

BEYOND LANGUAGE:
PUBLIC HEALTH AND 'CULTURAL COMPETENCY'

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My path to public health has been non-traditional, and in many ways I have medical anthropology to thank for that. After completing a Bachelor's degree in Anthropology from The College of Wooster (U.S.A.), where I undertook an independent thesis on the perceptions of HIV/AIDS in Japan and the USA, I landed a job in the divisive and emotional realm of American health policy. Here I quickly made the observation that many public policy decisions regarding 'health' are more often focused on saving money than on promoting or protecting health. I then went on to complete the MPhil in Medical Anthropology between 2007 and 2009. While at Oxford, my research focus was on tuberculosis (TB) policy among Australian Aboriginal and Torres Strait islander peoples and the influence that place and space, ethnomedicine, and a political-ecologic setting had on these policies (Graff 2009). Through this work my interests moved away from national health policy and towards an application of medical anthropological theories to international public health. Formerly the Policy Development Associate at the Trust for America's Health in Washington, DC, I am currently the Senior Policy Researcher at the UK Health Forum and studying for a Doctorate in Public Health at the London School of Hygiene and Tropical Medicine. Today my interests within public health include the influence of place and space on health and disease prevention, and the social determinants of health, health inequalities and cultural competency.

Ongoing attempts are being made to bring 'cultural competency' into public health, a field that prioritizes specific forms of evidence and best practice. Broadly speaking, 'cultural competency' in United States public health refers to the extent to which researchers, practitioners and organizations have the necessary skills, knowledge, attitudes and policies to work effectively in cross-cultural settings and situations (Gibbs et al. 2008). A simple example is the practice of having translators or multi-lingual public-health workers present during interventions. We expect the evidenced-based paradigm to continue to dominate public-health decision-making, and as proponents of globalization and development address growing rates of non-communicable diseases (NCDs), on top of the infectious disease burdens that are already present, global public health must continue to gain a better

understanding of socio-cultural complexities and must embrace them more. Simply speaking, equating ‘cultural competency’ with simply using the same language will not do.

In this commentary, I take ‘cultural competency’ to mean knowledge about, and humility towards, a given population or community. This knowledge goes beyond speaking their language to consider the political, economic and historical contexts, religious and social organization, kinship patterns, and geographical and environmental settings, both natural and built. These are areas around which public health has historically found itself uncomfortable, and as Sarah Willen and Elizabeth Carpenter-Song (2013: 244) point out in their introduction to a recent special issue of *Culture, Medicine and Psychiatry*, “‘culture’ is often deployed as either a euphemism or an empty category. Sometimes it is thrown around without any clear definition, operational or otherwise’. Furthermore, the term ‘cultural competency’ presents challenges in assuming both that culture can be fully understood from an outsider’s perspective, and that ‘a culture’ with stagnant and definable parameters can be assigned to a clearly defined ‘community’. As will become evident later in this paper, the definition of community identity can be debated even within what appears on the surface to be a homogenous group.

As Willen and Carpenter-Song (2013) also acknowledge, it is easy for anthropologists to criticize advocates of cultural competency. Building on the cultural relativist tradition of Franz Boas, the concept requires and deserves further unpacking to define cultural knowledge more holistically beyond ethnic group or geographical region. Public health is bound by its intentions and, just like any other societal agency, must be analysed as such. Mariella Pandolfi (2003), in her work on global humanitarian efforts, makes the point that actions are legitimized by socially sanctioned intentions. Public health is legitimized by its intention to protect the health of the population, and the incorporation of ‘cultural competency’ could be interpreted as a means of better achieving that intention.

Public health, while classically focused on protection from and the prevention of disease, has grown as a discipline to encompass the ‘upstream’ structural and societal drivers of health and well-being. A flexible mechanism for cultural understanding within public health is needed to inform the growing number of prevention-oriented policies and interventions. This is in part due to the growing burden of non-communicable diseases and their socio-structural drivers, a good example of the extent to which medical phenomena are also social phenomena. There is value in ‘broadening the dialogue to consider how issues of culture, difference, and inequality are, and could be, taken up by [public health]’ (Willen and Carpenter-Song 2013: 243). Through a collaborative process involving stakeholders at all levels, public health policy has the potential to produce greater dialogue, greater cultural awareness and thus more effective interventions.

In observing and being part of proceedings at the Trust for America’s Health (TFAH), a non-profit public health organization based in Washington, DC, there were many times when my background in medical anthropology was apparent, in particular my learned ability to think beyond the biomedical and evidenced-based parameters of public health. Having the ability to think critically about the impact of policy measures, especially with an understanding of the interaction between biology and culture, fuelled questions that are not always asked by others. For example: How will this policy measure be perceived by the community? Will it be ‘understood’ in the same way as we envision it? What might the unintended consequences be of a particular policy? What is considered ‘evidence’?

In this article, I present a critical consideration of ‘cultural competency’ in the context of both public health policy and anthropology, showing how medical anthropology can appraise and inform the public health discourse on the concept. I have observed the influence that anthropological theory and method can have on the development of public health policy. Despite the anthropologically perceived naivety of ‘cultural competency’ as both a term and a

concept, I follow Kirmayer (2012: 149) in noting that ‘conceptual analysis and critique of cultural competence can point toward ways to improve the cultural responsiveness, appropriateness, and effectiveness’ of public health. In particular, I will describe my experience of working across the boundaries of anthropology and policy, and outline a potentially effective device for developing more appropriate public health policies. Based on observations made during active participation in the development of policy recommendations for HIV prevention, I saw a process of ‘cultural competence’ in the making that went beyond shared language and acknowledged community complexities.

Convenings

In many ways the development of policy has great flexibility to explore new routes for coming to policy conclusions and interventions. Having expertise in relation to both political climates (in this example, the inner workings of Washington, DC) and population health fundamentals is crucial to understanding how the process works. I made observations of a progressive approach to policy development while working at the Trust for America’s Health (TFAH) on a recommendation process for Community Transformation Grants (CTGs) administered by the US Centers for Disease Control and Prevention (CDC). The aim of these grants is to set up an interface between prevention, community and cultural knowledge in order to transform the health of communities over time. They are awarded to towns, cities, counties and states that demonstrate collaborative work across sectors and creative ideas for tackling disease prevention and health inequalities (CDC 2013).

My thinking around this particular intersection of policy, anthropology and culture began while working in policy development and research for TFAH, an organization ‘dedicated to saving lives by protecting the health of every community and working to make disease prevention a national priority’ (TFAH 2013). Since early 2009, one of the main focus

areas of the organization has been the Patient Protection and Affordable Care Act (ACA) or ‘Obamacare’, as is now often referred to by friends and critics alike. This new health-care law contains significant amounts of federal funding for prevention and public health, which is why TFAH was involved in its implementation.

While at TFAH, a main area of focus for me was the ACA, including the Community Transformation Grants (CTGs) and the National Prevention Strategy, and specifically a project on HIV/AIDS prevention for gay and bisexual men and other men who have sex with men. I served as researcher and project manager on a series of collaborative recommendation processes, primarily focused on the CTGs and the HIV/AIDS project. Through a convening process developed by TFAH, our role was to serve as translators of policy need into policy action, from the stakeholders to the policy-makers.

Viewed from my perspective as ‘mini-ethnographies’ or field sessions, these facilitated convenings gathered a diverse, yet small group of community members and experts – usually no more than 15-30 people – in a relaxed and trusted environment. These sessions, which were usually run more than once per subject or project, opened doors into specific communities and allowed for many perspectives and members of these communities to tell their stories.

The convenings were always facilitated, which allowed for a more structured approach and assured movement through a discussion. It also allowed for the convening organization (in this case TFAH) to participate at appropriate times in the discussion as it laid the groundwork for policy outlines. At the time of my work with TFAH, convenings were always run by an outside, professional facilitator with an understanding of public health. The presence of an impartial facilitator served to moderate bias and influence from within the communities involved, with the aim of equalizing the discussion.

I will now explore in more detail the recommendation process for HIV/AIDS prevention for gay and bisexual men and other men who have sex with men. This two-phased project began in 2010 in partnership with the Foundation for AIDS Research (amfAR) and was funded by the MAC AIDS Fund. The initial goal of the project was to look beyond current clinical prevention methods to policy and structural changes, which would allow for this population to make healthier choices more easily and reduce risk-taking behaviours.

Community, consensus, and 'cultural competency': the HIV/AIDS prevention paradigm

Before discussion on community-identified need could really begin, a term and definition to describe the specific community had to be established, for ease of communication if nothing else. The term 'Men who have sex with men' or MSM (CDC 2010) was initially used to describe all gay, bisexual, and other men who have sex with men (i.e. men on the 'down low',¹ the incarcerated, etc.). Throughout the discussion during the first convening on this topic, it became clear that the majority of men in this population identify as simply gay or bisexual, and that in their minds this includes the majority of men who have sex with men. The term 'Gay and bisexual men' was then adopted to be the defining label of the population. However, after yet further discussion, there was concern that non-gay-identifying men who are having sex with men, who do not fall under this label, but who engage in some of the same risk behaviours – would inadvertently be excluded from policy directed towards them. At the time of the recommendation development, therefore, the label 'Gay, bisexual and other men who have sex with men' ultimately became the term of choice. For the purposes of this paper and ease of reading, however, this population will be identified from this point on as 'MSM'.

¹ 'Down-low' is an African American slang term that refers to a subculture of men who usually identify as heterosexual, but who have sex with men (Green 2006).

As illustrated, ‘community’ – much like ‘cultural competency’ – became both a concept and a subject in this process. Understood by many cultural anthropologists as structured groups of people, communities are where standards and norms are socially learned rather than biologically acquired (Haviland et al. 2011). At the time, TFAH defined communities both geographically and demographically. Geographical communities referred to a specific built or environmental community, town, city or region. Demographic communities, on the other hand, were defined as a specific population not necessarily defined by geographical boundaries, for instance women, people with disabilities, Latinos, etc. As with ‘cultural competency’, we encounter tension between disciplines and terminology. Public health and policy both require the means to compartmentalize sub-sections of a population to manageably inform their work. Anthropology, on the other hand, while acknowledging the cultural development and social need for ‘community’, provides the tools needed to dissect the complexity of labels in everyday life.

Through these broad and multi-dimensional perspectives on community, TFAH approached policy development more holistically than simply consulting with academic and government stakeholders. The guided discussions of various community members, with representation from diverse ‘expert stakeholders’ (academic, professional, community-based, etc.), often developed ‘consensus’ recommendations. Consensus is used loosely in this instance because there is very rarely 100% agreement within any community, and the realities of politics and bureaucracy have to be taken into account to achieve any policy change. However, TFAH made a strong effort to ensure that every participant saw something of their input in the recommendations.

The previous example illustrates how unclear the boundaries are for any community and how concepts and terminology in one community can mean something entirely different in another. For the HIV prevention discussions, the MSM community was represented by

participants from various sectors of the population: academics, community-based organizations (CBOs), US government agencies including the CDC, White House and National Institutes of Health, religious groups, educational and advocacy organizations, and MSM who were both HIV-negative and HIV-positive, representing multiple age-groups, ethnicities and socio-economic sectors. While in no way a complete picture of this multi-dimensional community, the collection around the table did have representatives who were not always engaged in policy development.

The one-day meeting for phase one of this project took place at a central Washington, DC hotel in a basement-level meeting room. As is common for these spaces in the US, there were no windows and a monotone colour palate – beige carpet, beige chairs, beige walls and beige table clothes. A flipchart was positioned in the corner. The discussion began with the group's acknowledgement that the United States needs a new framework for HIV prevention among MSM, one that looked beyond clinical prevention. The day focused on the environmental and social-structural changes that could be made. Sitting around a large 'open square' meeting table were representatives from the White House and the CDC together with top academic researchers (social scientists and epidemiologists), who sat between leaders from national HIV/AIDS and LGBT charity and advocacy organizations. Demographic and faith-specific community groups were there too. I was one of perhaps five or six women out of approximately thirty participants, and as a staff member I sat quietly at one corner of the table recording the day on a laptop. After brief introductions to the incidence and disease burden evidence from the CDC and academic researchers, the discussion – with the light-touch guidance of the facilitator – moved to the potential for policy to promote positive behaviour change, the cultural influences both within and outside the community that have an impact on prevention, and the barriers to clinical prevention that many MSM face.

The participants were invited to attend with the understanding that these were closed-door discussions, that no identity would be assigned to comments (similar to the UK's Chatham House Rule²), and that the public summary of the day would be reviewed by all participants prior to being shared with a wider audience. The goal from our perspective as the facilitating organization was to foster free and uninhibited conversation. To our surprise, there were a number of points where colleagues from within the same fields disagreed, for example, the use of the MSM population descriptor as illustrated earlier, and the prevalence of 'down-low' activity among African-American men. Discussion was often heated and passionate; the facilitator rarely, if at all, needed to encourage someone to speak.

Following the day, my colleagues and I sat down and, in a process not dissimilar to a qualitative review of ethnographic interviews, began to extract themes and key points from the discussion. A variety of specific policy recommendations that could be implemented through local, state and federal measures, including the CTGs and the National HIV/AIDS Prevention Strategy, took shape. Examples of these recommendations included:

- Changing the risk environment and community viral load³ for MSM, for example, through HIV screening standards: *all* MSM, even those who fall in traditionally 'non-risky' demographic groups, should be tested for HIV on a regular basis.
- An acknowledgement, written into legislation and regulations, of the need for flexible policies based on the diversity of MSM communities – ethnicity, age, and access to health coverage, for example.

² Chatham House Rule states: 'When a meeting, or part thereof, is held under the Chatham House Rule, participants are free to use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed' (Chatham House 2013).

³ Community viral load refers to the level of virus circulating within a neighborhood or social network, which has an important impact on the likelihood that a single episode of sexual behavior will result in HIV infection (TFAH and amfAR 2011).

- The elimination of anti-gay ballot measures, i.e. social legislation and institutional discrimination with a direct impact on the lives of MSM. This could include legalizing gay marriage, anti-bullying campaigns in schools, decriminalization of HIV and so forth.

These recommendations were later developed into an issue brief that was then used as the stepping-off point for the second phase of this project (TFAH and amfAR 2011). The second phase further expanded the understanding of HIV prevention for MSM, including how to link new biomedical research with the complexities of real life. For example, in 2011 a study was published citing HIV treatment as an effective prevention method (HPTN 2011). The study found that immediate anti-retroviral treatment (ART) for HIV-positive individuals led to a 96% reduction in HIV transmission among discordant couples (i.e., where one person is HIV-positive and one is HIV-negative). The idea of adapting this new evidence through ‘cultural competence’ thinking to have a positive impact on health through structural, environmental and behavioural changes is an example which takes us back to the tension between the desire to ‘appropriately do good’ and the honest critique of this intent by anthropologists. In a continued stride towards structural changes to tackle deep inequalities and implementing effective interventions, public health policy-makers, academics (including anthropologists) and community members will themselves have to think actively about how additions to the evidence base can shift the structural and cultural landscape of HIV prevention.⁴

⁴ As of December 2013, through the CTGs \$70 million have been awarded to forty communities across the US, and new HIV prevention measures are being implemented through the National HIV/AIDS Prevention Strategy.

Medical anthropology and public health

The concept of ‘cultural competency’ in public health is well intentioned but perhaps requires some critical self-awareness. As I have observed, there are ways in which public-health policy development can strive to incorporate cultural ‘lay knowledge’ into the evidence base. While in no way a silver bullet for improving the quality of understanding about culture in public health, consensus-building processes that incorporate *actual* members of a given community have shown that they can move the policy discussion forward towards the implementation of regulations and programs that are national and regional in nature but that also allow for cultural and community complexities, a move that is especially important in a country as large and diverse as the United States. These assertions regarding the validity of this method for improved public-health policy development come from my singular observations: further engagement within multiple disciplines should be undertaken to better understand the role and impact of collaborative ‘cultural competency’ mechanisms in public health and public health policy. Further research could also illuminate the role for anthropology in both critiquing and assisting public health efforts, as well as in assessing the perceived value of ‘cultural competency’ within and between disciplines.

Understandably anthropology, and specifically medical anthropology, may want to remain on the threshold with public health, as it does with other closely linked disciplines (Fassin 2011). If public health is legitimized by its actions to improve and protect health, then anthropology is legitimized by its actions to observe; whether or not these actions are for the ‘good of humanity’ remains in the individual anthropologist’s hands (Fassin and Stoczkowski 2008, Caduff 2011). ‘Cultural competency’ as a means for improving population health may breach the comfort zone of medical anthropology. If anthropologists do not engage, however, who will? As Fassin polemically puts it, scientists deal with questions and answers, whereas ‘...sociologists, anthropologists, historians deal with complex and impure situations –

because this is the reality of human life and social action' (Fassin 2012). We often take for granted the language we use and the concepts that drive our work, but it is time to move beyond language in order to tackle the complex, impure situations of human health collaboratively.

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