for the welfare of humanity;
10. Capable of deep appreciation of basic life-experience;
11. Establish deep satisfying interpersonal relationships with a few people;
12. Peak experiences;
13. Need for privacy;
14. Democratic attitudes;
15. Strong moral/ethical standards.

Behavior leading to self-actualization:
(a) Experiencing life like a child, with full absorption and concentration;
(b) Trying new things instead of sticking to safe paths;
(c) Listening to your own feelings in evaluating experiences instead of the voice of tradition, authority or the majority;
(d) Avoiding pretense ('game playing') and being honest;
(e) Being prepared to be unpopular if your views do not coincide with those of the majority;
(f) Taking responsibility and working hard;
(g) Trying to identify your defenses and having the courage to give them up.
Resources

Audio/Visual Materials

1. Video - Vanessa Goes to the Doctor (National LGBT Cancer Network, 2015)  
   https://www.hrc.org/blog/new-video-emphasizes-need-for-lgbt-cultural-competency-trainings-for-health

2. TED Talk: How to Talk & Listen to Transgender People (Jackson Bird, 2017)  
   https://www.ted.com/talks/jackson_bird_how_to_talk_and_listen_to_transgender_people/discussion#t-88337

   https://www.youtube.com/watch?v=1EoOmhxexlU

4. Video - Faces of HIV (We Make The Change, 2014)  
   https://www.youtube.com/user/wemakethechange/videos

5. Video - Living with HIV: Engagement in Care (California Prevention & Training Center, 2012)  
   https://www.youtube.com/watch?v=zq8fyns6JvY

   https://www.youtube.com/watch?v=fqB3bpC4czs


Helpful Documents

8. PDF – LGBT Non-Discrimination Policy Sign (American Medical Association)  

9. Empowering Queer Youth In Healthcare - Q Cards (Q Card Project)  
   http://www.qcardproject.com/

10. PDF - LGBT Welcoming Toolkit for Primary Care Practices (BWHC LGBT & Allies Employee Resource Group, 2016)


13. PDF – Key Ingredients for Successful Trauma-Informed Care Implementation (Center for Health Care Strategies, 2016) http://www.chcs.org/media/ATC_whitepaper_040616.pdf

Training Courses & Group Education


15. Breaking the Prejudice Habit (AHAA, 2016) http://breakingprejudice.org/teaching/group-activities/


HAB Reports and Other Resources

- Find the client-level data report and other resources at https://hab.hrsa.gov/data

  - National and state-level data on all clients served by RWHAP, including select indicators of the care continuum


  - AETC National Resource Center http://aidsetc.org/

- TARGET Center: Technical Assistance resources for programs to better serve people living with HIV https://careacttarget.org/
- National LGBT Health Education Center (Program of Fenway Institute)  
  https://www.lgbthealtheducation.org/
- Project Inform  
  https://www.projectinform.org/
- AIDSinfoNet  
  http://www.aidsinfonet.org/categories/

**CDC Info on Demand**

- Order or download books, fact sheets, brochures and other educational materials from an extensive library of CDC publications (includes ability to search by language).  