

Public Health 101

Module II: Cultural Competency and Cultural Humility

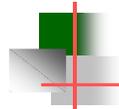
Developed by:

Alameda County Public Health Department
Community Assessment Planning & Education Unit:
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- Welcome everyone to the training.
- Have facilitators introduce themselves
- Go over logistics—when the training gets over, help yourself to food, MAKE SURE TO SIGN IN, CEUs, does everyone have copies, etc.
- Briefly reiterate the purpose of PH101—all moving towards address health inequities and they build on each other.
- We have a lot to get through, so we need to try to follow the agenda. We will end at 12:30.

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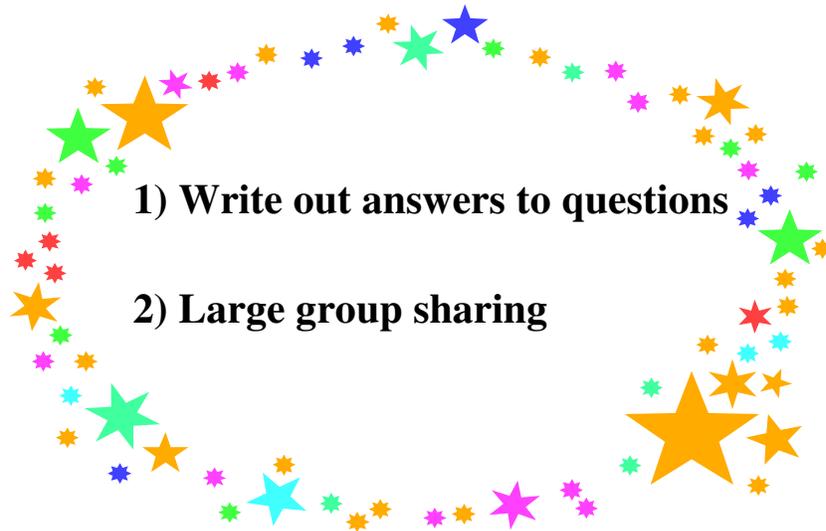
Agenda

- Welcome and Overview
- Introductions
- Ground Rules
- Part I: Cultural Competency
- Break
- Part II: Cultural Humility
- Part III: Cultural Competency and Cultural Humility Skills
- Case Studies
- Personal Commitments
- Evaluation



Cultural Awareness Activity #1

Your Hidden Talent



Instructions: have participants refer to the handouts...explain the first page...explain that the **GOAL OF THIS EXERCISE IS TO HAVE STAFF RECOGNIZE** the cultural beliefs, traditions, values, etc. that we all take for granted.

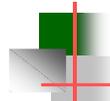
Have participants take a few minutes to write on their sheets individually. Then have each person introduce themselves.

It is easier and takes less time if you go in order and just have people going around the room rather than waiting for individuals to volunteer. Facilitators should introduce themselves too and one facilitator can start the discussion and give an easy example (meaning don't talk about a difficult to match talent, e.g. writing a novel by age 20).

Asking people to add their last name can be helpful as well so that people can put faces with names they may have seen via email and some people may want to add something about their name to the discussion.

Ask people their program as well.

- Create ground rules after this slide
 - Cell phones/pagers on silent
 - Step up; step down
 - The group makes the training
 - Any others you want to add

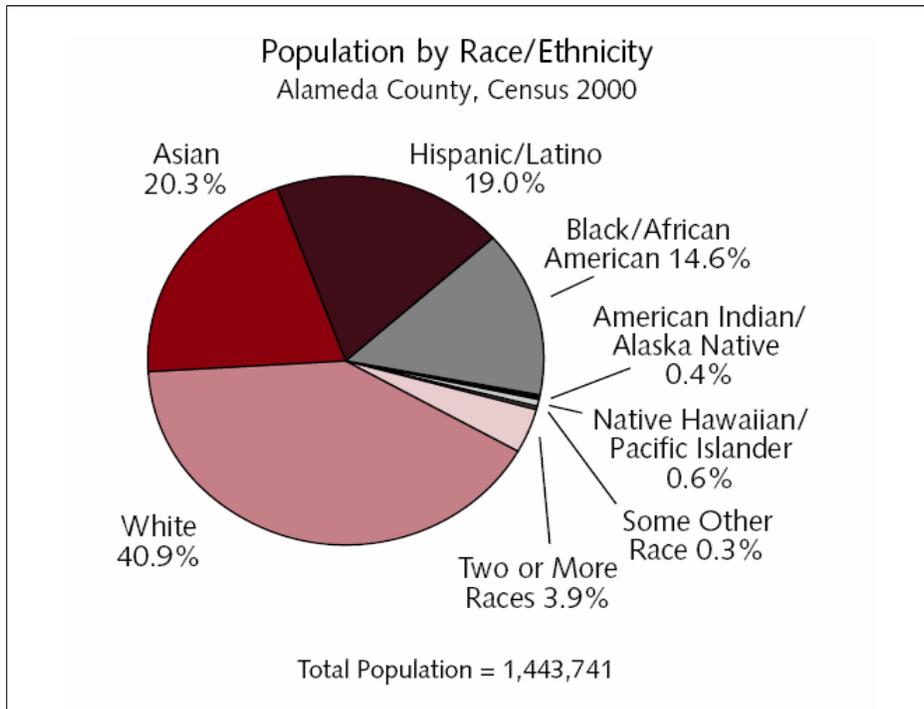


Learning Objectives

- Increase awareness and appreciation of the diversity in Alameda County's population
- Increase awareness and appreciation of ACPHD staff's cultural diversity
- Enhance our capacities and skills to work across different cultures and diverse groups
- Increase understanding of cultural competence and cultural humility in public health practice



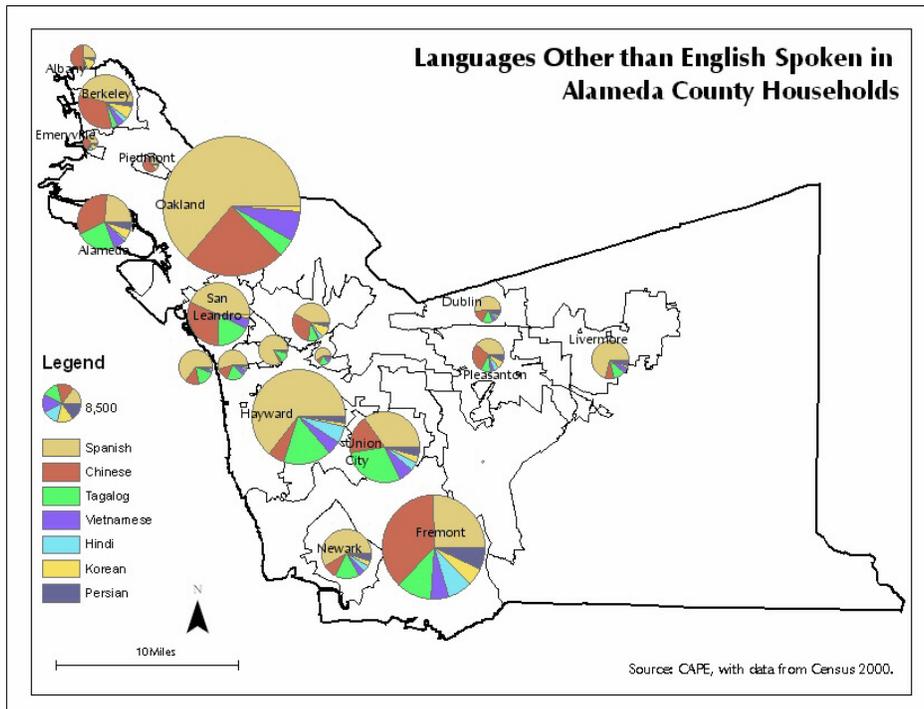
There is a lot of experience in the room and we are here as facilitators to bring about a discussion about that experience so everyone can learn from each other.



So why are we here today?

This slide shows what many of you know through your work. Alameda County is a very diverse place. (Read the percentages on the slide). Within the broad ethnic categories, there is an additional layer of diversity within these ethnicities, (give one example: such as Chinese, Japanese, Filipino, South Asian/Indian in the Asian category and Latinos who come from many countries and cultures throughout North, Central and South America and the Caribbean; African Americans from all across the U.S. and the Caribbean; etc. Pacific Islanders comprise of people from dozens of countries throughout the Pacific Islands....

ALCO is a relocation site for Native Americans, so we do serve a native American population.



We are also a diverse county in terms of languages spoke.

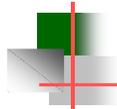
What languages do some of the people you work with speak? What languages are spoken by the people in the room today?

Each pie is a representation of which languages other than English are spoken at home. The larger the pie, the larger the number of people in that city who speak a language other than English at home.

For example, in Oakland there is a very large pie, so this means there are a lot of people speaking languages other than English at home. In looking at the colors of the pie, we can see that of the non-English speaking households, 2/3 speak Spanish and the remaining 1/3 speak an Asian language.

In Fremont, more people speak a Chinese language with Spanish being the second most commonly spoken language.

Again, this highlights how diverse the residents of Alameda County are.



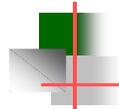
Part I

CULTURAL COMPETENCE



Our diverse population is one reason we need to understand more about Cultural Competence.

Some of you may have had cultural competency trainings before or have a lot of experience in the field. We can use this time to learn from each other. We are going to provide a brief overview of cultural competence and cultural humility and then have a lot of time for activities and discussion so you can learn from each others.



Culture

One definition:

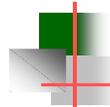
Culture is a set of learned beliefs, traditions, principles and guides for individual and collective behaviors that members of a particular group commonly share with each other.



We're exploring cultural competency and cultural humility today, so we need to start from a common definition of culture. This is just one.

Culture serves as a road map for perceiving and interacting with the world—read slide

Culture can include any of the aspects of what makes us who we are—ethnicity, where we grew up, our age, our career, religion. It has many different aspects. There is even a Public Health department culture—we use different terms & acronyms and people outside may not know what we are talking about.



What Is Cultural Competence?

“Cultural and linguistic competence is 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...*”

*U.S. Dept of Health and Human Services
Office of Minority Health (Cross, et al, 1989)*



Next, we'll explore the importance of cultural competence and cultural humility—first focusing on cultural competence. As the earlier slides illustrated, as ACPHD staff, we serve a very diverse population from many parts of the world, who have varied cultures and who speak many different languages.

Cultural competence in health services, including public health, is about being responsive to meet the diverse cultures, cultural health practices and languages of the populations we serve. *Emphasize the italicized section above.*

It's particularly important in public health because we perform important services and work with various populations.

Brief history of cultural competence in health care

PRE-CIVIL RIGHTS MOVEMENT: Rampant inequities between health care quality for Whites compared to non-Whites

- Jim Crow laws
- Unethical medical research—Tuskegee
- Forced sterilization of disenfranchised women and men



(don't read aloud everything; be comfortable enough with the main points to be able to discuss each issue)

In addition to the cultural perspectives that impact PH, history impacts our need for a culturally competent workforce. **WHY is cultural competency so important in our work as a government agency?** There is a history of government, academic, health, and medical related abuse of the population that affects how communities of color view government workers. There have been many unjust practices that were GOVERNMENT led against people of color and other populations in the U.S. Many of you are aware of these events, but because they have such an impact on how the community might view us as government workers, it's important to discuss them.

Jim Crow laws: imposed racial segregation from the end of the 19th century until the 60s, mainly in the south. These laws segregated health services between Whites and non-Whites and it meant much poorer conditions for health care for non-Whites. Additionally, it segregated determinants that we know relate to health—things like education, transportation, jobs.

A lot of you have heard of Tuskegee, but not everyone may be familiar with the details. Can someone describe what happened during this time? *(depending on how accurate they are, fill in the details)*

•1932-72 (40 years). Treatment for syphilis was withheld from 399 Af-Am men, mostly illiterate sharecroppers who were promised free medical care and did not realize what they were signing up for. By the end, 28 died from syphilis, 100 had related complications, 40 wives and 19 children had also contracted syphilis—all at the hands of our government.

Forced sterilization: As of 1982, 15% of white women had been sterilized, vs. 24% of Af-Am women, 35% of Puerto Rican women, and 42% of Native American women. Early 1970s: 100,000 to 150,000 low-income individuals were annually sterilized under federally funded programs—so again, a policy created and instituted by our government. Other groups targeted: mentally ill and disabled, deaf, blind, epileptic, and physically deformed women and men. Sterilization was sometimes an official policy of government; sometimes physicians were highly suggestive and offered few alternatives. California sterilized more people than any other state. (Pre WWII) Information about the California sterilization program was produced into a book form that was used by Hitler.

These are just a few examples of oppression at the hands of the government. Have any of these issues come up as you have been working with the community or with partners?

Brief history of cultural competence in health care

Title VI of the Civil Rights Act (1964): services provided with the funding from the federal government must be delivered without regard to race, color, or national origin.

National Standards on Culturally and Linguistically Appropriate Services (2001)
(Federal funding requirements:
Standards 4, 5, 6, 7)



Since this time, there have been positive steps forward, at least legally. The Civil Rights (1964) movement led to Title VI of the Civil Rights Act, which states that services provided with funding from the federal government must be delivered without regard to race, color, or national origin.

National Standards of Culturally and Linguistically Appropriate Services (CLAS)- 2001

The set of national standards for culturally and linguistically appropriate services (CLAS) issued by the U.S Department of Health and Human Services Office of Minority Health serves to "ensure equitable and effective treatment" to all people using the healthcare system. They are on the handout.

We know that what the Civil Rights Act and these National Standards are not always being met—for example, the Boston Globe (July 20, 2007)recently had an article showing how ER trainees exhibited signs of racial bias in the care they provided—and there are MANY other studies like this. But, understanding and being able to use these standards can help us address these issues. They are a tool we can use to ensure better health outcomes for our communities.

Brief history of cultural competence in health care

National Standards on Culturally and Linguistically Appropriate Services (Federal funding requirements)

Standard 4: Provision of language assistance services at no cost to the patient.

Standard 5: Verbal and written notices in preferred language on right to receive language services

Standard 6: Competence of language assistance providers

Standard 7: Easily understood patient-related materials.



Hand out brochure and other handouts on CLAS.

There is one brief handout and then a longer one that goes more into depth on the standards. Participants do NOT have to take the long version if you don't want to)

Discuss and ask if they have seen these in practice (or not being practiced)

Some issues that typically come up:

- Clarification use of children in translation; mention the brochure: Family members under 18 are not viewed as appropriate translators.
- Gender may be an issues for standard 4—some people may not be comfortable speaking to someone of a particular gender for cultural reasons.
- Through these discussions, we know that as the health department, we need to do more to help staff meet these. This is being relayed to leadership. The goal of PH 101 is education, but a long-term opportunity is to address issues like this. Staff can also take on these issues if they see ways to improve.

Brief history of cultural competence in health care

State of California:

1999: California Department of Health Services requirements for Medi-cal plans and providers

- *quality interpretation and translation*
- *needs assessments*
- *cultural competence training*
- *community input*



In California, we've also adapted other requirements, including: (slide)

Brief history of cultural competence in health care

State of California:

AB 1195 (2005)—continuing medical education courses...include curriculum in the subjects of cultural and linguistic competency in the practice of medicine...

AB 800 (2005)—Requires all medical facilities, including, but not limited to hospitals, clinics, and physician and surgeon's offices, to include a patient's language preference on the patient's health records.



AB 1195: (you don't have to read all of these—just be familiar with this and summarize what the bill did in your own words)

- On October 4, 2005, Governor Arnold Schwarzenegger signed Assembly Bill 1195 (AB 1195) into law. AB 1195, “Continuing Education: Cultural and Linguistic Competency,” went into effect July 2006. The law mandates that the CME accrediting agencies (the ACCME and IMQ/CMA) must develop standards for compliance.
- This bill requires on and after July 1, 2006, that continuing medical education courses, except as specified, include curriculum in the subjects of cultural and linguistic competency in the practice of medicine, as defined. The bill would require accreditation associations to develop standards for this curriculum before July 1, 2006.
- This bill requires accreditation association to develop standards by July 1st, 2006, for continuing medical education courses to include curriculum in cultural and linguistic competency in all coursework that includes direct patient care. Enacted July 1st, 2006.

AB 800 guarantees a patient’s spoken language is included in his/her medical records. (Authored by Senator Leland Yee, PhD)

Brief history of cultural competence in health care

State of California:

SB 853 Health Care Language Assistance Act
(2009)—health plans and health insurers are now required to provide their enrollees with interpreters and translated documents. They also must collect data on race, ethnicity, and language to address health inequities.

http://org2.democracynaction.org/o/5261/t/2271/content.jsp?content_KEY=661



This is focused on health plans, but it is important and ground-breaking legislation.

As the [Sacramento Bee reported](#), "Millions of Californians with limited English proficiency now have the right to an interpreter from their commercial health and dental plans - made possible by a first-in-the-nation law aimed at dismantling the language barriers that get in the way of good medicine"

Organizations are working to ensure our communities know about their new rights to language services, demand them from their providers, and know the process of filing a complaint if they are denied their rights.

Website has:

- [Summary of Key Provisions of SB 853 and Its Regulations](#),
- “I speak” cards in 13 languages
- And other information

Brief history of cultural competence in health care

National:

The Hill-Burton Act—public and non-profit hospitals deliver non-discriminatory practices in health services if they accept public funds for construction and renovations.

Medicaid—requires providers to render culturally and linguistically appropriate services

Medicare—requires linguistically accessible services

Emergency Medical Treatment and Active Labor Act
Patient Anti-Dumping Act



(You do not need to read all of this out loud—just be familiar with it to give a brief description about each act)

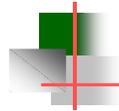
The Hill-Burton Act – The Hill-Burton Act, enacted by Congress in 1946, encouraged the construction and modernization of public and nonprofit community hospitals and health centers. In return for receiving these funds, recipients agreed to comply with a "community service obligation," one of which is a general principle of non-discrimination in the delivery of services. The Office of Civil Rights has consistently interpreted this as an obligation to provide language assistance to those in need of such services.

Medicaid - Medicaid regulations require Medicaid providers and participating agencies, including long-term care facilities, to render culturally and linguistically appropriate services. The Health Care Financing Administration, the Federal agency that oversees Medicaid, requires that states communicate both orally and in writing "in a language understood by the beneficiary" and provide interpretation services at Medicaid hearings.

Medicare – Medicare addresses linguistic access in its reimbursement and outreach education policies. Medicare "providers are encouraged to make bilingual services available to patients wherever the services are necessary to adequately serve a multilingual population." Medicare reimburses hospitals for the cost of the provision of bilingual services to patients.

Emergency Medical Treatment and Active Labor Act – The Emergency Medical Treatment and Active Labor Act, also known as the Patient Anti-dumping Act, requires hospitals that participate in the Medicare program that have emergency departments to treat all patients (including women in labor) in an emergency without regard to their ability to pay. Hospitals that fail to provide language assistance to persons of limited-English proficiency are potentially liable to Federal authorities for civil penalties, as well as relief to the extent deemed appropriate by a court.

It's important for us to be aware of the different standards so that we can at least help enforce them when it's not happening.



Summary: Cultural Competency

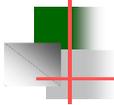
To recap, *cultural competency* includes *mandates, laws, rules, policies, standards, practices*, and *attitudes* used to increase the quality of interactions within the public health system, thereby producing better outcomes.



Cultural competency is about historical and legalized standards:

Cultural competence is defined as a set of congruent behaviors, attitudes, and policies that come together in a system, agency, or among professionals and enables that system, agency, or those professionals to work effectively in cross-cultural situations (Cross et al., 1989; Isaacs & Benjamin, 1991). Operationally defined, cultural competence is the integration and transformation of knowledge about individuals and groups of people into specific standards, policies, practices, and attitudes used in appropriate cultural settings to increase the quality of services; thereby producing better outcomes (Davis, 1997 referring to health outcomes).

http://cecp.air.org/cultural/Q_integrated.htm#def



“Simple justice requires that public funds, to which all taxpayers of all races (colors, and national origins) contribute, not be spent in any fashion which encourages, entrenches, subsidizes or results in racial (color and national origin), discrimination...” President John F. Kennedy, 1963



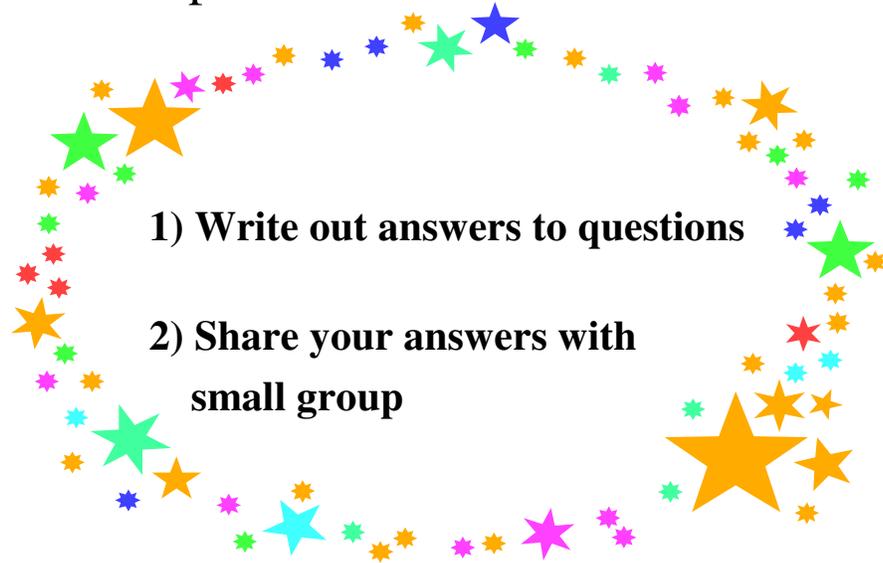
So these are just some of the laws and standards we can use. Depending on your position, this is just an overview and there is much more information out there.

Again, we have a lot to face, but there has been progress. We can learn, use, & understand these laws & standards around cultural competence to make sure we are meeting the needs of our community.

We are all government workers and our government has a divided past. As mentioned, our government has used it's power to harm people. It has also used it's power, as exemplified in this quote from JFK, to try to right these wrongs.

When we work with the community or provide services, we have to questions, which part of the government do they see when they see us coming? And how does our governmental past affect our work today? How can we use our governmental power to make things better?

Cultural Awareness Activity #2 & #3 Experiences with our Cultures

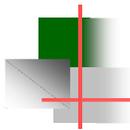


Instructions: have participants refer to the handouts...explain the first page...explain that the **GOAL OF THIS EXERCISE IS TO HAVE STAFF RECOGNIZE** the cultural beliefs, traditions, values, etc. that we all take for granted.

Tell them that at the end of this exercise, they will come together as a large group. During that time, ask for volunteers on what they shared in the small groups. Ask large group to reflect on the common values or themes that emerged from the small group sharing.

This is really focused at the personal and interpersonal level we just mentioned.

Debrief: What did you learn? What a-ha moments did you have? What did your group have in coming? Remember to share your ideas and observations instead of reading specifically what others said.



Part II.

CULTURAL HUMILITY



Cultural competency really started out by looking at how service providers worked with clients. Many of you might have been in other cultural competency courses, as many people started to go through classes that tried to help them **master others' cultures**. This doesn't really work for two **reasons—it's impossible to master every other culture and this can also lead to stereotypes**.

So standards of cultural competency have been helpful in many ways as mentioned, but it's lacking in other areas. This is where "cultural humility" comes in.

Cultural Humility

- Does not require mastery of lists of different cultures and peculiar health beliefs and behaviors.
- Entails developing a respectful partnership with diverse individuals, groups and communities.

-Drs. Melanie Tervalon and Jan Murray-Garcia



Whereas the term cultural competency encompasses mandates, policies, standards, etc., **cultural competency is a lifelong commitment to self-evaluation and self-critique and developing beneficial and non-paternalistic relationships.**

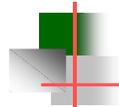
(<http://healthresearch.berkeley.edu/disparities/docs/CulturalHumility.pdf>)

According to Drs. Melanie Tervalon and Jan Murray-Garcia:

Common misconceptions in clinical settings that cultures can be represented, identified and codified with certain characteristics can lead to stereotyping of cultures. Additionally, cultures can be diagnosed and treated.

Clinicians view inappropriate or exotic behaviors as culturally influenced that can be controlled and adjusted to resemble norms of the dominant group.

Not everyone may work with clients covered by cultural competency laws, but everyone works with other people and cultural humility can help improve those relationships as well as with clients, residents, and partners.



Cultural Humility: Values

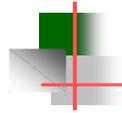
- Openness
- Appreciation
- Acceptance
- Flexibility



In earlier slides we discussed the areas of cultural competency...to go further into this discussion, let's talk more about **values/orientation, knowledge and skills that we can develop as PH workers.**

First here are the values that lend to cultural competency and humility:
read slide bullet points

Every situation we face will be different and there is no way to prepare for each one. But, we can use these as a checklist to help us assess whether we are approaching the situation with cultural humility



Knowledge Of Cultural Influences

History and social context of populations

- migration/resettlement
- colonization
- religious influences
- territorial shifts
- other social/political forces



We cannot know everything about every culture but we can at least become familiar with how culture influences health beliefs and health practices...

KNOWLEDGE ABOUT CULTURAL INFLUENCES:

Related to health beliefs and health care practices among diverse populations:

in obtaining health care, asking doctors and nurses questions about health related concerns

in following medical advice

in taking medications

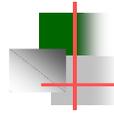
about healthy behaviors

Another key area that we'll be exploring more in Module 4 is the history and social context of various groups

History and social contexts of populations are important to know as well as you can—for example, some cultural groups have a long history of migration and re-settlement across the globe that have contributed to their present-day customs, beliefs, living conditions.

Many populations have been colonized by at least one nation that add to the cultural systems of these groups/populations

The next 2 slides look at things that culture can influence and are things we can be aware of as we try to practice cultural humility.



Knowledge Of Cultural Influences

- Sense of self and space
- Communication and language
- Dress & appearance
- Food & eating habits
- Time and time consciousness



Part of the reason we can't master another's culture is that we are a unique intersection of all of these various aspects of culture.

Sense of self and space

distance touch formal/informal open/closed

Communication and language

language/dialect gestures/expressions/tone
direct/indirect

Dress & appearance

clothing hair grooming

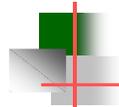
Food & eating habits

food restrictions/taboo utensils/hands
manners (example: home visits)

Time and time consciousness

promptness age/status pace

(example: pausing to say hello and ask how you are and really wanting to know the answer rather than just passing by in the hall and various levels of interaction on that spectrum)



Knowledge Of Cultural Influences

- Relationships
- Values and norms
- Beliefs and attitudes
- Mental processes and learning
- Work habits and practices



Relationships

family age/gender/kindred status
(example: who makes decisions in the family)

Values and norms—very important

group vs. individual independence vs. conformity
privacy respect
competition vs. cooperation
(example: how we view what is appropriate to share)

Beliefs and attitudes

religion position of women
social order/authority

Mental processes and learning

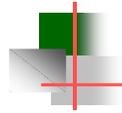
left/right brain emphasis logic/illogic

Work habits and practices

work ethic rewards/promotions
status of type of work division of labor/organization

Many people in the previous activity typically say everyone wants to be respected, but how people view “respect” may be very different from person to person. How do we know how to respect another person in a way that reflects their values?

How have these issues come up in your work?



Summary: Cultural Humility

To recap, *cultural humility* entails a lifelong **commitment to self-evaluation and critique.**

It includes:

- addressing power relations
- and working in partnerships



Tervalon & Murray-Garcia, 1998

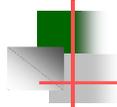
Cultural humility is best defined ...as a commitment and active engagement in a lifelong process that individuals enter into on an ongoing basis with patients, communities, colleagues, and with **themselves...a process that requires humility in how we bring into check the power imbalances that exist in the dynamics of communication.**

As government workers, we have various internal power differentials and also in many cases, power over those we work with externally. For example, we have the information that someone might need. How do we use this power?

So if we have had conflict with someone, we can ask where is this conflict really coming from? Is it personal and is it that I really don't like that person or what they are doing? Or is it more of a cultural understanding? We are in the same situation, but are perceiving it in two different ways.

Does anyone have an example of this? A conflict that you realized was based on cultural misunderstandings?

What about in working in with clients? What are the power relations?

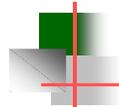


Part III.

**CULTURAL COMPETENCY
AND
CULTURAL HUMILITY
SKILLS**



We've talked now a bit about cultural competency and cultural humility. Now let's look at what are some of the skills necessary to do both.



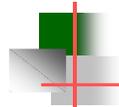
Skills Across all Domains

- Personal
- Interpersonal
- Program Planning
- Organizational
- Policy and Advocacy



We can assess situations across various levels to see if there are ways to improve.

In a few minutes, we will do some case studies and these are ways we can look at the situations in the case studies.



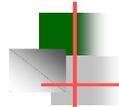
Personal Skills

- Ability to regularly conduct self-evaluation about how values and beliefs impact worldviews
- Commitment to continued learning about other cultures



For the **personal area**: this means that as we serve our clients, we need to be aware of our OWN personal values attitudes and knowledge about other's health beliefs and practices...since we have such a diversity of populations in the county, gaining knowledge about the dozens of cultures represented here would take us a while. However, we can at least reflect on our values and attitudes about other cultures so that we can respond in the most appropriate ways to respond to people we serve.

Example: One participant in a previous discussion said she would try to learn to say hello in all the languages her coworkers use as a way to learn more about their culture and language.



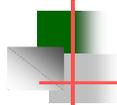
Interpersonal Skills

- Ability to communicate with others who have different language and worldview
- Capability to translate ways of seeing and behaving from one culture into another



In terms of skills, practicing cultural humility requires us to communicate with others from their vantage point...not just from ours. Give an example or ask for an example:

One example: in the community forums for the strategic plan, we didn't anticipate that some residents would be illiterate. The agenda included an interactive activity where residents had to write down their ideas. We were fortunate that one man let the facilitator know that they would prefer to talk rather than write. For future sessions, health department scribes instead recorded ideas and eliminated the need for residents to write.



Program Planning Skills

- Ability to show respect for another culture's values and identity
- Capacity to include the cultural, social and environmental influences on communities in program design
- Talent for building trust, developing relationships and working with culturally diverse community members



Cultural perspectives influence how programs are designed and implemented

Populations respond to programs differently—what works with one group, neighborhood, population may NOT work in another setting

When we design programs that serve diverse cultural groups, we can practice cultural humility by respecting other people's values and identity

This is more than just language issues—it's really about showing respect and sharing some power.

How do we do these things?—ask for examples from participants.

What are some things that have gone well? Not as well?

Organizational Development Skills

- Ability to establish organizational vision and leadership that promotes a positive multicultural work environment
- Capability to create and implement policies and procedures to foster diversity and inclusion



in hiring, promotion and retention

In a larger context, we are developing our agency/organization's ability to be culturally humble—how we're doing this: community forums, working with residents in participatory program planning, our strategic planning process invites community input.

We are building a critical mass among staff to address these things and support and retain staff.

Policy And Advocacy Skills

- Capability to assess and revise existing policies and procedures in the planning, delivery and evaluation of comprehensive programs and services for diverse populations
- Capacity to review and revise policies that allocate resources for culturally diverse populations, such as translation and interpretation services



And even more broadly, what are our policies? Do we have translation/interpretation services as a regular practice? Do we allocate resources for these needs?

We are moving towards this level as a health department.

ACPHD is well known across the country for progressive work and because of this we are trying to go where not many health departments have gone before.

What policies might affect our ability to work in a culturally humble manner at this level? Internally? Externally?

Cultural Competency and Cultural Humility

Cultural Competency can include:

- mandates
- laws
- rules
- policies
- standards
- practices
- attitudes

Cultural Humility is a process and a lifelong commitment to self-evaluation and critique to improve relationships and outcomes.



Recap across all levels again:

Personal

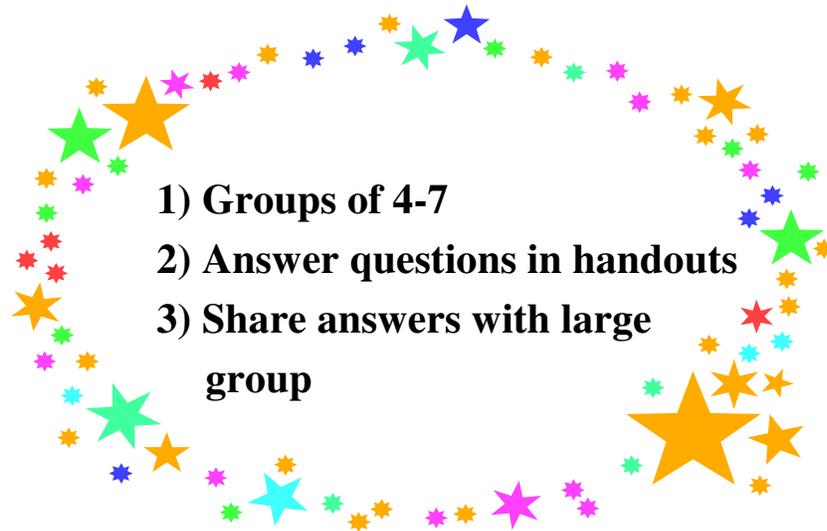
Interpersonal

Program Planning

Organizational

Policy and Advocacy

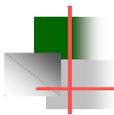
Cultural Awareness Activity #4 Small Group Discussions on Case Studies



Instructions: have participants refer to the handouts...explain the first page...explain that the GOAL OF THIS EXERCISE IS TO HAVE STAFF RECOGNIZE the cultural beliefs, traditions, values, etc. that we all take for granted.

This also ties into making life-long reflection a goal.

At the end of this exercise, have large group come together; ask for volunteers on what they shared in the small groups. Ask large group to reflect on the common values or themes that emerged from the small group sharing.

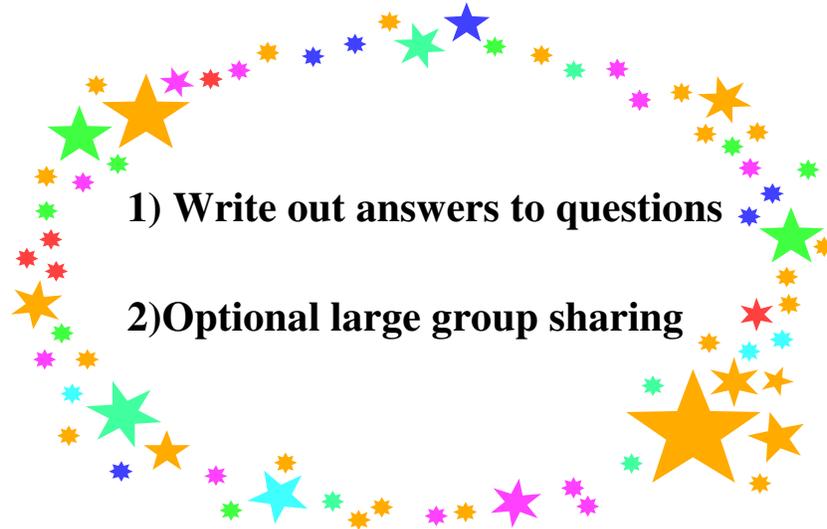


Why do we work on cultural competency and cultural humility?

- Helps to provide the highest quality of services to Alameda County residents
- Helps create positive working conditions among ACPHD employees



Cultural Awareness Activity #5 Creating a personal commitment...



Instructions: have participants refer to the handouts...explain the first page...explain that the GOAL OF THIS EXERCISE IS TO HAVE STAFF RECOGNIZE the cultural beliefs, traditions, values, etc. that we all take for granted.

At the end of this exercise, have large group come together; ask for volunteers on what they shared in the small groups. Ask large group to reflect on the common values or themes that emerged from the small group sharing.

Next Steps for PH 101

- Module III: Undoing Racism
- Module IV: Health Inequities
- Module V: Community Capacity Building



Resources

The California Endowment:

http://www.calendow.org/reference/publications/cultural_competence.stm

<http://www.calendow.org/reference/publications/healthmatters.stm>

Community Toolbox:

<http://ctb.ku.edu/>

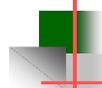
Hablamos Juntos "More Than Words" toolkit

<http://www.hablamosjuntos.org/mtw/default.toolkit.asp>

The National Center for Cultural Competence:

<http://www11.georgetown.edu/research/gucchd/nccc/>





Resources

DHHS/ Office of Minority Health:

<http://www.omhrc.gov/>

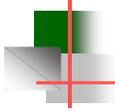
California Standards for Healthcare Interpreters:
Ethical Principles, Protocols, and Guidance on Roles
& Intervention

http://chia.ws/documents/publications/CA_standards_healthcare_interpreters.pdf

California Health Advocates

<http://www.cahealthadvocates.org/newsletter/2007/04/humility.html>





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