CULTURAL COMPETENCE:
Resources

National Center for Cultural Competence at the Georgetown University Child Development Center [http://gucdc.georgetown.edu/nccc/cultural.html](http://gucdc.georgetown.edu/nccc/cultural.html) An MCHB-funded center that provides training, technical assistance and consultation; networking, linkages and information exchange; and knowledge and product development and dissemination. The website includes a variety of documents (including those cited below), resources (including self-assessment checklists for individuals, programs and agencies), and links to other organizations.


The Cultural Competence Exchange Newsletter

Center for Cross-Cultural Health ([http://www.crosshealth.com/](http://www.crosshealth.com/)) is a non-profit group that provides information to health care providers in Minnesota and nationwide. The center is a clearinghouse and source of information, training, and research on the role of culture in health. Publications include those listed below:

**Caring Across Cultures: The Providers Guide to Cross-cultural Health Care, 2nd edition.** A resource guide for providers concerned about cultural competence. It includes chapters on developing cultural competence, communication across cultures, and issues in interpreting, cross-cultural mental health, spirituality and health across cultures, tools and health models, and community profiles of groups in Minnesota. $27.50 plus shipping.

**Six Steps Toward Cultural Competence.** This is a report of the Minnesota Public Health Association’s Immigrant Health Task Force and is intended to assist health care professionals, consumers, administrators, scholars, and policy makers become more culturally competent.
Cross-Cultural Health Care Program: [http://www.xculture.org](http://www.xculture.org). This program is a clearinghouse and source of information, training, and research on the role of culture in health. Training in cultural competence is offered, and the group maintains a library in Seattle. Publications include those listed below:

**CCHCP’s Community Profile Series**, a description of the history, culture and beliefs of various ethnic communities in the US, including Cambodian, Chinese, Filipino, Hmong, Japanese, Lao, and Vietnamese.

**Medical Glossaries: Expanded**, a word list of 2100, translated by teams of bilingual professionals to English from Amharic, Somali, Spanish, Tigrinia, and Vietnamese.

**Websites**
Association of Asian Pacific Community Health Organizations [http://www.aapcho.org](http://www.aapcho.org)
Indian Health Services [www.his.gov](http://www.his.gov)
Latino Link Home Page [www.latinolink.com](http://www.latinolink.com)
Minority Health Network [www.pitt.edu](http://www.pitt.edu)
The National Center for Cultural Healing [www.cultural-healing.com](http://www.cultural-healing.com)
Native American Voices [www.umc.org/naco](http://www.umc.org/naco)
Naturally Native Production [www.umc.org/naco/redhorse.htm](http://www.umc.org/naco/redhorse.htm)
Office of Minority Health [www.os.dhhs.gov/proorg/ophs/omh](http://www.os.dhhs.gov/proorg/ophs/omh)
Resources for Diversity [www.nova.edu/interLink/diversity.html](http://www.nova.edu/interLink/diversity.html)
The Texas Cancer Council [www.tdcd.mdacc](http://www.tdcd.mdacc) (guidebooks on written and video materials for both African-Americans and Hispanics are available on-line).
The Universal Black Pages [www.gatech.edu/bgsa/blackpages.html](http://www.gatech.edu/bgsa/blackpages.html)

Taken from: Writing and Designing Print Materials for Beneficiaries: A guide for state Medicaid agencies. US DHHS, HCFA, October 1999.
CULTURAL COMPETENCE: Definitions

What is culture?

Culture is a group’s preferred way of perceiving, judging, and organizing the ideas, situations, and events they encounter in their daily lives (Cushner, 1996; based on Maehr, 1974)

What is cultural competence?

Cultural competence begins with awareness of your own taken-for-granted cultural beliefs and practices, and recognition that people from other cultures may not share them.

Thus, it means more than speaking another language or recognizing the cultural icons of a people. It means changing any prejudices or biases you may have of a people’s cultural beliefs and customs.

What is the difference between a stereotype and a generalization?

Stereotype: I assume that Mexicans have large families. I meet Rosa, and I assume that she has a large family because she is Mexican.

Generalization: I think that Mexicans often have large families. I meet Rosa, and I wonder if she has a large family.

“A stereotype is an ending point. No attempt is made to learn whether the individual in question fits the statement. Stereotyping patients can have negative results.” (Galanti, 1977)

Progress toward cultural competence

<p>| Ignorant, insensitive, culturally self-centered | Culturally competent |
| Lacking in awareness of and knowledge about cultural differences and their impact on health-related attitudes and behaviors | Aware of and knowledgeable about cultural differences and their impact on health-related attitudes and behaviors |
| “ethnocentric” view that your own culture is best | Sensitive, understanding, non-judgmental, and respectful in dealings with people whose culture is different from your own |
| Threatened by of defensive about cultural differences | Flexible and skillful in responding and adapting to different cultural contexts and circumstances |</p>
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<th>Concept or practice</th>
<th>World view of Western medicine (or Anglo-American culture)</th>
<th>Examples of other world views from different cultures</th>
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| Beliefs about the cause of the illness | Consistent with the Anglo-American value of emphasis on scientific reasoning, Western medicine tends to emphasize biological explanations (such as bacteria, viruses) or environmental causes. | Three main types of beliefs about cause of illness are found in other cultures:  
  - *Natural:* such as illness caused by damp cold, or among the Chinese, the yin and yang being out of balance  
  - *Supernatural:* illness is caused by someone (or thing or spirit) that is angry with you and puts hexes/curses/fixes on you. It can be caused by breaking a taboo  
  - *Religious/spiritual:* illness caused by thinking or doing evil, not praying enough, not having faith, lying, cheating, or not respecting your elders or spiritual leaders. |
| Beliefs about appropriate treatment | Consistent with a scientific approach, Western medicine emphasizes pharmaceutical and surgical approaches to treatment, and preventive care | Many cultures rely on traditional healers, herbal remedies, massage, acupuncture, spiritual rites, and many other remedies that are referred to as “alternative” from the perspective of conventional Western medicine.  
  Hmong culture strongly prizes the integrity of the physical body, believing that body parts which are cut or mutilated in accidents, surgery, or autopsy will remain that way when a person is reincarnated. |
| Beliefs about the role of the patient and how new decisions are made | Consistent with Anglo-American values that emphasize individualism and the nuclear family, Western medicine expects patients to make their own decisions about their care | In many cultures, extended families and community elders play an important role in decision making about the health care of individuals.  
  For example, when a Hmong person becomes ill, a clan elder, father, older brother, uncle, in-laws, shaman, and even the wider community may become involved in the decision making, especially in times of crisis or emergency. |
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<td>Assumptions about the meanings of non-verbal communication</td>
<td>Providers with limited knowledge of other cultures may assume that a patient who doesn’t make eye contact is expressing dislike, mistrust, or isn’t listening, and that a smile expresses friendliness.</td>
<td>People in many cultures, including many Hispanic/Latino and Asian cultures, are trained to avoid eye contact with authority figures such as physicians as a sign of respect. In East Africa, it is impolite for a Nuer woman to make eye contact with someone outside the family. Thus, during discussion, it may appear (to an Anglo-American) that women are not paying attention. Since health care providers in the Soviet Union did not smile as much as American providers, some Ukrainian and Russian Jewish immigrant patients may interpret frequent smiling by a provider as taking illness too lightly.</td>
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<td>Assumptions about shared meaning of everyday household objects and cultural symbols</td>
<td>Providers may be unaware of cross-cultural differences in the nature and meaning of familiar objects.</td>
<td>A Laotian patient at a rural California clinic is told to give her child one teaspoon of medicine every four hours. The only spoon in her house is a porcelain soup spoon; the medicine runs out long before the prescribed 10 days. A Thai patient speaks to an intake worker who takes notes in red ink. The patient is alarmed because in Thailand red ink is only used in criminal proceedings.</td>
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“In the end, strategies are all any Guide can offer. No one can learn the cultural details of every group, nor write documents that address every cultural nuance.

The social diversity in our country, the diversity within social, racial, and ethnic populations themselves, and the diversity among individuals in those populations make no advice fool proof, no formulas absolute.

Becoming culturally-competent is an ongoing process of learning for all of us, and given the continuing changes in American society, it appears that the process will never end.”

Reference
Writing and Designing Print Materials for Beneficiaries: A guide for state Medicaid agencies. US DHHS, HCFA, October 1999.
Promoting Cultural Diversity and Cultural Competency
Self-Assessment Checklist for Personnel Providing Services and Supports to Children with Special Health Care Needs and their Families

This checklist is intended to heighten the awareness and sensitivity of personnel to the importance of cultural diversity and cultural competence in human service settings. It provides concrete examples of the kinds of values and practices which foster such an environment.

Select A, B, or C for each item listed below.

A = Things I do frequently
B = Things I do occasionally
C = Things I do rarely or never

Physical environment, materials and resources

1. I display pictures, posters and other materials which reflect the cultures and ethnic backgrounds of children and families served by my program or agency.

2. I insure that magazines, brochures and other printed materials in reception area are of interest to and reflect the different cultures of children and families served by my program or agency.

3. When using videos, film or other media resources for health education, treatment or other interventions, I insure that they reflect the cultures of children and families served by my program or agency.

4. When using food during an assessment, I insure that meals provided include foods that are unique to the cultural and ethnic backgrounds of children and families served by my program or agency.

5. I insure that toys and other play accessories in reception areas and those which are used during assessment are representative of the various cultural and ethnic groups within the local community and society in general.

Communication Styles

6. For children who speak languages or dialects other than English, I attempt to learn and use key words in their language so that I am better able to communicate with them during assessment, treatment or other interventions.

7. I attempt to determine any familial colloquialisms used by children and families that may have an impact on assessment, treatment or other interventions.

8. I use visual aids, gestures and physical prompts in my interactions with children who have limited English proficiency.

9. I use bilingual staff or trained volunteers to serve as interpreters during assessment, meetings or other events for parents who would require this level of assistance.
10. When interacting with parents who have limited English proficiency, I always keep in mind that:

- limitations in English proficiency is in no way a reflection of their level of intellectual functioning
- their limited ability to speak the language of the dominant culture has no bearing on their ability to communicate effectively in their language or origin
- they may or may not be literate in their language of origin or English

11. When possible, I insure that all notices and communiques to parents are written in their language of origin.

12. I understand that it may be necessary to use alternatives to written communications for some families, as word of mouth may be a preferred method of receiving information.

Values and Attitudes

13. I avoid imposing values that may conflict or be inconsistent with those of cultures or ethnic groups other than my own.

14. In group therapy or treatment situations, I discourage children from using racial and ethnic slurs by helping them understand that certain words can hurt others.

15. I screen books, movies and other media resources for negative cultural, ethnic or racial stereotypes before sharing them with children and their families served by my agency.

16. I intervene in an appropriate manner when I observe other staff or families within my agency or program engaging in behaviors that show cultural insensitivity or prejudice.

17. I understand and accept that family is defined differently by different cultures (e.g., extended family members, fictive kin, godparents).

18. I recognize and accept that individuals from culturally diverse backgrounds may desire varying degrees of acculturation into the dominant culture.

19. I accept and respect that male-female roles in families may vary significantly among different cultures (e.g., who makes major decisions for the family, play and social interactions expected of male and female children).

20. I understand that age and life cycle factors must be considered in interactions with individuals and families (e.g., high value placed on the decisions of elders or the role of the eldest male in families).

21. Even though my professional or moral viewpoints may differ, I accept the family/parents as the ultimate decision-makers for services and supports for their children.

22. I recognize that the meaning or value of medical treatment and health education may vary greatly among cultures.

23. I accept that religion and other beliefs may influence how families respond to illness, disease and death.
24. I recognize and accept that folk and religious beliefs may influence a family's reaction and approach to a child born with a disability or later diagnosed with a disability or special health care need.

25. I understand that traditional approaches to disciplining children are influenced by culture.

26. I understand that families from different cultures will have different expectations of their children for acquiring toileting, dressing, feeding and other self-help skills.

27. I accept and respect that customs and beliefs about food, its value, preparation and use are different from culture to culture.

28. Before visiting or providing services in the home setting, I seek information on acceptable behaviors, courtesies, customs and expectations which are specific to families of specific cultures and ethnic groups served by my program or agency.

29. I see information from family members or other key community informants, which will assist in service adaptation to respond to the needs and preferences of culturally and ethnically diverse children and families served by my program or agency.

30. I advocate for the review of my program’s or agency’s mission statement, goals, policies and procedures to insure that they incorporate principles and practices that promote cultural diversity and cultural competence.

There is no answer key with correct responses. However, if you frequently responded “c,” you may not necessarily demonstrate values and engage in practices that promote a culturally-diverse and culturally-competent service delivery system for children and families.


This self-assessment tool is available on the Internet: http://gucdc.georgetown.edu/nccc/cultural.html