

## Prescription 4: Cultural Sensitivity

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### Facilitator Overview

Competency:	<i>Cultural Sensitivity</i>
Content:	Covers the reasons cultural sensitivity is important; sensitivity continuum; diversity <i>within</i> groups; organizational culture; culturally defined behaviors; and the application of cultural sensitivity in the health center.
Lessons:	<ul style="list-style-type: none"><li>• Lesson A: <i>Understanding Your Own Culture</i></li><li>• Lesson B: <i>Whom Do We Serve?</i></li><li>• Lesson C: <i>The Continuum</i></li></ul>
Estimated Total Time:	5 hours 15 minutes max
Methods / Media	<ul style="list-style-type: none"><li>• “Reader”</li><li>• Self-identification</li><li>• Team discussion</li><li>• Analysis</li><li>• Small-group activity</li></ul>
Assessment Method:	<ul style="list-style-type: none"><li>• Pre- and Post-test</li><li>• Worksheet</li><li>• Report back</li></ul>

Facilitator Preparation



**What You Will Need for All Lessons in this Prescription:**

- easel
- flip pad
- large colored markers
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**Introduction to the Prescription – 5 minutes**

The Competency



**Present** the definition of this prescription:

- Cultural Sensitivity is a set of skills that enables you to learn about and get to know people who are different from you, thereby coming to understand how to serve them better within their own communities.



**Point out** the lesson(s) that you have selected for the Site Team to cover in this module, from the 3 lessons available to you.

If you will have other presenters or lessons separate from this curriculum, **review** the schedule with the Team.

## Lesson A: Understanding Your Own Cultures

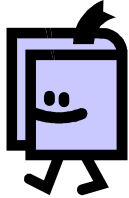
Lesson:	<i>Understanding Your Own Cultures</i>
Objectives:	<p><i>Note: This session should be included in Pre-Service Orientation.</i></p> <p>After completing this Lesson, members will be able to:</p> <ul style="list-style-type: none"> <li>• Define <i>culture</i>.</li> <li>• Describe 3 cultural attitudes, beliefs, and/or practices related to health and health care.</li> <li>• List 2 ways that his/her own cultures influence his/her thoughts, actions, attitudes, and beliefs toward health and health care.</li> <li>• Identify 5-10 cultures and subcultures represented in your center's patient population.</li> </ul>
You will need:	<ul style="list-style-type: none"> <li>• "HealthCorps Reader" for this module</li> <li>• Prepared flip page labeled <i>Lesson Objectives</i></li> <li>• Prepared flip page labeled <i>Characteristics of Culture</i> based on Coordinator Sheet of that name</li> <li>• Prepared decorative poster saying "We see things not as they are, but as we are."</li> <li>• Worksheet: <i>Self-Identification Diagram</i></li> <li>• Prepared flip page labeled <i>Patient Cultures and Subcultures</i> derived from UDS date. (Be sure to include subcultures like gender, age, sexual orientation, and homelessness.)</li> </ul>
Estimated Time:	2 hours 15 minutes max
Gaining an Understanding:	<ol style="list-style-type: none"> <li>1. Ask members to share the first word they think of when you say <i>culture</i>.</li> <li>2. Record their responses.</li> <li>3. Emphasize any variety among the responses.</li> <li>4. <b>Members read the "Reader," Part One.</b></li> <li>5. Ask questions from the "Reader."</li> <li>6. <b>Introduce lesson objectives.</b></li> <li>7. Members discuss definition of <i>culture</i>.</li> <li>8. Ask why people explore their own cultures, then why members <i>should</i>.</li> <li>9. Display prepared decorative poster.</li> <li>10. Members complete Worksheet: <i>Self-Identification Diagram</i>.</li> </ol>

	<p>11. Draw 2 overlapping circles on new flip page and discuss <i>subculture</i>.</p> <p>12. Debrief worksheet with questions.</p> <p>13. Discuss <i>self-identification</i>.</p> <p>14. Ask why this lesson title uses the plural <i>cultures</i>.</p>
Break:	Give a 10-15 minute break.
Building Skills:	<ol style="list-style-type: none"> <li>1. Member leads a Team self-identification.</li> <li>2. Debrief with questions.</li> <li>3. Members discuss the effect of culture on one's health and health-related behavior.</li> </ol>
Reflection might include:	<p>Suggested journal questions:</p> <ul style="list-style-type: none"> <li>• Do I perceive myself any differently after the self-identification activities than I did before?</li> <li>• Can I identify an asset related to each of my cultures?</li> <li>• Do I dislike myself for any cultural reasons?</li> <li>• Has there ever been a time when one of my cultures was a barrier or seemed to be a barrier keeping me from accessing health care?</li> <li>• Has a health care provider ever adapted his / her services to meet one of my cultural needs?</li> </ul>
Follow-up activities might include:	<ul style="list-style-type: none"> <li>• Members self-identify their current position on the cultural competence continuum and make a contract with a teammate to make conscious efforts to reach the next level up. Make time during team meetings for partners to discuss privately the efforts and progress they've been making.</li> <li>• Members share regularly at Team meetings about cultural practices / attitudes they have observed in the health center and/or the community served.</li> </ul>

Lesson A



**Understanding Your Own Cultures** -- 2 hours 15 minutes max



**Direct** members to Prescription 4: Cultural Competence in the Participant Guide.



*Note: Wait to introduce the lesson objective. See the Step-by-Step script.*

After completing this Lesson, members will be able to:

- Define *culture*.
- Describe 3 cultural attitudes, beliefs, and/or practices related to health and health care.
- List 2 ways that his/her own cultures influence his/her thoughts, actions, attitudes, and beliefs toward health and health care.
- Identify 5-10 cultures and subcultures represented in your center's patient population.

Gaining an Understanding

1 hour 15 min. max



**Explain** that you are going to say a single word out loud and you want everyone to hold the very first thing that comes into their mind so they can share it.

Because members will probably be expecting *culture*, **throw them off track** by doing it first with any other word — *participation* or *service* or *leadership*. **Call on** a few members to share their very first responses and **thank** them.

Now **do it for real** with *culture*.



**Go around the room** quickly getting responses. **Record** them quickly on a new flip page.

Once everyone has shared, **emphasize** the range of responses.

**Explain** that you will not “correct” any of the responses, because:

- *Culture* can mean so many different things, and
- Members will learn a lot about it right away through reading.



**Direct** members to locate the “HealthCorps Reader” for this module and read Part One: Why Cultural Competence Is Important.

**Allow** 10 minutes.

**Ask** questions to increase understanding, but **hold off** on the definition of *culture* until later. For example:

- “Is a person’s culture determined solely by *ethnicity*, that is by ancestry, language, and traditions?”
- “What is it called when a person from one culture blends into another, such as when some Native Americans chose to wear European clothing and speak a European language, leaving their own practices and language behind?”
- “What is it called when people from one culture learn to function in another culture without losing their own ways?”
- “Which one is represented by the *salad bowl* and which by the *melting pot*?”
- “If I am *culturally competent*, what am I better able to do?”
- “What are the relationships between *cultural Sensitivity* and the world of health care?”
- “Why is the Federal government so interested in promoting *cultural competence*?”

- “Would anyone like to describe the *cultural competence continuum* for us?”
- “What do you think is another word for *continuum*?”
- “Did any one of the steps along this *continuum* particularly interest you? Which one?”

**Compliment** the Team on their grasp of the material.

Lesson Objectives



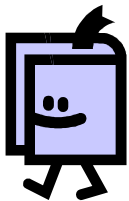
**Now introduce** the objectives of this lesson:

After completing this Lesson, members will be able to:

- Define *culture*.
- Describe 3 cultural attitudes, beliefs, and/or practices related to health and health care.
- List 2 ways that his/her own cultures influence his/her thoughts, actions, attitudes, and beliefs toward health and health care.
- Identify 5-10 cultures and subcultures represented in your center’s patient population.

**Ask**, “What’s the first thing we have to do here?”

*Answer: Learn or figure out the definition of culture.*



**Direct** members to mark with pencil or highlighter in Part One of the “Reader” anything that will help build a definition of *culture*.

**Allow** 3-5 minutes.

**Ask**, “In the process of marking those passages in the ‘Reader,’ did anyone come up with a clear and simple definition?”

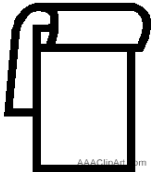
**Call on** any volunteers. **Invite** the Team to select one of the volunteered definitions if they agree with it enough.



If the Team does select a definition:

- **Record** it on a new flip page,
- **Tweak** it if necessary to make it completely accurate, and
- **Explain** why.

**Direct** everyone to record it in the Participant Guide.



If the Team does not select one, **write** your preferred definition on a new flip page and **direct** everyone to record it in the Participant Guide.

**Point out** that trying to reach agreement on a definition is more important than memorizing one. **Ask**, “Why is that true for all AmeriCorps members? And especially for HealthCorps members?”

*Answer:*

- ✓ *Working towards a definition makes us think about many different elements of culture, so we learn more about it.*
- ✓ *AmeriCorps members benefit themselves and the communities they serve if they understand culture in its broadest sense.*
- ✓ *HealthCorps members have a special responsibility to serve those whose own cultures create or are perceived as creating barriers to access to health care.*

To close out this discussion, **display** the prepared flip page labeled *Characteristics of Culture*. **Ask** members to identify any items on the list that relate to the *culture* definition the Team is now using.



**Ask** why people are interested in their own cultures and seek to learn about them?

*Answers are likely to include:*

- ✓ *They are curious.*
- ✓ *There are medical reasons to know more about their ancestry.*
- ✓ *They’ve heard bits and pieces of their family history and want a more complete picture.*
- ✓ *They’ve inherited old belongings from family members and want to learn about them.*
- ✓ *The elders in their family or culture are dying off and they want to capture what information they can.*
- ✓ *They don’t want their culture to disappear.*
- ✓ *Another member of their culture starts gathering information about it and so they get involved.*
- ✓ *It brings members of the culture together.*

**Ask** why HealthCorps members have a special responsibility to understand their own culture.

*Answer: If they don't understand their own they are far less likely to understand and appreciate others'.*



**Display** the decorative poster that reads, “We see things not as they are, but as we see them.” **Leave it up** throughout the lesson.

**Ask**, “What does this tell you about why we should learn our own culture?”

*Answer: If everyone has a culture, then everyone has some sort of bias and will act on it without realizing it; if they understand what their bias is, they can seek to set it aside when it is a barrier.*

**Point out** that some cultural biases create barriers whereas others remove barriers. **Ask** for volunteers to describe examples of each.

*Answers might include:*

- ✓ *Creates barriers: If my culture believes that all other cultures are bad in some way, it creates a barrier between me and anyone outside of my culture.*
- ✓ *Removes barriers: If my culture teaches openness and understanding about the whole world, then members of my culture can help remove all sorts of barriers.*



**Direct** members to locate Worksheet: *Self-Identification Diagram* and read the instructions.

**Allow** 2 minutes.

**Ask:**

- If members have any questions about the instructions.
- For a volunteer to give an example of what s/he could put on his or her diagram.

**Direct** members to complete the activity.

**Allow** 5-7 minutes.

**Circulate** to see how members are doing and **help** as needed.

**Call** “Time!”



**Ask**, “If you have one culture, how can you have more than one spoke on your diagram?”

*Answer: Everyone has a culture made up of ancestral relationships and practices, but everyone also belongs to various subcultures either totally inside their ancestral culture or overlapping it.*

**Draw** on a fresh flip page 2 circles that overlap in the middle. Make the overlapped segment large enough to write in.

**Ask** for a volunteer to name any *ancestral culture*. **Write** that name in the first circle.

**Ask** for another volunteer to name some other kind of culture or group (*e.g., movie fanatics, house painters, rural residents*). **Write** that name in the other circle.

**Ask** the members, “How would we identify the people who are part of both cultures?”

*Answer will be the equivalent of:*

- ✓ *Italian-Americans who like to bowl.*
- ✓ *Soccer players from San Salvador.*
- ✓ *City residents who are descended from the Irish.*

**Write** that phrase in the overlapped segment of the drawing.

**Point out** that, generally speaking, anything not actually a part of the *ancestral culture* is considered a *subculture*.

**Ask**, “If I am a believer in a religion, is that one of my *subcultures*?”

*Answer: Generally speaking, if that religion is a common or essential part of my ancestral culture, then it is not a subculture. However, if I converted away from the religion of my ancestral culture, then it would be one of my subcultures.*



**Ask** questions to get discussion going about members’ Worksheet:

- “Does anyone believe they made enough spokes to identify all of the cultures they belong to?”
- “Just for fun, whose diagram has the most spokes?”
- “Do you think your diagram is a permanent portrait of you — or a snapshot?”
- “Is one spoke more important to you than the others?”



**Discuss** briefly the term *self-identify*. **Explain** that one of the characteristics of strong cultural competence is respect for the other person’s right to *self-identify*, that is, to define or describe how they see themselves as fitting in — as opposed to letting another person or an organization tell them how they fit in.

**Give** an example, such as:

- A woman self-identifies as a free-lance writer, but her mother identifies her as unemployed.
- A teenage boy self-identifies as gay, but his friends don’t really want to hear about it.
- A man self-identifies as Malaysian, because he’s lived on the Malay Peninsula for decades and speaks the language fluently, but native Malays disagree.

**Go around** the room quickly, inviting each member to share one item from their personal diagram.

**Comment** on a few items to differentiate “cultures I was born into” and “cultures I joined.” **Ask**, “Is there a culture you used to belong to but don’t anymore?”

**Point out** that members will revisit their self-identification diagrams later in the program year — to see if anything in their “cultural world” has changed!



**Give a 10-15 minute break.**

Building Skills  
1 hour max

**Ask** members to raise their hands if they put “AmeriCorps” or “HealthCorps” on their self-identification diagram.

**Ask** those members, “Has being in Community HealthCorps



changed your behavior or attitudes in any way? Or do you think that is could” **Ask** for examples.

**Emphasize** that this training in cultural competence is focused on how culture influences people’s behavior.

**Point out** that being HealthCorps members makes the program one of their *subcultures*.

**Ask** for a volunteer or call on someone to help you investigate their new *subculture*.



**Direct** the member to:

- Come up to the easel,
- Draw a self-identification diagram on a new flip page, and
- Label the circle, “ (your site) HealthCorps Team.”

**Explain** that the Team will now create a *group self-identification* by identifying all of the things they have in common: attitudes, knowledge, characteristics, backgrounds, beliefs, education, hopes, gender, language, clothing, and so on.

**Turn** the activity over to the volunteer.

**Allow** 10-15 minutes or simply wait until discussion dies down.



**Thank** the volunteer.

**Explain** that the diagram shows the Team’s *organizational culture*: the list of attributes by which people outside the Team identify you as members of this organization.

**Ask** the Team, “Did any item here surprise you? Did you expect to have so many / so few things in common with your teammates?”

*Note: The next set of questions should perhaps wait until members know one another better, especially for a very mixed group of members with many differences between them.*

**Ask**, “Were there any assumptions you made about the others on this Team before you arrived at the health center and met them? If so, where do you think those assumptions came from? Did they prove true or not?”



**Ask**, “Does anyone recall what I said was the focus of this particular training in cultural competence?”

*Answer: How culture influences people’s behavior*

**Explain** that the central idea is even narrower than that — how

culture influences people's behavior in relation to their own health, the health of their families, and their approach to health care.

**Ask** for examples of this, both from members' own experiences and from their communities of origin.

If they need clues **ask**, "How do people differ in what they consider healthy food? How do they differ about going to the doctor for an annual check-up?"

*Answers might include:*

- ✓ *"My mother comes from a culture where it is frowned upon for her to take really good care of herself, but she is expected to keep the family in good health."*
- ✓ *"These days, it seems as if half the world believes carbs are totally unhealthy while the rest say they aren't that bad."*
- ✓ *"I knew someone who believed that doctors and medicines could not help anyone in any way, that only God could, so he never went to a doctor."*

**Ask**, "If you want to learn about the health care attitudes and behaviors among the cultures and subcultures represented in our health center's patient population, what's something that would be helpful to know at the start?"

*Answer: The cultures and subcultures in the patient population*

**Invite** the Team to pick a recorder who will jot down all of their ideas as they try to list as many as they can. **Allow** 3-5 minutes.



**Display** the prepared flip page labeled *Patient Cultures and Subcultures*.

**Ask** the recorder, "How did the Team do?"

**Invite** the Team to come up to the easel and check off cultures / subcultures whose members they have met so far in the health center and/or the community served.



**Highlight** these facts:

- Although we might be characterized as belonging to a particular *ancestral culture*, each of us belongs in a particular set of cultures as well, and that set makes us unique.
- There are plenty of *subcultures* we have not yet discussed at any length. *Give examples of groupings that did not come up during this lesson, perhaps gender, sexual orientation, or physical ability status.*
- Just because a person behaves in a particular way does not mean the influence you see is from his or her ethnic or racial group. Instead it could be because she's a woman, or a mother, or a fitness enthusiast, or a vertebrate paleontologist!\*\*

*\*\*In other words, it could be any aspect of who she is.*

- There will be more discussion in this module about the relation between *culture* and people's behaviors around health care.



Suggested journal questions:

- Do I perceive myself any differently after the self-identification activities than I did before?
- Can I identify an asset related to each of my cultures?
- Do I dislike myself for any cultural reasons?
- Has there ever been a time when one of my cultures was a barrier or seemed to be a barrier keeping me from accessing health care?
- Has a health care provider ever adapted his / her services to meet one of my cultural needs?

Follow-up  
Suggestions



- Members self-identify their current position on the cultural competence continuum and make a contract with a teammate to make conscious efforts to reach the next level up. Make time during team meetings for partners to discuss privately the efforts and progress they've been making.
- Members share regularly at Team meetings about cultural practices / attitudes they have observed in the health center and/or the community served.



**Proceed to:**

- Lesson B: *Whom Do We Serve?*, Module 4: Cultural Sensitivity, or to:
- The beginning of Prescription 5: Civic Engagement.

**Thank you!**

*NOTE:*  
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## **Lesson A: Understanding Your Own Cultures**

### **Coordinator Sheet: Characteristics of Culture**

*Instructions:*

- 1. Prepare a flip page with this title and bulleted list. (Write them as shown here, without capitals or ending punctuation.)*
- 2. Do not shorten any of the terms in the list.*
- 3. Display the flip page after the Team's discussion of the definition of culture.*

### **CHARACTERISTICS OF CULTURE**

- ❖ everyone has a culture**
- ❖ culture reflects tradition**
- ❖ culture is learned**
- ❖ it is not consciously expressed**
- ❖ it drives the person's beliefs and behaviors**
- ❖ culture is dynamic — it changes over time**
- ❖ everyone belongs to a variety of subcultures**

*NOTE:  
This page is intentionally left blank.*

## **Lesson A: Understanding Your Own Cultures**

### **Worksheet: Self-Identification Diagram**

*Instructions:*

- 1. On the center of this page, draw a circle large enough to write your full name inside.*
- 2. Write your full name in the circle.*
- 3. Draw a straight line out from the circle like a spoke from the hub of a wheel.*
- 4. At the end of the spoke, write a fact about yourself. It could be your age, gender, ethnicity, nationality, occupation, or anything else.*
- 5. Continue making spokes and writing a different fact about yourself at the end of each.*

## Lesson B: *Whom Do We Serve?*

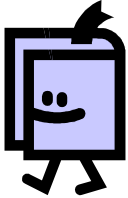
Lesson:	<i>Whom Do We Serve?</i>
Objectives:	<p><i>Note: This lesson should be included in Pre-Service Orientation or delivered very soon after.</i></p> <p>After completing this Lesson, members will be able to:</p> <ul style="list-style-type: none"> <li>• Name 2 attitudes / beliefs / practices related to health and health care for each of 4 cultures / subcultures served by the health center.</li> </ul>
You will need:	<ul style="list-style-type: none"> <li>• Prepared flip page (from Lesson A) labeled <i>Patient Cultures and Subcultures</i></li> <li>• Prepared flip page labeled <i>Lesson Objective</i></li> <li>• UDS materials / information “revealing” as many cultures and subcultures as possible (format: photocopied as handouts, enlarged as posters, or copied by hand onto flip pages)</li> <li>• List of jurisdictions served by the health center</li> <li>• “<i>HealthCorps Reader</i>” for this module</li> <li>• Bag or basket full of cut paper, each with a question about the “Reader,” Part Two</li> </ul>
Estimated Time:	<p>1 hour 45 minutes max</p> <p>+ 20-minute break that includes reading assignment</p>
Gaining an Understanding:	<ol style="list-style-type: none"> <li>1. Display prepared flip page labeled <i>Patient Cultures and Subcultures</i>.</li> <li>2. Members check off any of the listed cultures whose members they have met <u>since</u> doing Lesson A.</li> <li><b>3. Introduce lesson objective.</b></li> <li>4. Provide UDS materials / information.</li> <li>5. Members analyze and discuss.</li> <li>6. Divide the Team into groups of 3.</li> <li>7. Each group selects <i>either</i> one culture / subculture <i>or</i> one jurisdiction served by the health center.</li> </ol>
Break:	Give a 20-minute break <b>during which members are responsible for reading Part Two of the “Reader.”</b>

Building Skills:	<ol style="list-style-type: none"> <li>1. Pass around questions from “Reader,” Part Two.</li> <li>2. Each member selects and answers 1-3 questions.</li> <li>3. Members meet in their groups of 3.</li> <li>4. Explain the group activity to gather information.</li> <li>5. Groups meet to pool what they already know and design strategy for collecting more information.</li> </ol>
Reflection might include:	<p>Suggested journal questions:</p> <ul style="list-style-type: none"> <li>• Am I meeting people from cultures / populations I’ve not come in contact with before? Which ones?</li> <li>• In what ways do they seem most like me?</li> <li>• In what ways most different?</li> <li>• Am I nervous about public speaking? If so, what is the worst that could happen during my group’s report back to the Team?</li> </ul>
Follow-up activities:	<p>Required follow-up:</p> <ul style="list-style-type: none"> <li>• Groups of 3 report back to the Team by presenting for 3-5 minutes. Audience members for each presentation will ask questions and complete “support forms for anonymous evaluation.”</li> </ul> <p>Suggested follow-up:</p> <ul style="list-style-type: none"> <li>• If not done during the Lesson, members can interview health center staff or other community residents known by the members to learn more about the populations served by the health center.</li> <li>• Invite a member from the community to speak about his/her culture and approach to health care.</li> <li>• Visit a local cultural museum or center. Talk with staff to learn more about the cultures represented there.</li> <li>• If appropriate, visit your local Department of Health to learn more about their Office of Emerging Majorities (previously known as the Office of Minority Health).</li> </ul>

Lesson B



**Whom Do We Serve?** -- 1 hour 45 minutes max



**Direct** members to Prescription 4: Cultural Sensitivity in the Participant Guide.

Lesson Objectives



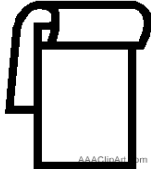
*Note: Wait to introduce the lesson objective. See the Step-by-Step script.*

After completing this Lesson, members will be able to:

- Name 2 attitudes / beliefs / practices related to health and health care for each of 4 cultures / subcultures served by the health center.

Gaining an Understanding

45 minutes max



**Display** the prepared flip page labeled *Patient Cultures and Subcultures* (used in Lesson A).

**Remind** members that:

- This is a list of many / all of the cultures and subcultures represented among the patients of your health center.
- The groups checked off on the list are those from which the Team had met one or more people so far.

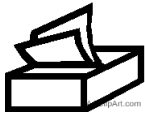
**Ask**, “Have you met community members from any of the other groups on this list?”

If so, **direct** members to come up to the easel and check off the additional group(s).

Now **introduce** the lesson objective.

**Explain** that members will meet this objective by:

- Studying demographic information from the health center, and
- Gathering information on their own, during and after this lesson.



**Provide** members with the UDS materials / information you have selected for their use, whether it is in the form of handouts, posters, or flip pages.



**Walk** members through enough of the material so they understand:

- Where the information comes from,
- Why the health center collects this information, and
- How to read it in the format provided.

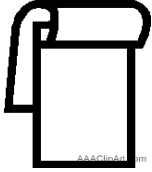
**Ask** a few questions about the information you have just covered to ensure that all members understand it.

Then either:

- **Continue** walking the Team through the material together, asking a variety of questions as you go along so that the members are doing more and more of the *analysis* themselves, or
- **Divide** the Team into groups of 2-3, giving everyone the same assignment for the next set of UDS information, and getting back together for discussion, or
- **Divide** the Team into groups of 2-3, giving each a separate assignment / set of information, and having each group present

to the Team.

**Close out** the analysis of the UDS information by asking whether members have any remaining questions.



Either:

- **Keep** members in their groups of 3, or
- **Divide** the Team now into groups of 3.

**Display** or **point to** the prepared flip page labeled *Patient Cultures and Subcultures*.

**Explain** that each group will:

- Either select one of the cultures / subcultures from that list or one of the jurisdictions served by the health center (a neighborhood of the city or a separate town or county), and
- Gather information between now and \_\_\_\_\_.

*Note:*

- *If there are some cultures / subcultures on the list which you know will be hard to get much information on, explain to the team that those may not be selected.*
- *If necessary, steer the groups so that some select ancestral cultures, some subcultures, and some jurisdictions.*

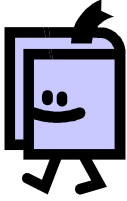
**Point out** that a group selecting a jurisdiction will gather information about:

- Which cultures / subcultures are prevalent there,
- How they came to live in that place, and
- Which health center services those groups tend to use.

**Allow** 2-3 minutes for the groups to meet and decide on a first and a second choice.

**Go around** the room, asking each group in turn to name their first choice. For each culture that has not yet been selected, **assign** it to the first group that requests it, otherwise **move on** to their second choice, and so on.

**Explain** that their information gathering will begin after a break.



**Direct** members to:

- Locate the “Reader” in the Participant Guide and read Part Two: Cultural Competence in our Health Centers during the 20-minute break, and
- Be ready to answer questions from Part Two immediately after the break.



**Give a 20-minute break.**

Meanwhile, **prepare** for Building Skills:

- **Get ready** the bag or basket of cut pieces of paper, each with a question based on the reading assignment.

Building Skills

1 hour max

**Pass around** the bag or basket of questions related to the “Reader,” Part Two.

**Direct** each member to take one question this first time around.



**Direct** the Team to:

- Locate the answer to their questions in the “Reader,” and
- Prepare to answer their questions when called upon.

**Allow** 3 minutes.

**Tell** the Team that they will have a chance to answer another member’s question if that member either answers incorrectly or leaves out an essential part of the answer.

**Call on** a member who is clearly ready. **Direct** the member to:

- Read the question aloud, and
- Answer the question as briefly as possible.

**Ask** the Team whether the answer is correct and includes all essential information:

- If not, **call on** someone to “make it right” or
- If so, **call on** another member at random for the next question.

**Continue** until the first round of questions has been answered. **Do** a second and third round as time permits.

Afterwards, **commend** the Team for the level of accuracy overall.

**Direct** members to:

- Meet in their groups of 3,

*Note:*  
If your team is small, go for three rounds to cover enough of the reading.



- Pool what they already know about the culture or subculture they have selected,
- Discuss the best format their 3-5 minute report back might take, and
- Decide how they will gather more information — especially information focused on attitudes / beliefs / practices related to health and health care — whether on the Web, in the library, by reading relevant health center information, by interviewing health center staff and/or members of the community served.

**Invite** groups to interview staff — but only through you, so you can advise members how best to make the appointments.



**Allow** 10-20 minutes.

**Explain** to the Team the ground rules for their report back:

- All groups will report back on \_\_\_\_\_ or the groups will be divided up.
- Each group will have 3-5 minutes to present.
- During presentations, other members are expected to ask questions.
- You will probably ask each group one question as well.
- At the end of each presentation, the group must recommend “next steps” for anyone wishing to know more about that particular culture / subculture or jurisdiction
- And audience members will fill out “support forms for anonymous evaluation” just as they did in Lesson D: *Speaking in Public*, Module 3: Professional Development.

**Ask** if members have any questions about the directions.



Suggested journal questions:

- Am I meeting people from cultures / populations I’ve not come in contact with before? Which ones?
- In what ways do they seem most like me?
- In what ways most different?
- Am I nervous about public speaking? If so, what is the worst that could happen during my group’s report back to the Team?
- If not done during the Lesson, members can interview health center staff or community residents known by the members to learn more about the populations served by the health center.
- Invite a member from the community to speak about his/her

Follow-up  
Suggestions



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culture and approach to health care.

- Visit a local cultural museum or center. Talk with staff to learn more about the cultures represented there.
- If appropriate, visit your local Department of Health to learn more about their Office of Emerging Majorities (previously known as the Office of Minority Health).



**Proceed to:**

- Lesson C: *The Continuum*, Prescription 4: Cultural Sensitivity, or to:
- The beginning of Prescription 5: Civic Engagement.

**Thank you!**

## Lesson C: Cultural Sensitive Continuum

Lesson:	<b>Cultural Sensitive Continuum</b>
Objectives:	<p><i>Note:</i></p> <ul style="list-style-type: none"> <li>• This lesson should be part of Pre-Service Orientation or delivered soon after.</li> <li>• You may wish to co-facilitate this lesson with a guest speaker (health center staff member, outside expert) or have the guest deliver the lesson alone.</li> </ul> <p>After completing this lesson, members will be able to:</p> <ul style="list-style-type: none"> <li>• Define <i>cultural sensitive</i>.</li> <li>• Draw the <i>cultural sensitive continuum</i>.</li> </ul>
You will need:	<ul style="list-style-type: none"> <li>• Prepared flip page labeled <i>Lesson Objectives</i></li> <li>• Worksheet: <i>Definition of Cultural Sensitive</i>.</li> <li>• Several scissors and glue sticks.</li> <li>• Prepared flip page labeled <i>Definition of Cultural Sensitive</i> with text written out (see page 4)</li> <li>• “HealthCorps Reader” for this module</li> <li>• Worksheet: <i>Scenes along the Continuum of Cultural Sensitive</i></li> <li>• 6 differently colored stickers (round, from office supply store) each designated to represent one level on the continuum</li> <li>• Prepared flip page labeled <i>Cultural Sensitive Continuum</i> showing continuum diagram and each step labeled to match a sticker color</li> </ul>
Estimated Time:	1 hour 15 minutes max
Gaining an Understanding:	<ol style="list-style-type: none"> <li>1. Introduce lesson objectives.</li> <li>2. Divide the Team into groups of 2-4.</li> <li>3. Groups complete Worksheet: <i>Definition of Cultural Sensitive</i>.</li> <li>4. Groups read results aloud and compare.</li> <li>5. Display prepared flip page labeled <i>Definition of Cultural Sensitive</i>.</li> <li><b>6. Members read the “Reader,” Part Three.</b></li> <li>7. Members share which fact(s) in the “Reader” they found most interesting.</li> </ol>

Building Skills:	<ol style="list-style-type: none"> <li>1. Hand out to each member a few of <u>every</u> color of sticker and <u>one</u> scenario.</li> <li>2. Display the prepared flip labeled <i>Cultural Sensitive Continuum</i>.</li> <li>3. Members consult “Reader” Part Two.</li> <li>4. Members place scenarios along the continuum.</li> <li>5. Members discuss / change scenario placements.</li> <li>6. Remind Team to practice techniques in “Reader,” Part Three.</li> </ol>
Reflection might include:	<p>Suggested journal questions:</p> <ul style="list-style-type: none"> <li>• What was the most difficult part of this activity? How will this training impact my service experience?</li> <li>• Did the activity make me think about any of my personal beliefs, attitudes, or practices?</li> </ul>
Follow-up activities might include:	<ul style="list-style-type: none"> <li>• At a later Team meeting or series of meetings, direct members in twos and threes to prepare brief skits based on techniques in the “Reader,” Part Three. The audience guesses which techniques are being demonstrated.</li> <li>• At your service site, take a look at the services provided by your center and where they fall in the cultural Sensitive continuum. <i>In an ideal world with unlimited money, what could be improved?</i></li> </ul>

Lesson C



**Cultural Sensitive Continuum** -- 1 hour 15 minutes max



**Direct** members to Prescription 4: Cultural Sensitive in the Participants Guide.

Lesson Objectives



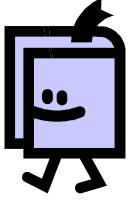
**Introduce** the lesson objectives:

After completing this lesson, members will be able to:

- Define *cultural sensitive*.
- Draw the *cultural sensitive continuum*.

Gaining an Understanding

45 minutes max



**Direct** members to locate Worksheet: *Definition of Cultural Sensitive* and read the instructions.

**Allow** 2 minutes.

**Point out** that although they are solving the puzzle together in groups, each member should cut and paste or write the final definition in the Participants Guide.

**Ask** members if they have any questions about the instructions.



**Divide** the team into groups of 2-4.

**Hand out** a pair of scissors and a glue stick to each group.

**Allow** 5 minutes.



**Ask** for a volunteer to read his or her group's solution to the puzzle. Whatever is read aloud, **do not indicate** in any way whether it is "right" or "wrong."

**Ask** how many groups got the same exact wording.

**Direct** any groups that got a sentence that is different in any way to read theirs aloud.

**Direct** the Team to reach consensus on "their final answer."

**Allow** 3-5 minutes, depending on how many versions there are.

**Direct** the Team to select a member to read it aloud.

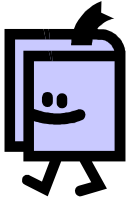


**Display** the prepared flip page labeled *Definition of Culturally Sensitive*:

**"Culturally Sensitive is defined as a set of congruent behaviors, attitudes, and policies that come together in a system or among professionals and enable that system or those professionals to work effectively in cross-cultural situations."**

*Note: If you wish, share the following quotations with the Team or paraphrase them for the Team:*

- “The word **culture** is used because it implies the integrated patterns of human behavior that include thoughts, communications, actions, customs, beliefs, values and institutions of a racial, ethnic, religious or social group.”
- “The word **sensitivity** is used because it implies understanding the need to be tactful in relation to the feelings of others.”



**Tell** the Team, “Now that you have this definition in mind and in your book, it’s a good time to read about a variety of ideas and communication techniques that are sometimes or often determined by culture.”

**Direct** members to locate the “HealthCorps Reader” and read Part Three: *A Variety of Culturally Defined Behaviors*.

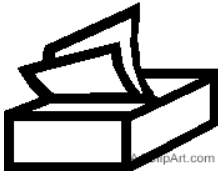
**Allow** 5-7 minutes.

**Go around** the room and **ask** each member to share 1-2 items from Part Three that interest him or her.

Once the Team is done, **point out** whether their responses were varied or much the same.

Building Skills

30 minutes max



**Hand out to each member:**

- **A few of every color of sticker, and**
- **One scenario on a strip of paper.**

**Direct** members to write their first names on their slips.

**Display** the prepared flip page labeled *Cultural Sensitive Continuum* showing:

- The continuum diagram and
- Each step labeled to match a sticker color



**Present** the activity:

- “What does the flip page have in common with your stickers?”
- “Yes, each step of this continuum diagram is labeled in a separate color that matches a set of stickers.”
- “Would anyone like to guess why each of you has a scenario or statement and some stickers?”
- “That’s it exactly — each of you must decide individually where your scenario or statement fits best along the continuum and then you’ll use stickers of the correct color to post the strip of paper onto the diagram.”
- “What resource do you have that you can look at for help?”
- “You are free to consult Part Two of the “Reader” however much you want to.”
- “You will have up to 10 minutes to make your decision!”
- “After that, you can post your papers.”

**Ask** if members have any questions about the instructions.

**Allow** 10 minutes.

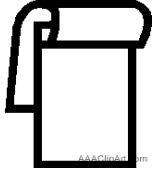
**Do not circulate**, so members feel that their one resource is the “Reader.”

**Direct** anyone who wants to post their paper before others are ready to wait. *Note: This is to prevent pressuring other members.*

**Alert** the Team when 1 minute remains.

**Call** “Time!”





*Note:*

If the Team is large,  
invite them up in  
groups, help them find  
space on the diagram.



**Invite** all members to come up to the easel and post their papers.

**Keep** an eye out for members using a color of sticker that does not match the step where they are placing their papers and **help** them.

Once that is done, **straighten** things out a little as necessary.

Starting from the lower end of the diagram, **read** the scenarios / statements aloud one at a time in sequence. After each, **ask** the Team if they think that it is correctly placed.

**Tell** members that they are free to suggest a different placement as long as they can give evidence for their suggestion from the “Reader.”

- If all members agree with the placement, **move on**.
- If any members say it is not correctly placed, then **invite only** 1 or 2 of them to suggest a different placement and cite their evidence. Then **invite** the member who placed the paper to give his or her rationale. **Allow** a bit of discussion if the Team is very interested. If necessary, **tell** the Team where the scenario / statement should be placed and **move** the paper if necessary.

**Continue** all of the way up the diagram.

To close out the lesson, **direct** members to practice some of the communication techniques in Part Three of the “Reader.”



Follow-up  
Suggestions



Suggested journal questions:

- What was the most difficult part of this activity? How will this training impact my service experience?
- Did the activity make me think about any of my personal beliefs, attitudes, or practices?
- At a later Team meeting or series of meetings, direct members in twos and threes to prepare brief skits based on techniques in the “Reader,” Part Three. The audience guesses which techniques are being demonstrated.
- At your service site, take a look at the services provided by your center and where they fall in the cultural Sensitive continuum. *In an ideal world with unlimited money*, what could be improved?



**Proceed to:**

- The beginning of Prescription 5: Civic Engagement.

**Thank you!**

## **Lesson C: Cultural Sensitive Continuum**

### **Worksheet: Definition of Cultural Sensitive**

*Instructions:*

- 1. Cut up this sheet so each of the 8 words and phrases is separate.*
- 2. Rearrange the words to make a definition of cultural Sensitive.*
- 3. Glue the words in place on the back of the previous page in the Participant Guide.*

**THOSE PROFESSIONALS**

**IN CROSS-CULTURAL SITUATIONS**

**IN A SYSTEM AND**

**AMONG PROFESSIONALS**

**CONGRUENT BEHAVIORS**

**TO WORK EFFECTIVELY**

**OR AND**

**POLICIES THAT COME TOGETHER**

**ATTITUDES OR**

**ENABLE THAT SYSTEM**

*NOTE:  
This page is intentionally*

## **Lesson C: Cultural Sensitive Continuum**

### **Worksheet:**

#### **Scenes along the Continuum of Cultural Sensitive**

*Instructions:*

1. Your facilitator will assign you one of the following scenarios.

**#1: “I can’t see why all of these immigrants can’t learn to speak English — I did!”**

**#2: “I am who I am because of the culture into which I was born.”**

**#3: “All cultures essentially treat all people the same — why do it any differently?”**

**#4: “Arranged marriages are acceptable in my culture.”**

**#5: The health center produced health education materials in six languages to address the needs of families.**

**#6: “It’s okay that Mr. Goldstein cannot come to the parent group on Saturday, because that is his Sabbath.”**

**#7: “I was raised in a family that values education.”**

**#8: “While on a home visit with a newly immigrated family, I asked them why they decided to come to the United States, so I can learn more about their cultural values.”**

**#9: “My friend Kim Yu eats different types of food and speaks a different language because of her racial and ethnic background.”**

**#10: “I think it’s just wonderful that we have so many different cultures all blending into one!”**

**#11: The local hospital does not have an interpreter available when a Vietnamese-speaking family, of which there are many in our area, arrives seeking services.**

**#12: During their Pre-Service Orientation, the HealthCorps Team meets with community residents to learn more about the cultures whose members they will serve.**

**#13: “I think it is completely unacceptable that people have pre-marital sex.”**

**#14: “The USA is a salad bowl where cultures are intermixed and yet maintain their own identities.”**

**#15: HealthCorps members conducting health outreach to a Buddhist community speak with the community’s elders before implementing their outreach activities.**

**#16: “I think it is truly great to have so many different cultures and languages in the US.”**

## ***Part One: Why Cultural Sensitivity Is Important***

Culture shapes how people experience the world, yet it is not an easy term to define. Culture is a set of values, social practices, and forms of expression held in common by a group of people. People within the group usually identify themselves and are identified by outsiders according to ancestry, language, and traditions. Although culture is often determined in this way — by ethnicity— it can also involve geography, religion, and socio-economic status. In fact, some people identify themselves as a group because they have similar gender status, sexual orientation, physical or mental ability, academic or professional experience.

To further illustrate the complexity of this subject, there are many people who have been raised within one culture but then choose to blend in with another. In the United States, many natives and immigrants have blended into the dominant European-American culture of the last 250 years or more, leaving their original language, values, and practices behind. This is called *assimilation* and has led to the U.S. being called a “melting pot.” Centuries of experience with assimilation have shown that it sometimes causes great pain within families and communities and other times causes great success and development.

*Acculturation* is a more recent idea, defined as the modification of the culture of a group or individual as a result of contact with a different culture (American Heritage Dictionary), in this case a dominant culture. Through acculturation, people hold onto their original culture while also learning enough of the dominant language, values, and practices to move comfortably through daily life. With larger non-European populations than before and with more people encouraged to acculturate rather than assimilate, the U.S. has now come to be called a “salad bowl.”

Service in community health care may involve a single culture that is new to the HealthCorps member or a number of diverse cultures. HealthCorps members develop

effective skills for working with clients, their families, and communities whatever their backgrounds and identities.

### *Cultural Sensitivity*

The term *cultural sensitivity* embodies the knowledge, understanding, skills, and protocols that allow an individual or system to provide services across cultural lines in the best possible way. Cultural Sensitivity permits us to respond with respect and empathy to people of all nationalities, classes, races, religions, ethnic backgrounds and other groups in a manner that recognizes, affirms, and values their worth.

In the health care setting, cultural sensitivity is important for several additional reasons. Cultures vary in their beliefs about the cause, prevention, and treatment of illness. These beliefs may dictate the practices that people use to maintain their health. Cultural attitudes can also affect the relationship with providers. Too often, we interpret the behavior of others as negative because we don't understand the underlying value system of their culture.

The natural tendency is to assume that our *own* values or customs are more sensible or correct – “more normal” – than someone else's. To provide quality care for any client, it is important to acknowledge that client's different beliefs and behaviors, adapting health care delivery to a cultural framework that is acceptable to the client. After all, we want to develop the full range of skills required to work successfully with people – whatever their background and self-identification.

Additionally, cultural Sensitivity is championed by the Bureau of Primary Health Care, within the federal Department of Health and Human Services, which provides funding for all Federally Qualified Health Centers. In recent years, the Bureau has placed a high priority on the development of sensitivity, knowledge, and skills around cultural issues. In their 1999 curriculum, *National Health Service Corps Educational Program for Clinical and Community Issues in Primary Care*, is the statement, “The practice of culturally appropriate medicine can ease health care delivery, improve patient adherence to therapeutic regimens, and minimize confusing communication.”

### **Diversity within a Group**

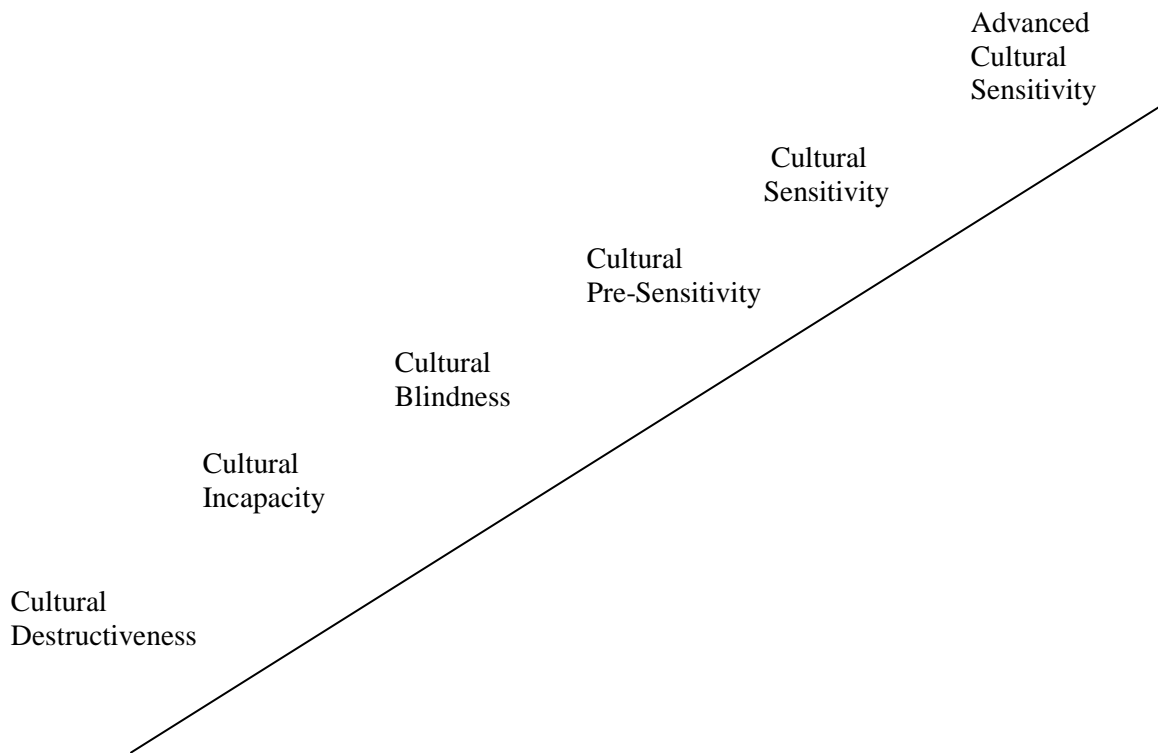
Diversity within a group is often greater than it is between groups! Think of all of the ways that you differ from various other people within your own culture. For each of these characteristics, are you in the majority or a minority within your culture?

- Gender
- Age
- Length of time in the U.S. or your current region, county, city
- Religion
- Education
- Degree of assimilation (if any) from your family's original culture
- Occupation choice
- Income prospects
- Familiarity or contact with your culture's elders or other leaders

### **The Cultural Sensitive Continuum**

Cultural Sensitivity may be viewed as a goal toward which we can all strive.

Accordingly, becoming culturally competent is a developmental process: there will always be room for growth. To understand better where each of us currently stands in the process of becoming more culturally competent, it is useful to think of the possible ways of responding to cultural differences. As delineated by Terry L. Cross, M.S.W., there is a continuum or spectrum that ranges from *cultural destructiveness* to *cultural proficiency*, that is, from negative attitudes and behaviors about diversity to positive ones. There are a variety of possibilities between these two extremes. Below is a diagram of the continuum followed by a description of the stages along the continuum.



Term & Definition	Primary Characteristics
<p><b>Cultural Destructiveness.</b> The most negative end of the continuum is represented by attitudes, policies and practices which are <i>destructive to cultures</i> and consequently to the individuals within the cultures.</p>	<ul style="list-style-type: none"> <li>• Regarding others who are culturally different with prejudice;</li> <li>• Using power to control, exploit, or destroy others; and</li> <li>• Designing programs that specifically limit access to certain populations (by selection of location and service hours, physical inaccessibility, etc.).</li> </ul>
<p><b>Cultural Incapacity.</b> The next position on the continuum is where individuals do not intentionally seek to be culturally destructive but rather <i>lack the capacity to help</i> diverse clients or communities. The individual remains extremely biased, believes in the racial superiority of the dominant group, and assumes a paternal posture toward "lesser" groups.</p>	<ul style="list-style-type: none"> <li>• Creating or promoting negative stereotypes; and</li> <li>• Having unrealistic fears of people who look, act, or believe differently.</li> </ul>
Term & Definition	Primary Characteristics
<p><b>Cultural Blindness.</b> At the midpoint on</p>	<ul style="list-style-type: none"> <li>• Assume everyone can access services in</li> </ul>

<p>the continuum, individuals <i>think they are unbiased</i>. They function with the belief that culture makes no difference and we are all the same. Such attitudes ignore cultural strengths and blame the clients for their own problems.</p>	<p>the same way;</p> <ul style="list-style-type: none"> <li>• Do not see the need even to adapt their oral and written communication;</li> <li>• Encourage people from other cultures to assimilate into the dominant culture, thus letting go of their own language, traditions, and values;</li> <li>• Believe that helping approaches traditionally used by their own culture and/or the dominant culture are universally applicable; and</li> <li>• Believe that, if the system worked as it should, all people — regardless of culture, language, race, sexual orientation, ability status, or anything else — would be served with equal effectiveness.</li> </ul>
<p><b>Cultural Pre-Sensitivity.</b> The next position up the continuum is where people <i>realize on their own</i> any weakness in their service to culturally diverse clients and <i>attempt to improve</i> their service.</p>	<ul style="list-style-type: none"> <li>• Acceptance of and respect for difference;</li> <li>• Pleasure in recognizing and exploring differences, <i>for example</i>: asking a patient whether she has tried any cultural remedies recently for her condition and, if so, discussing politely any which are known to be either effective or dangerous;</li> <li>• Willingness to experiment and try new things, <i>for example</i>: asking to be taught a few words of the client’s language;</li> <li>• Continuous self-assessment about one’s own culture and its relation to others;</li> <li>• Careful attention to the dynamics of difference;</li> <li>• Continuous expansion of cultural knowledge and resources; and</li> <li>• Comfort in knowing there is no one right answer.</li> </ul>

Term & Definition	Primary Characteristics
<p><b>Cultural Sensitivity.</b> Culturally competent individuals are <i>open</i> to the cultural experiences of others and to new information about cultures.</p>	<ul style="list-style-type: none"> <li>• Treating people as individuals, not as stereotypes;</li> <li>• Examining one’s assumptions about difference;</li> <li>• Being open to the challenge of learning through others’ points of view;</li> <li>• Building empowered and interdependent relationships with people one regards as different; and</li> <li>• Demonstrating the willingness and ability to adapt the <u>organization’s</u> practice of health care to many different cultural situations.</li> </ul>
<p><b>Advanced Cultural Sensitivity.</b> This is the most positive end of the spectrum and represents the willingness and ability to adapt the <b>organization’s</b> practice of health care to many different cultural situations. Providers at this level seek to <i>add to their knowledge base</i> through culturally relevant research, then <i>develop new approaches</i> based on that research.</p>	<ul style="list-style-type: none"> <li>• Hold cultural diversity in high esteem – understanding that it adds strength to a community;</li> <li>• Advocate for cultural Sensitivity throughout the service system;</li> <li>• Include local census and other demographic data in their decision making about what services are needed and how best to provide them;</li> <li>• Analyze their particular organization’s way of “doing business” by evaluating location, hours, transportation, policies, procedures, and physical structure through the lens of the cultures in the community they serve;</li> <li>• Implement cultural training for both administrative and clinical staff;</li> <li>• Include cultural competency indicators in job descriptions; and</li> <li>• Ensure that terminology used is understood by patients; providing interpreters and translated materials for people who are hearing / speech impaired and those with limited English proficiency.</li> </ul>

## ***Part Two: Cultural Sensitivity in Our Health Centers***

Health centers strive to create programs that are culturally competent and address the needs of the individual client or the patient population. HealthCorps members should be attuned to issues of language, ethnicity, gender identity, sexual orientation, ability status, educational experience, and economic background (that is, their culture).

Now is the time to begin developing the key understanding, skills, and knowledge that will enhance *your* activities in the health center's community!

An interesting way to learn how to observe and evaluate relationships within a culture is to think about the framework of expectations, codes of behavior, and set of values within an organization. Yes — AmeriCorps, Community HealthCorps, and the health center each has its own *organizational culture*. We can analyze each of these cultures with a series of questions:

- What is expected of most or all people in the organization?
- How do they choose to communicate?
- Do they share belief in a mission or cause?
- Is some conduct discouraged or banned?
- Do we like some aspects of the culture and dislike others?
- Do people coming in contact with the organization have stereotypes about it?

Looking at organizational culture can make it more comfortable to ask and learn about such questions, because issues that sometimes divide people and make discussion uncomfortable — such as religious or political beliefs — are less involved in the daily life of this type of culture.

Another interesting question is whether there are subgroups or minority groups inside the organization. Within the health center we tend to see people in different types of job as subgroups: *for example*: administrative, clinical, social work, and building

maintenance. From this fact springs other important questions: Do the subgroups have stereotypes about each other? And do all groups have an equal responsibility to become culturally competent regarding the others?

### *Groups Are Made up of Individuals*

Working with clients from diverse backgrounds takes a commitment to learning not only about the client's culture but also about the client as an individual. No culture or group is absolutely the same throughout (i.e., monolithic). *For example:* All people who must use wheelchairs to be mobile do not have the same medical condition. All people with brown skin are not from the same part of the world. All people from China do not understand one another when they speak. If we assume that the opposite is true, then we do not understand *either* the group or the individuals who belong to it.

There is a fairly straightforward way to assess our own attitudes and beliefs about another culture and the people who identify themselves as a part of that culture. It is recognizing the difference between *stereotypes* and *generalizations*:

A stereotype is an ending point. It is a standardized mental picture that represents an oversimplified opinion, a prejudiced attitude, and/or an uncritical judgment. Furthermore, the mental picture is shared by people within a group *about members of another group*. It is an ending, because no attempt is made to learn whether the statement fits the individual of that group or not. In fact, the mental picture is *so* firm that those who believe it might never think of checking it for accuracy.

*For example:* I meet Rosa, and I am told she is from Mexico. I say to myself, "Rosa is Mexican; she must have a large family." I am stereotyping. I do not ask Rosa if she has a large family nor I do not test my assumption in any other way.

Stereotyping limits the way we serve members of the other group. *For example:* If all Mexicans have large families, then health educators should always talk to all Mexican women clients about contraception. Without the stereotype, we would instead adapt our approach to the individual and situation. We might decide to talk about it only if the client said she already had many children and it was causing a problem for her.

A generalization is a starting point. It is a vague or incomplete thought about another group and members of the group; the person having the thought is willing to incorporate further information to complete it or test its accuracy. Generalizations can come from what we read or see on TV or hear others talking about. We start thinking something like, “I guess such-and-such people are generally...”

*For example:* If, instead of thinking that all Mexicans have large families and therefore Rosa must have a large family, I think, “I’ve heard that many Mexican families are large. I wonder if Rosa has a lot of children”  
— I am generalizing.

Generalizing is an opportunity to learn more about other people and their cultures. When we follow through and seek out more information, then generalizing has been helpful. However, if we don’t test our incomplete thought and instead repeat it to others, it may become a stereotype.

### *Bridging the Gap between Cultures*

What can health center providers do to ensure that they are providing the best possible care to all clients?

- Treat each person as an individual and celebrate diversity among individuals;
- Reflect on their own cultural background and values (what they learned growing up) so they can more easily find parallels between their own lives and the clients’;
- Build trust;
- Learn about various cultures, especially those in the community served;
- Explore factors that influence decision making in those cultures;
- Confront their own misconceptions about various cultures. Challenge themselves to identify when they are acting as if *their* cultural norms should be *everyone’s* norms;
- Develop face-to-face communication styles and written communication formats that are successful with most patients most of the time; and

- Keep in mind the particular psychosocial stressors relevant to certain groups. These include war trauma, living in refugee camps, migration, acculturation stress, and socioeconomic status.

What can health center management do to increase the usefulness of their services to the community?

- Assess and evaluate any current services targeted to specific populations for acceptance within the community and for effectiveness in health outcomes. Work to improve the comfort level and success rate;
- Make informed decisions on what the organization can and cannot provide, *for example*: Senior staff recognize the high value of providing medical interpreters for patients with little or no English skills, however there may be no money to offer that service;
- Advertise and offer their services through natural channels within the community, *for example*: newspapers put out by that community for its members, other newspapers and local radio stations in the language of the community served; and
- Use terminology that is understood by the members of the community. Ensure that health center staff learn words and phrases used in the other language(s) to describe certain critical symptoms and events.

### ***Part Three: A Variety of Culturally Defined Behaviors***

This part of the HealthCorps Reader on cultural sensitivity provides information about some culturally defined behaviors – and their underlying values – which can affect the level of communication and understanding in a health care setting.

**The value of time.** Our sense of time is a learned characteristic, like all of culture. Groups that have less experience with formal schooling and hierarchical employment structures, commuting to work or using public transportation, are less likely to employ strict time measurement in daily life. Some groups place other things ahead of “being on time” and “not wasting time.” We can see the clash between health centers booking all examinations, tests, and classes strictly by time and community members who tend to present for their appointments 30, 60, 90 minutes later than scheduled.

This is not a moral issue; that is, neither “side” is morally right or wrong. However, the patient *does* want to be helped and the center *does* want to be of help. While the patient bears some responsibility for learning the health center’s way of working, the center bears the larger share of the effort to bridge the gap.

The cultural issue of time is not to be confused with other reasons a patient is late, such as poorly run public transportation or lack of a clock or watch.

**Literacy and language.** Oral communication is frequently the best way to provide information, at least initially. Whether the client speaks English comfortably or another language, they may not be able to read in *any* language. When providers sense that this is the case, they can probe gently, *for example*: “Would you like me to say that again?” “I can repeat the information while we go over the pictures, would that be helpful?” “We have a brochure on pregnancy in both English and Spanish. Do you have someone at home who can read it to you?”

When asking patients to complete medical history forms, providers should keep in mind not only predominant language and level of literacy – but also that patients may be unfamiliar with standardized forms with check-boxes, multiple-response options, rating scales, and “skip-to” directions.

**Personal identity.** Within some cultures, people are not defined or named individually. Instead, their names and behaviors relate solely or primarily to their parents, their extended family, or their spouse.

**Decision making.** Decisions regarding medical screening and intervention may not be decided by the individual in a particular culture, but by the family as a whole. This means that the patient may not be in a position to give consent while in the doctor's office, instead returning home, discussing the matter, and calling back another day.

How people treat and talk about their bodies and bodily functions tend to be strictly determined by cultural and religious beliefs. Even for individuals who have chosen to leave their culture/religion, these behaviors are learned so early in life that they can be difficult to change. The health care provider must be ready to observe and learn what makes people uncomfortable. Patience will be needed when a client finds it embarrassing to describe symptoms or says firmly that they are not allowed to follow a particular treatment.

Meanwhile, some cultures put a high degree of trust in the personal physician regarding all health matters and will follow his/her directions conscientiously.

**Respect for authority.** For some ethnic groups, their public etiquette may prevent a person from raising questions because to do so implies doubt in the doctor's opinion or knowledge. Thus the patient may make an effort to please the health care provider rather than explore the medical situation as the provider's partner in the treatment.

**Comfort level with the individual service provider.** Community members arrive with their own stereotypes and generalizations. A given client may be uncomfortable with a provider's age, gender, sexual orientation, educational level, or race. When this occurs, it is **not** about the provider personally, but it can affect how well a provider's, health educator's or outreach worker's ideas, suggestions, materials, and programs are accepted in the community.

**Appropriate vs. inappropriate questions.** Culture, religion, and direct personal experience tend to determine the types of questions that an individual feels are prying,

too personal, and even unsafe. *For example:* To discuss income may be considered boasting and therefore impolite; for other people, it may be shameful if they are poor. Religion may place strict limits on discussion of sexual practices; perhaps it is only permissible woman-to-woman and man-to-man. And those who have lived for any length of time under dictatorship may worry that the health center will know too much about them, something that was very risky in their past.

Consider the many different ways there are to ask a question. In face-to-face interviewing, some clients respond comfortably to very direct questions. For others, it works best to ask a series of more subtle and indirect questions that ultimately lead to the same type and amount of information.

**Experience with medical research.** Members of several racial and cultural groups (around the world and in the U.S.) have been used as subjects in medical research without their informed consent. People have heard of instances when the confidentiality of medical records was not protected. At the same time, some U.S. communities have been studied over and over by doctoral students and others for the same health issue or neighborhood condition without anyone coming back to take action and improve the situation.

All of these can cause community members to be skeptical or even afraid of sharing any personal information.

**Bad luck.** Members of some cultures choose not to behave or speak in certain ways because they believe that to do so will bring on “the evil eye.” *For example:* Some do not speak in positive terms about their spouse, children, or possessions because they feel it brings attention which in turn can cause bad luck.

**Self-identification.** People self-identify in many different ways. *For example,* on the west coast of the U.S., the term *Hispanic* is often considered derogatory and *Latino/Latina* is more politically correct. But on the east coast it is acceptable to use the term *Hispanic*. Similarly, some individuals prefer the term *African-American* while others prefer *Black*. It doesn't take much time to find out from a client what he or she prefers.

Another issue is not so much about terminology as it is about being grouped with others solely or primarily due to one's looks. *For example:* A person who is generally considered to look Asian actually prefers to be identified as Pacific Islander. The health center may also have clients who physically look male but self-identify as female.

### *Culturally Related Styles of Communication*

Communication is so important in establishing a good relationship between yourself and the community member that the subject should be looked at in great detail. Think how important communication is to making the correct diagnosis and ensuring that the patient follows through correctly on health education sessions.

#### **Nonverbal Communication**

- **Silence.** Some cultures view silence as awkward, however others are quite comfortable with periods of silence.
- **Distance.** The most comfortable physical distance between two people varies according to culture.
- **Eye contact.** The amount of eye contact that is comfortable varies with each culture. Some are comfortable with looking people straight in the eye; others have been taught not to make eye contact. Staring is considered impolite in some groups. However, if we avoid eye contact or break eye contact too frequently, it the client may misinterpret it as disinterest. If a provider is unsure, how can s/he show s/he cares — without being intimidating? S/he can sit *next* to the person rather than directly across, thus reducing the need for eye contact.
- **Facial expression.** Showing emotion varies by culture from very expressive to very passive.
- **Body language.** The position, gestures, and motion of the body can be interpreted differently depending on culture. The use of hands is a common vehicle for nonverbal expression. A firm handshake may be a positive gesture of goodwill in some cultures while others prefer only a light touch or no handshake at all. Standing with hands on hips may imply anger to some

clients and dominance to others. Pointing or beckoning with a finger may appear disrespectful.

How can you set people at ease? Conservative use of body language is wise when you are uncertain as to what is appropriate within a cultural group or with an individual. Observing the client's actions and interactions can give you clues. Being open with clients and asking general questions about body language can also help.

**Verbal Communication.** *How* we speak is always as important as *what* we say.

- **Making yourself understood.** Many of us have found ourselves speaking louder to a person who has little understanding of English, as if volume will solve the problem. We probably do this unwittingly, making things very uncomfortable for the other person!
- **Formality.** Seniors and people from certain cultures view being addressed by their first name as too familiar and inferring disrespect. Asking how someone prefers to be addressed is the easiest solution. When in doubt, we can start with the more formal address (“Mrs. Hampstead”) until the client asks us to use the more familiar form (“Oh, please call me Sandy.”)
- **Slang and technical jargon.** Although people sometimes use slang to make their communication seem “friendlier,” it can be very confusing to those without a strong English vocabulary. Medical and other technical terms increase efficiency between trained professionals but will not help most community members.

Cultural competency is a useful tool to build effective relationships with clients so that they receive the best care possible. It is also a dynamic tool: we can always learn more about *other* cultures, their value systems, beliefs, and behaviors — as well as *our own*.