Exploring Cultural Competence and Humility in the Care of HIV Patients Learning Collaborative

National Center for Health in Public Housing

April 10, 2024

Session 1: Reducing stigma and discrimination

Housekeeping

- All participants muted upon entry
- Engage in chat
- Raise hand if you would like to unmute
- Meeting is being recorded
- Slides and recording link will be sent via email

National Center for Health in Public Housing

- The National Center for Health in Public Housing (NCHPH) is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number U30CS09734, a National Training and Technical Assistance Partner (NTTAP) for $2,006,400 and is 100% financed by this grant. This information or content and conclusions are those of the author and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.
- The mission of the National Center for Health in Public Housing (NCHPH) is to strengthen the capacity of federally funded Public Housing Primary Care (PHPC) health centers and other health center grantees by providing training and a range of technical assistance.

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National Center for Health in Public Housing

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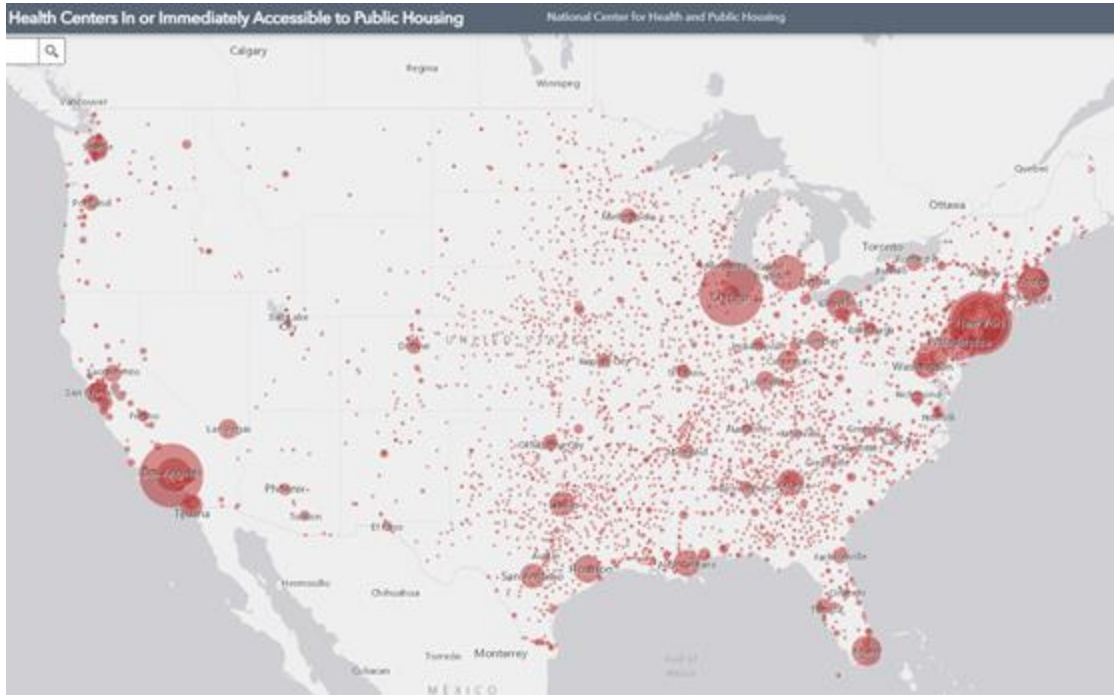
NCHPH
National Center for Health in Public Housing

Health Centers Close to Public Housing

- **1,370 Federally Qualified Health Centers (FQHC) = 30.5 million patients**
- **483 FQHCs In or Immediately Accessible to Public Housing = 6.1 million patients**
- **107 Public Housing Primary Care (PHPC) = 935,823 patients**

Source: 2022 Health Center Data



Source: Health Centers in or Immediately Accessible to Public Housing Map

Public Housing Demographics

1.5 Million Residents

2 Persons Per Household

38% Disabled

52% White

91% Low Income

43% African-American

26% Latinx

19% Elderly

36% Children

32% Female Headed Households with Children

Source: HUD 2023

Learning Collaborative Expectations

1. Make a personal commitment to come prepared and to actively contribute to the group. (all sessions are interactive)
2. Be willing to make mistakes
3. It's always OK to say "pass" or that you don't know.
4. Respect differences in people's background preparation and thinking styles.
5. Assume that everybody in the group is doing their best and working to progress. (Peer-to-peer learning)
6. Give each other the opportunity to speak and ask questions.
7. If you have been speaking a lot, step back and give others a turn.
8. Be an active listener: listen fully and ask for clarification if needed.
9. Help others clear up confusion productively, focusing on the points of confusion and not the person.
10. The participants, SMEs and facilitators all learn from each other.

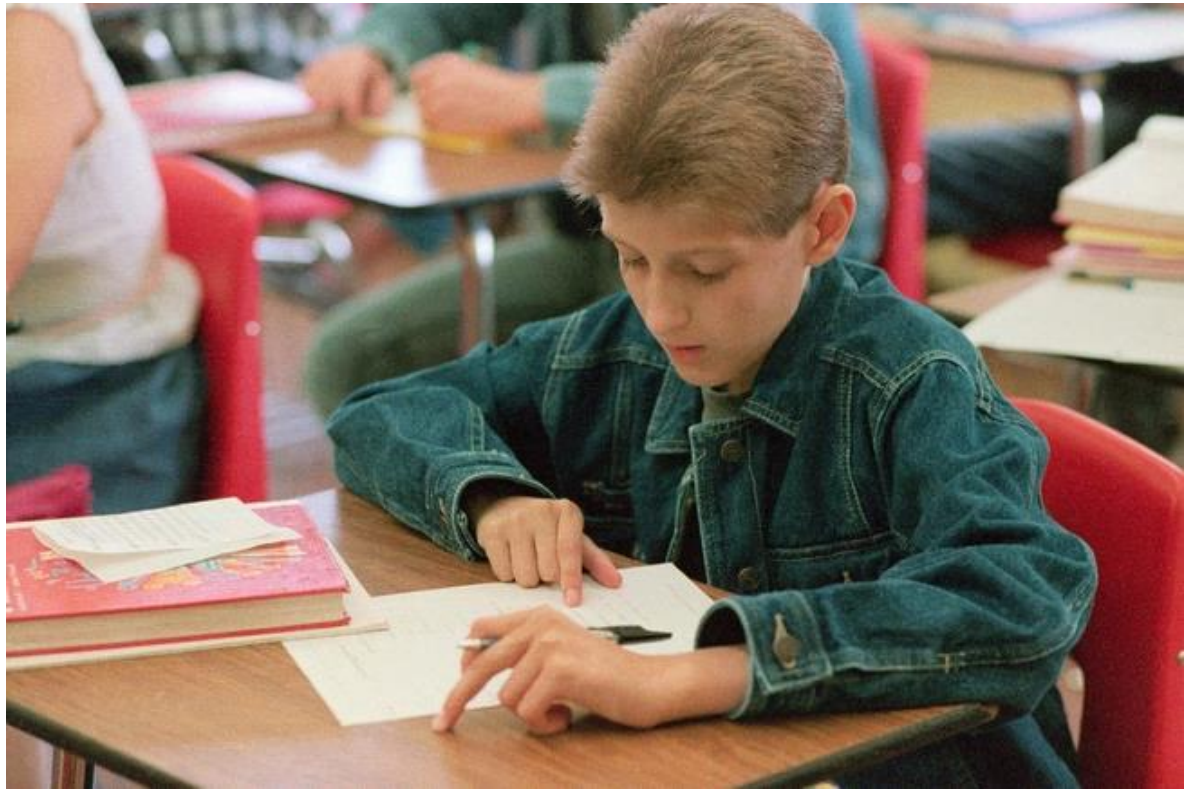
Learning Objectives

1. Define Cultural Competence and Humility
2. Describe the impact of cultural competence and humility on HIV patients
3. Develop individual and institutional strategies for creating culturally competent environments

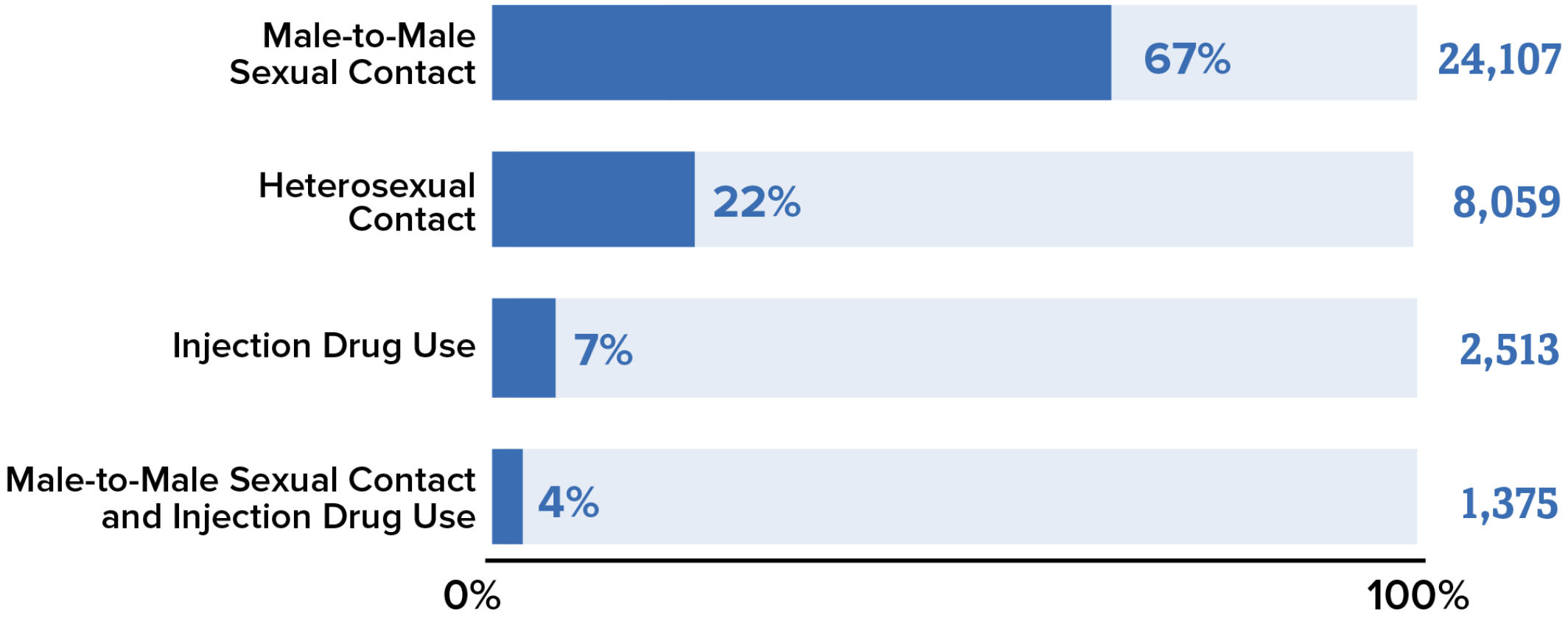
Ice breaker

What three items would you bring with you on a deserted island?

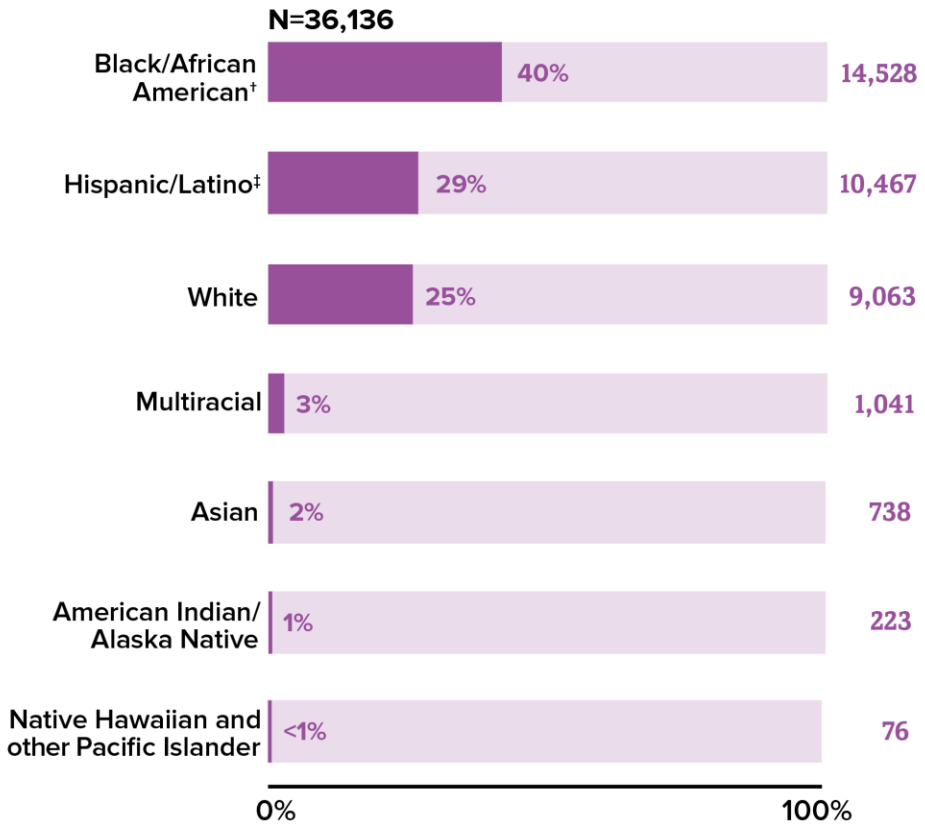
(HIV=LGBTQIA+)?



New HIV Diagnoses in the US and Dependent Areas by Transmission Category, 2021

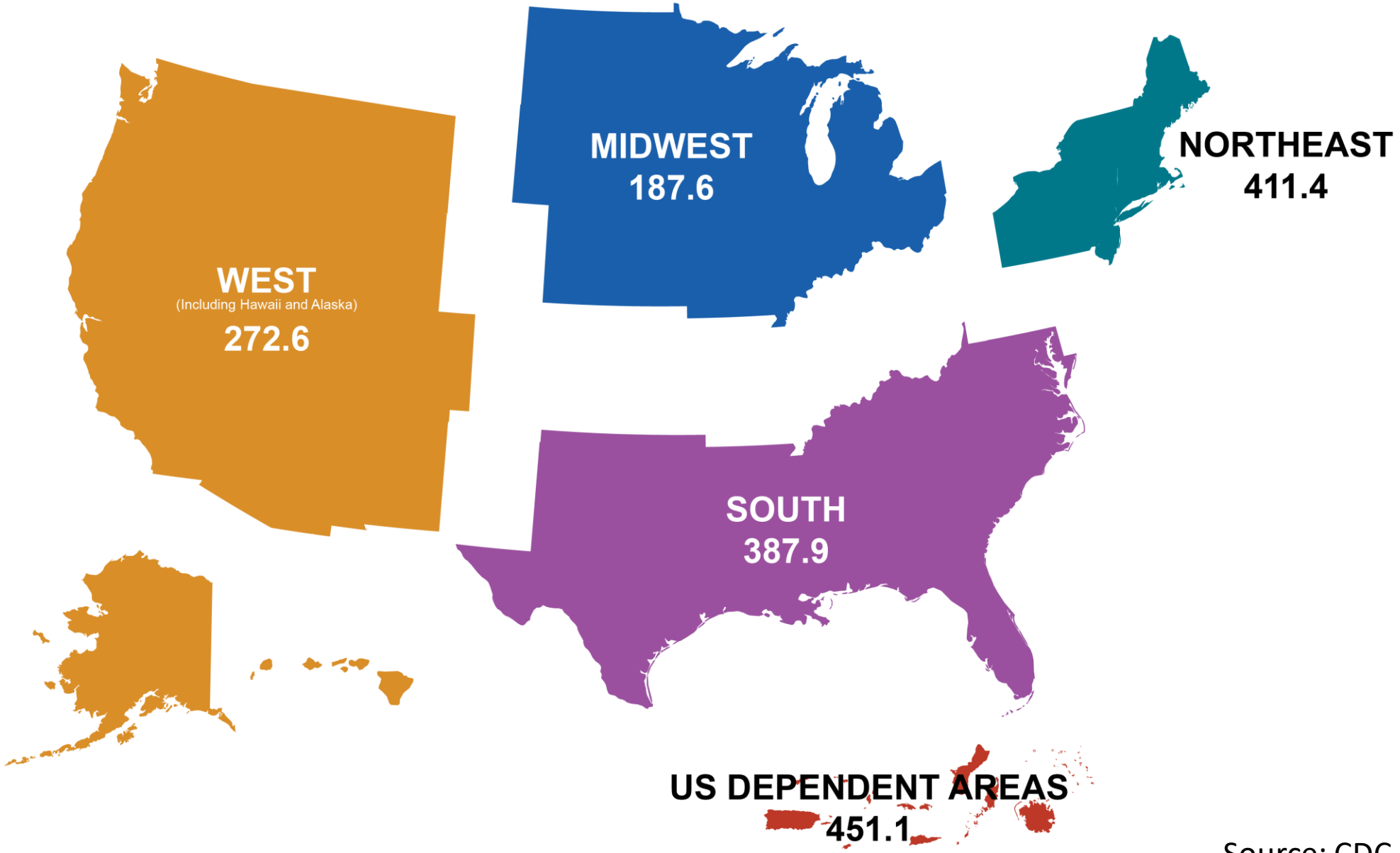


Site: CDC.gov



Racial and ethnic differences in HIV diagnoses persist.

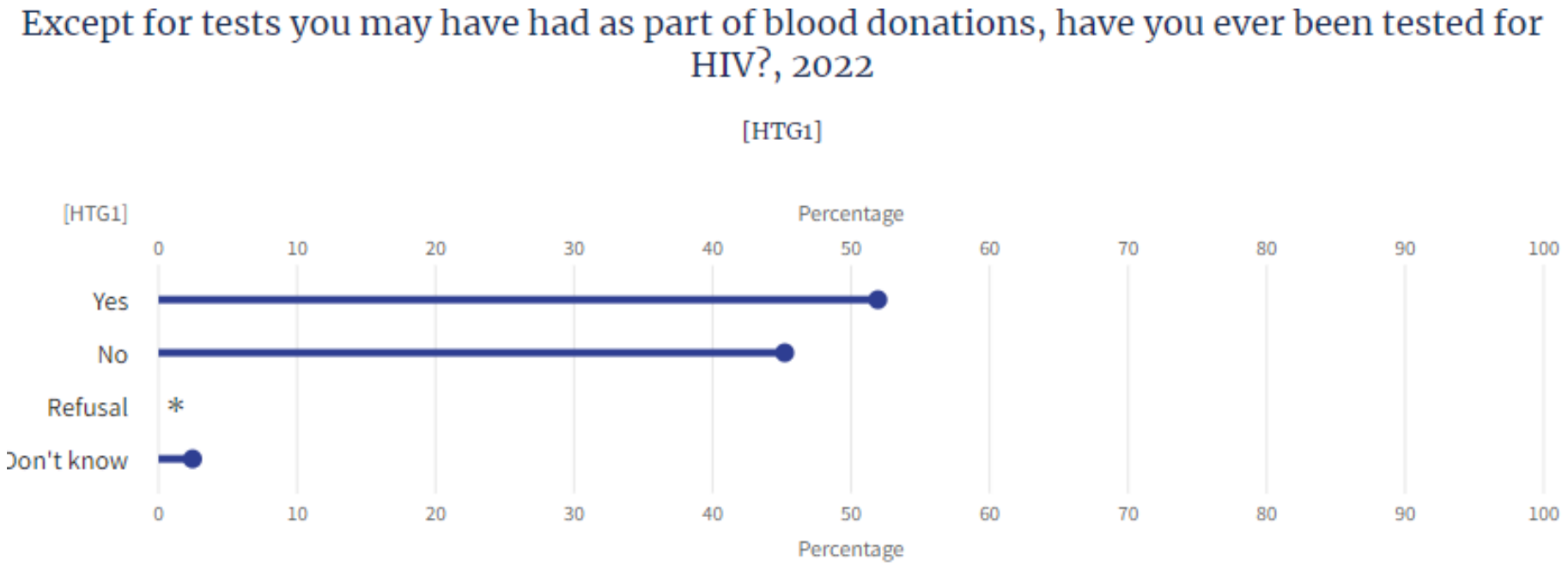
Site: CDC.gov



Source: CDC.gov

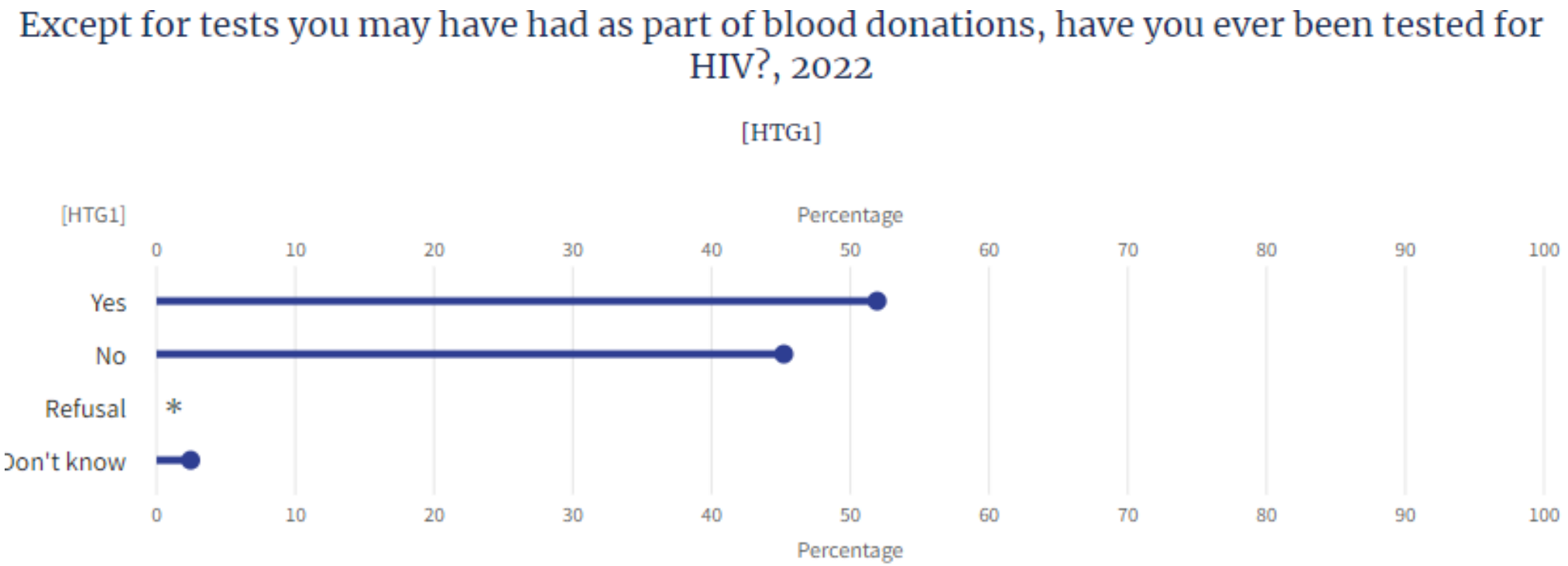
Table 2: HIV Metrics, 2020-2022

HIV Data Points	2020	2021	2022
Number of HIV Tests	2,489,031	3,272,865	3,492,034
Number of HIV Patients	189,970	200,006	199,442
% New Diagnoses Linked to Care within 30 Days	81.41%	82.70%	82.20%



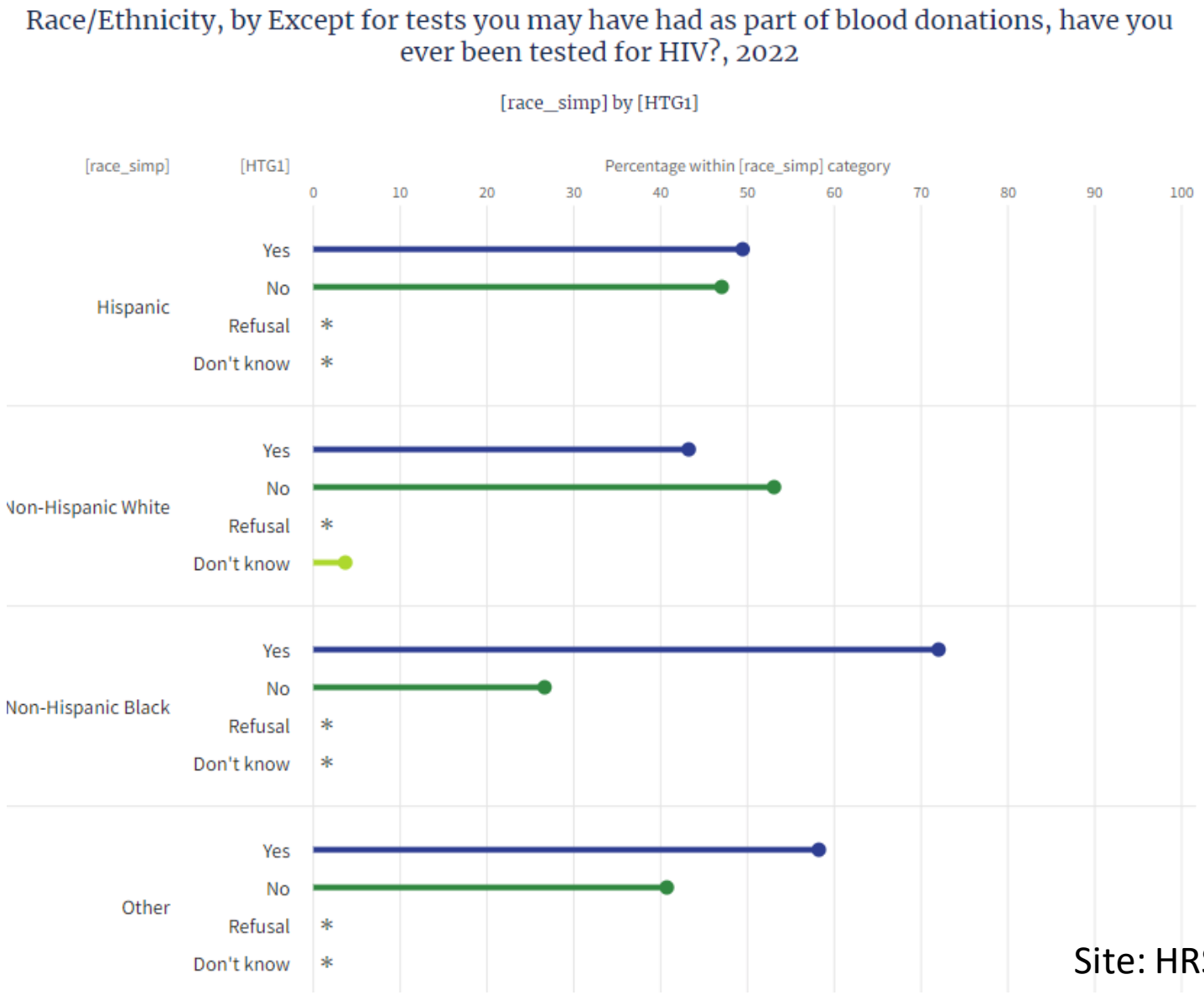
Source: HRSA.gov

HIV Testing by Race/Ethnicity



Site: HRSA.gov

HIV Testing by Race/Ethnicity



Site: HRSA.gov

Culture and the Practice of Medicine

People are shaped by their culture. An individual's diverse beliefs, behaviors, attitudes toward medicine, and even the outcome of their medical treatments are all influenced by the cultures that comprise them. 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
- Attitude toward physical touch
- Desire for interaction vs. desire to be alone
- Food and diet, Religious customs , Desire for personal space
- Understood acceptable amount of personal space

Cultural Competence

Cultural competence is a set of congruent behaviors, attitudes, and policies that come together in a system, agency or among professionals and enable that system, agency or those professions to work effectively in cross-cultural situations.

Source: CDC.gov

Cultural Humility

A willingness to suspend what you know, or what you think you know, about a person based on generalizations about their culture. It focuses on self-humility rather than achieving a state of knowledge or awareness.

What is HIV Stigma?

HIV stigma is negative attitudes and beliefs about people with HIV. It is the prejudice that comes with labeling an individual as part of a group that is believed to be socially unacceptable.

Here are a few examples:

- Believing that only certain groups of people can get HIV
- Making moral judgments about people who take steps to prevent HIV transmission
- Feeling that people deserve to get HIV because of their choices

What causes HIV stigma

- HIV stigma is rooted in a fear of HIV. Many of our ideas about HIV come from the HIV images that first appeared in the early 1980s. There are still misconceptions about how HIV is transmitted and what it means to live with HIV today.

- The lack of information and awareness combined with outdated beliefs lead people to fear getting HIV. Additionally, many people think of HIV as a disease that only certain groups get. This leads to negative value judgements about people who are living with HIV.

HIV Fears

Homophobic and moralistic images of 1980's still haunt our view of HIV

THE BIAS

ICEBERG MODEL

MINDFUL CHOICES
(CONSCIOUS DRIVERS)

THINKING BRAIN
(PRE-FRONTAL/NEOCORTEX)

PRECONSCIOUS BIAS
(PERSONALITY BASED DRIVERS)

FEELING BRAIN
(HIPPOCAMPUS, AMYGDALA, HYPOTHALAMUS)

UNCONSCIOUS BIAS
(NEUROBIOLOGICAL BASED DRIVERS)

HIV - Discrimination

While stigma refers to an attitude or belief, discrimination is the behaviors that result from those attitudes or beliefs. HIV discrimination is the act of treating people living with HIV differently than those without HIV.

Here are a few examples:

- A health care professional refusing to provide care or services to a person living with HIV
- Refusing casual contact with someone living with HIV
- Socially isolating a member of a community because they are HIV positive
- Referring to people as HIVers or Positives

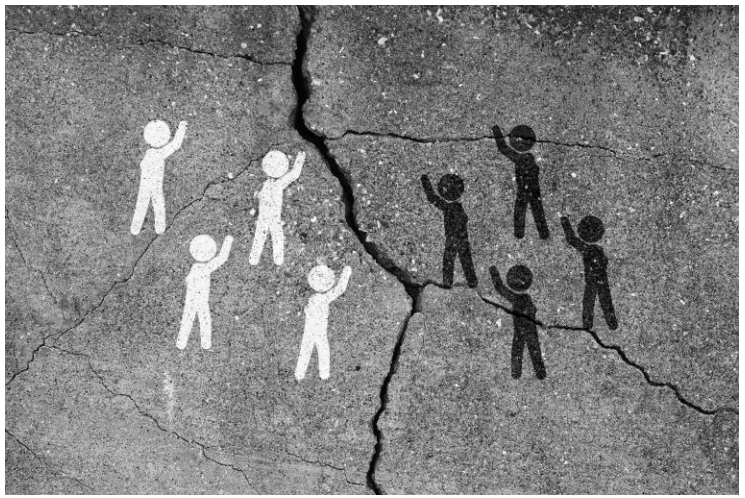


Table 2 Cultural sensitivity and awareness checklist

Focus	Instructions
1. Communication method	Identify the patient's preferred method of communication. Make necessary arrangements if translators are needed.
2. Language barriers	Identify potential language barriers (verbal and non-verbal). List possible compensations.
3. Cultural identification	Identify the patient's culture. Contact your organisation's culturally specific support team (CSST) for assistance.
4. Comprehension	Double-check: Does the patient and/or family comprehend the situation at hand?
5. Beliefs	Identify religious/spiritual beliefs. Make appropriate support contacts.
6. Trust	Double-check: Does the patient and/or family appear to trust the caregivers? Remember to watch for both verbal and non-verbal cues. If not, seek advice from the CSST.
7. Recovery	Double-check: Does the patient and/or family have misconceptions or unrealistic views about the caregivers, treatment, or recovery process? Make necessary adjustments.
8. Diet	Address culture-specific dietary considerations.
9. Assessments	Conduct assessments with cultural sensitivity in mind. Watch for inaccuracies.
10. Health care provider bias	Always remember, we all have biases and prejudices. Examine and recognise yours.

Source: Aidsetc.org

Multicultural Intake Checklist

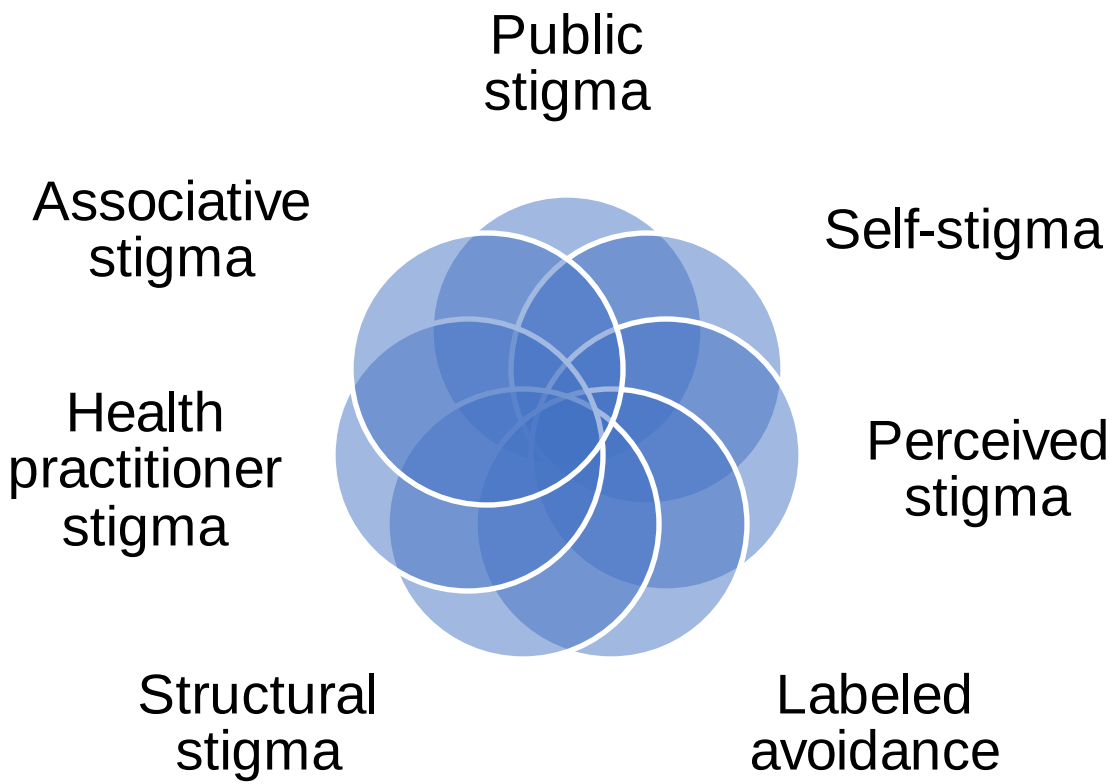
- ☐ Immigration history
- ☐ Relocations (current migration patterns)
- ☐ Losses associated with immigration and relocation history
- ☐ English language fluency
- ☐ Bilingual or multilingual fluency
- ☐ Individualistic/collectivistic orientation
- ☐ Racial, ethnic, and cultural identities
- ☐ Tribal affiliation, if appropriate
- ☐ Geographic location
- ☐ Family and extended family concerns (including nonblood kinships)
- ☐ Acculturation level (e.g., traditional, bicultural)
- ☐ Acculturation stress
- ☐ History of discrimination/racism
- ☐ Trauma history
- ☐ Historical trauma
- ☐ Intergenerational family history and concerns
- ☐ Gender roles and expectations
- ☐ Birth order roles and expectations
- ☐ Relationship and dating concerns
- ☐ Sexual and gender orientation
- ☐ Health concerns
- ☐ Traditional healing practices
- ☐ Help-seeking patterns
- ☐ Beliefs about wellness
- ☐ Beliefs about mental illness and mental health treatment
- ☐ Beliefs about substance use, abuse, and dependence
- ☐ Beliefs about substance abuse treatment
- ☐ Family views on substance use and substance abuse treatment
- ☐ Treatment concerns related to cultural differences
- ☐ Cultural approaches to healing or treatment of substance use and mental disorders
- ☐ Education history and concerns
- ☐ Work history and concerns
- ☐ SES and financial concerns
- ☐ Cultural group affiliation
- ☐ Current network of support
- ☐ Community concerns
- ☐ Review of confidentiality parameters and concerns
- ☐ Cultural concepts of distress (DSM-5*)
- ☐ DSM-5 culturally related V-codes

Source: SAMHSA.gov

Stigmatized Characteristics

- Age
- Body size
- Physical appearance
- Mental health
- Sexual orientation
- Housing status

Types of stigma



Break out Room 1. How are these people's health affected by Stigma?, How would you help them?

"I'll never forget it. I just wanted to die. I just felt like I was useless, and I shouldn't live, and I felt real disgraced, shamed. I just felt bad. Other than feeling bad mentally I felt bad physically. I just, it took me a long time. I stayed in denial for a long time."

"Most employers would not employ me because I am HIV positive."

a) Public stigma
b) Self-stigma
c) Perceived stigma
d) Labeled avoidance
e) Structural stigma
f) Health practitioner stigma
g) Associative stigma

Break out Room 2. How is these people's health affected by stigma. What would you do to help them?

"My neighbors would not like living next door to me if they knew I had HIV."

"They think people with HIV should live in separate houses."

a) Public stigma
b) Self-stigma
c) Perceived stigma
d) Labeled avoidance
e) Structural stigma
f) Health practitioner stigma
g) Associative stigma

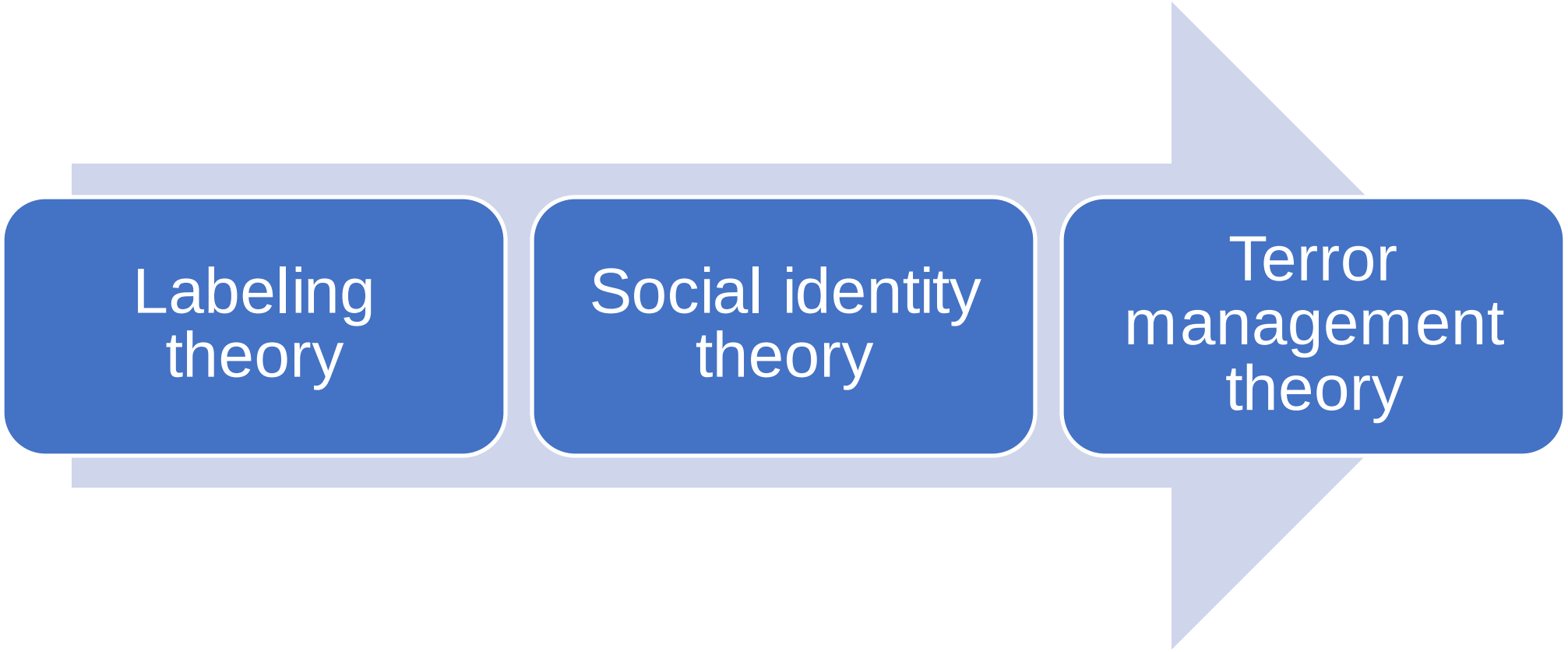
Break out Room 3. How is these people's health affected by stigma? What can you do to help them?

"They talk about you like a dog. People are just uncaring, insensitive… point their fingers and look down on people living with HIV like modern day leprosy."

"People say 'She got AIDS… just stay away from that person."

a) Public stigma
b) Self-stigma
c) Perceived stigma
d) Labeled avoidance
e) Structural stigma
f) Health practitioner stigma
g) Associative stigma

Theories to explain stigma



Group Activity:

What are the harmful effects of stigma?

Stigma: What is the impact?

Lack of access to treatment

Risks of personal safety

Lower quality of care

How do we develop cultural competency?

- **Practice openness** by demonstrating acceptance of difference.
- **Be flexible** by demonstrating acceptance of ambiguity.
- **Demonstrate humility** through suspension of judgment and the ability to learn.
- **Be sensitive to others** by appreciating cultural differences.
- **Show a spirit of adventure** by showing curiosity and seeing opportunities in different situations.
- **Use a sense of humor** through the ability to laugh at ourselves.
- **Practice positive change or action** by demonstrating a successful interaction with the identified culture.

Source: Penn State University

Cultural Competence Strategies

- Learn the terminology and pronouns
- Understand the unique factors and challenges your patients face in health and healthcare
- Understand how discrimination and prejudices create unfair obstacles
- Create welcoming environments
- Implement meaningful changes to overcome barriers

Source: Penn State University

Cultural Competence Basics

• 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 status with "relationship status" on forms , which allows persons to indicate their relationship status.

• Demonstrate openness and avoid assumption

• 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.9

• 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.

Case study

Tala is a 26-year-old Filipino woman who got tested at a health center after reading about the multicultural staff in a local newspaper. She reported that her husband has been seeing commercial sex workers for several years, has been in and out of drug treatment programs, and has been physically abusive toward her while intoxicated. Her husband refuses to use condoms when they are sexually active. Tala speaks minimal English and is concerned that she is HIV positive. She says that she feels fine and does not have any symptoms, but she is worried because of her husband's risky behavior. She reports that she has no job, no close friends and all of her family members are in the Philippines. She spends most of her time alone in their small apartment cooking and caring for their two small children. She has not seen a doctor since arriving in the United States sixteen months ago.

suggested approaches for effective, culturally competent initial encounters

Discuss other Cultural Competence issues that may impact retention into care and treatment.

Dialogue with your patients

May I ask you a few questions about your sexual health and sexual practices? I understand that these questions are personal, but they are important for your overall health.

- At this point in the visit I generally ask some questions regarding your sexual life. Will that be ok?

- I ask these questions to all my patients, regardless of age, gender, or marital status. These questions are as important as the questions about other areas of your physical and mental health. Like the rest of our visits, this information is kept in strict confidence unless you or someone else is being hurt or is in danger. Do you have any questions before we get started?

- Do you have any questions or concerns about your sexual health?

Source: nastad.org

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

Source: nastad.org

Institutional Basics

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.15
- 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. Incorporate educational trainings into onboarding protocols or mandatory staff meetings
- Conduct an individual and organizational assessment, on an ongoing basis, of cultural and linguistic competence in order to identify areas for growth.16

Source: nastad.org

Tips to your team

1) Examine your own attitudes, leave any bias or prejudice at home
2) Realize that we serve diverse populations
3) Include people living with HIV or members of key affected populations on your team
4) Be explicit and don't assume your patients feel comfortalble with you
5) Use non-verbal communication

Source: NASTAD.org

SPARE people of stigma

- **S**
- **P**
- **A**
- **R**
- **E**

- **S**can/Survey
- **P**reemptively determine who can be stigmatized
- **A**ctivate proactive preventive measures
- **R**eemphasize the science
- **E**ngage the communities that may be affected by stigmatization

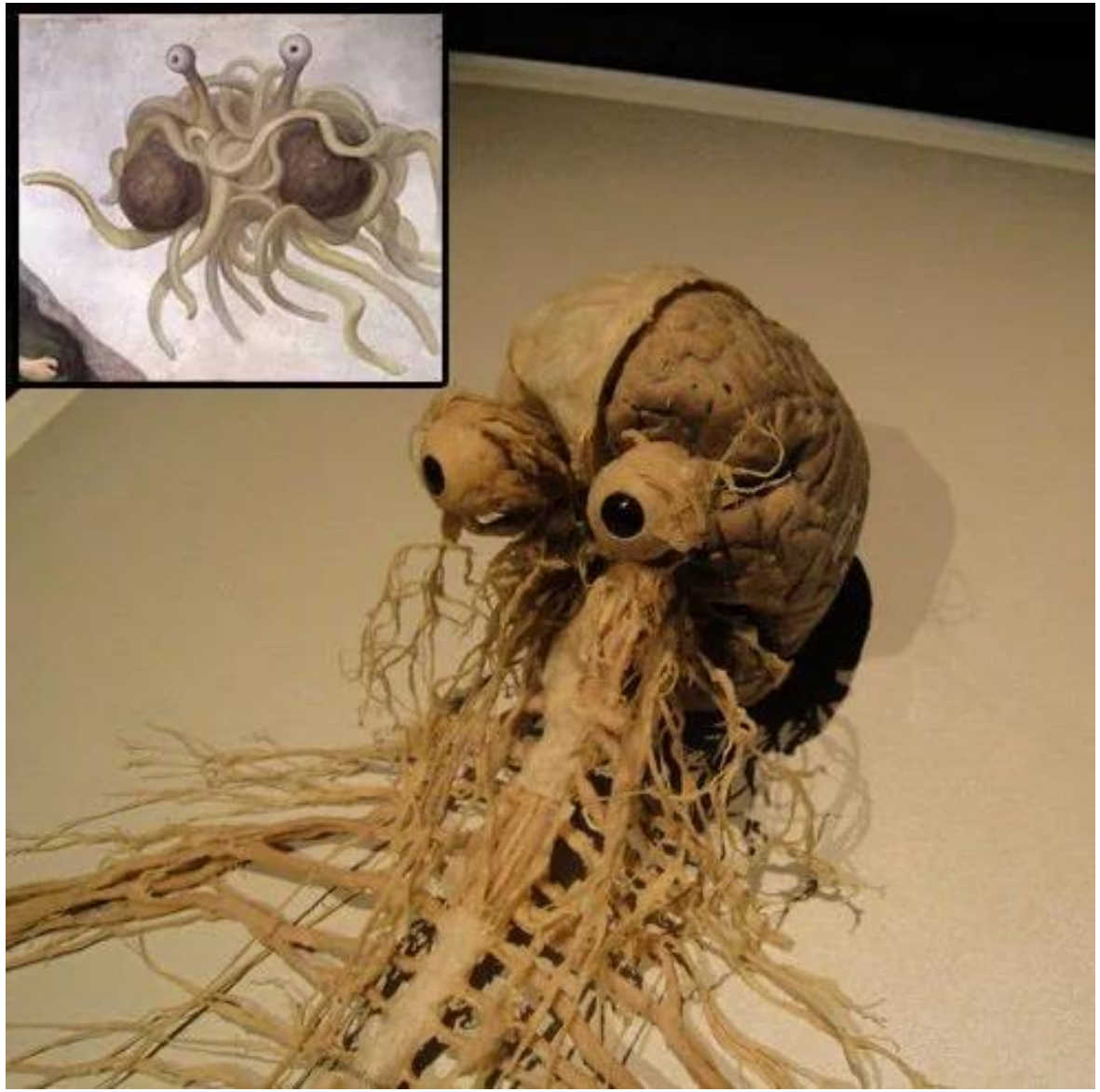
Source: nastad.org

Source: The health policy project

Case Study

Sara is a 30-year-old sex worker. One day she went to a health facility for an STI check and a supply of condoms. When she arrived at the health facility, she was kept waiting for a long time. Clients who arrived after her were treated before her. When she asked one nurse for help, the nurse said, “You’ll just have to wait. We know you—ladies of the night! You wait all night for men, so why can’t you wait a few more minutes?” The nurse said this in the presence of all of the other clients; Sara felt humiliated.

This is how we are



Upcoming Sessions Reminder

- **Session 2 (04/17/2024) at 1:00 pm EDT:** How to destigmatize HIV
- **Session 3 (04/24/2024) at 1:00 pm EDT:** Cultural competence models for African Americans
- **Session 4 (05/01/2024) at 1:00 pm EDT:** Cultural competence models for Hispanics

Q&A Session

Complete our Post Evaluation Survey

National Center for Health in Public Housing

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Thank you!